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Stress. How many times a day do we say or hear someone say, “I’m so stressed,” or we turn on the news to stories about how stress is affecting our lives?

Because this important and timely topic, “Stress in the 21st Century: Promoting Health and Resilience,” is the theme for this issue of The Ohio Psychologist and also serves as the theme for the 2006 Ohio Psychological Association Convention October 25-27, 2006. Understanding how people cope with stress and learning how to apply this knowledge to promote health and resilience is a worthy goal for psychologists to pursue in our efforts to improve the human condition.

Most of the articles attempt to either describe the types of factors or characteristics that help answer the question “What makes people resilient to stress?” or offer ideas about what actions can help people cope with, persevere, and overcome stress under even extraordinary circumstances. While most authors take a research-based approach, others draw on their own personal experiences.

Articles in the issue touch on how technology can create stress in our lives (Dr. Lou Sauer), ways to reduce stress from using cell phones (Drs. Craig and Fiona Travis), and identification of common stressors experienced by psychology graduate students (Cynthia A. Yamokoski-Maynhart). Drs. Lisa Stines and Norah Feeney explore the use of exposure-based treatment of post-traumatic stress disorder (PTSD), while Christine Agaibi defines the concept of resilience. Dr. Amy Burleson looks at the relationship of sports participation and coping with stress. A highly personal account by Dr. Kathy Platoni graphically describes the intensity of daily life in a military war zone. Another personal piece by Devon Cummings focuses on resilience factors of a minority group with criminal justice experience. Also included in this issue are research pieces by the 2005 OPA Student Poster Session Winners, Barbara Beimesch and Candace Allen-Staten.

I want to thank the authors who submitted articles for this issue and our new panel of reviewers, William Bauer, PhD, Milton E. Becknell, PhD, Charles D. Dolph, PhD, Michael Dwyer, PhD, Elizabeth Swenson, PhD, JD, Janette E. McDonald, PhD, and Richard M. Ashbrook, PhD, who gave their time and effort in reviewing articles.

—Kenneth P. Drude, PhD
Abstract
Resilience is an important concept in today’s world of natural and man made stresses. Understanding what resilience means also is important for conceptualizing and applying it to individuals who have encountered stresses. Though there are many definitions in scientific and nonscientific literature that are applied to the concept of resilience, this article offers a comprehensive definition of resilience after review of the literature. Examples of resilient individuals are given from Holocaust and war survivors, as well as at-risk children to provide hope for those undergoing stress in addition to determining the facets of resilience to assist these individuals.

On September 14, 2005, “The Washington Post” told the story of 86-year-old Katrina victim Pearline Chambers. The “Post” stated, “She spent two days alone in her one-story house in the submerged Ninth Ward of New Orleans, with hurricane floodwater up to her neck. She lost her false teeth, her wig and her cats…After she was rescued—two men floating by on a board heard her screams—she spent two more semiconscious days in the city, struggling to walk, severely dehydrated and hungry. As she recalled, ‘I didn’t know where I was. I laid somewhere, I’m not sure where, and people walked around me.’” The “Post,” however, also declared that two weeks after Katrina, Chambers felt fine emotionally and physically and moved to live with her sister’s family in northern Louisiana (Harden, 2005).

Chambers story is one of many from individuals that have experienced difficulty. In fact, only five years and a few months into a new century the world has already seen many calamities. News about natural disasters, terror attacks, and war has been broadcasted on various media forms all over the world. Even beyond this there are global disasters such as crime, domestic violence, poverty, abuse, disease, accidents, and occupational stressors in our communities virtually every day. It is sometimes a mystery how survival is accomplished and daily tasks are completed without feeling disheartened or discouraged. Though the vast majority of individuals seem to gather and maintain the strength to cope and take control of life, there are some for which this is difficult. Understanding resilience from a model of those who have used it under the most difficult of circumstances can help individuals to tap into its characteristics and then employ them with current and future generations of individuals undergoing stress. This concept will be explored further in the coming sections.

Introduction: Use of Resilience Historically and Today
Friedrich Nietzsche once said, “That which does not kill us makes us stronger.” Even though Nietzsche recited this quote over a century ago, this phrase still speaks volumes today. It has become a common proverb of comfort for those who have encountered difficult times, and it is often recited by and to those who have suffered, proclaiming that ‘tomorrow is another day.’ It gives hope that difficult experiences can be overcome. The interesting question becomes understanding what gives one the proclivity to overcome trauma and stress. To accomplish that, this article looks briefly at defining resilience, and then it looks at how individuals undergoing difficult situations overcame those stresses and became resilient. Finally, potential themes offered by these individuals will be discussed so as to advocate for resilience in today’s trauma victims and assist those who have suffered severe catastrophes such as natural disasters (like Hurricane Katrina), terror attacks, war, and everyday stressors.

Definition of Resilience
Resilience has many definitions in the scientific and nonscientific literature. The “Oxford English Dictionary” defines resilience as “the capacity to recoil, rebound or springing back after a sort of compression or stressor.” A more comprehensive definition of resilience given by Bell (2001) better helps one to understand and conceptualize resilience and the resilient person from the perspective of the scientific literature. This definition states that resilience is: having curiosity and intellectual mastery, having compassion and the ability to detach and be independent, having the ability to conceptualize, having the assurance that one is to survive, having the ability to remember good and sustaining figures in one’s life, being able to deal with and not suppress affects that arise, having goals for which one lives, having the ability to invite and use support, desiring and seeing the possibility of reinstating
moral order, desiring to help others and obtaining the ability to do so, having an affective repertoire, being resourceful and imaginative regarding dealing with a problem, being altruistic towards others, turning from traumatic helplessness to learned helplessness. (Bell, 2001, p.375).

Looking for these characteristics in individuals who have overcome trauma is particularly important. A study by Waysman, Schwwarzwaldf & Solomon (2001) found that exploring an individual's hardiness as a moderating effect from the experience of a traumatic event can lead to long-term positive change and prevent pathology. Hardiness was found beneficial to those with stressful and traumatic experience such as war. In fact, hardiness was more pronounced in POWs than among combat controls.

Resilient Characteristics in Traumatized Children
Quota, El-Sarraj & Punamkai (2001) found that children can be resilient through the use of mental flexibility as a means of coping, and have an incredible ability to plan for the future while still keeping mind to present activities. Resilient children have been studied copiously in the literature and for the most part have been found able to reshape his/her environment and adapt to it. Rak & Patterson (1996) also looked at at-risk children and found that those who focused on ways in which coping occurred in the past in order to solve current problems were resilient. It was suggested that self-expression and modeling positive behaviors and healthy self-concept all lead to resilience.

Protective Factors and Resilient Characteristics in Individuals
Resilience is malleable by the experience. That is, in some people exposure to repeated trauma may increase resilience, while in other people it may erode resiliency away (Yehuda, 1998). Maes, Mylle, Delmeire, and Janca (2001) stated that there are several risk factors associated with the development (or lack thereof) of Posttraumatic stress disorder (PTSD). Pre-exposure risk depends on the quantity of multiple traumas in the past, history of psychiatric disorders, and/or specific personality traits such as introversion. Peri-traumatic risk encompasses the intensity and duration of exposure to the traumatic event, and the extent of loss of control or observations made during the traumatic event. Finally, post-traumatic risk involves the extent of physical injury or other harm which resulted from being present during a traumatic event. Maes et al. stated that the greater the severity of each of these risk areas, the greater the chance for PTSD.

Though attention should be paid to the severity of pre, peri, and post morbidity risk factors, it is important to note that protective factors also play a role in the development of resilience (as opposed to PTSD). While risk factors include stressors, environmental changes, family conflicts, emotional disorders, and losses in family or peers, protective factors allow the individual experiencing the stressor to avoid the effects of the trauma. Garnezy, (1991) finds protective factors to be a modification of stressful events through use of internal temperment, the ability to reflect/deflect the situation, the use of cognitive skills to better understand the situation, and through having an overall positive responsiveness to the event.

In this regard, even survivors of such dismal environments as the Holocaust have been found to be resilient individuals. Though suffering through appalling conditions, death, starvation, torture, abuse, isolation, and annihilation of their race, Holocaust survivors, like Viktor Frankl (1946) survived and spoke of experiences as a way to find meaning. It has been depicted that resilient individuals develop meaning, understanding, love, and empathy as well as personal strength to sustain them. Similar to the at-risk children just discussed, these survivors seem to cope by telling stories of endurance, resilience and adaptability to situations as ways of depicting and announcing their continued existence.

If individuals that survived horrific events, such as war, or the Holocaust, or even an at-risk childhood, are able to be resilient from trauma, then what can be learned from those individuals that can be applied to today's traumas? The next section will explore this further.

Promoting Resilience in the 21st Century: General and Specific Strategies
In a review of an article by Agaibi and Wilson (2005) that focuses on a multidimensional model to overcoming trauma, the literature, as well as personal clinical work with clients who have experienced difficult events, it was determined that many characteristics can be found that are important for resilience. For example, social support, having adaptive mechanisms and mental flexibility, as well as perseverance and hope, are highlighted as important characteristics of the resilient individual.

Also remaining connected to others and to one's spirituality is important for resilience to develop because it helps one to develop a higher order of life meaning. Being emotionally expressive and having a positive outlook are also important. Having problem solving skills, creativity, and the ability to tap into one's past for solutions to similar problems are equally important. In addition, obvious necessities such as food, shelter, and water help to prevent future unnecessary strain.

Thus, a return to the initial question asks: how can victims of current and future disasters be taught resilience? First, the basics of food, shelter, and water need to be provided. Second, acquiring and fostering support from the community, family, religious/spiritual organizations, and mental health agencies need to be assembled. Drawing on client strengths and developing unique strategies to cope are also important.

Assessing the level of pre, peri, and post traumatic risk is necessary. Allowing clients to tell his/her story while empowering him/her by explaining that currently, he/she has the power to control memories
of the situation and he/she is now safe is helpful. Ascertaining what gives the client meaning and vision for the future and then working toward enhancing that is also essential. Teaching mental flexibility and adaptability over time to new situations through problem solving and coping techniques could also decrease trauma and as a result increase resilience not only for the short term, but for future scenarios as well.

Observation of clients in the literature and in practice showed many ways to promote resilience. Survivors of horrific events such as the Holocaust give hope that if these individuals can endure and still cope, so can victims of today’s tragedies. With a mixture of change in cognition, affect, social communication and support, as well as meeting the physical needs, individuals who experience today’s traumas as well as future traumas would be well on the way to establishing resilience.

**About the Author:** Christine E. Agaibi, MA, is currently a doctoral candidate in counseling psychology at The University of Akron. She received her bachelor’s degree in 1999 from John Carroll University and her master’s in clinical/counseling psychology in 2003 from Cleveland State University. Her professional and research interests are in the area of resilience, coping, child development, and posttraumatic growth. She has authored a literature review from her master’s thesis titled “Understanding Resilience to the Effects of Traumatic Stress.” She has also authored an article and co-authored a book chapter on related topics. She is a student affiliate member of the American Psychological Association, Teaching of Psychology (APA Division 2), the Society of Counseling Psychology (APA Division 17), Division of Theoretical and Philosophical Psychology (APA Division 24), Division of Women Psychology (APA Division 35), Religion and Psychology, (APA Division 36), and Division of Clinical Neuropsychology (APA Division 40), The Ohio Psychological Association (online student affiliate), the Cleveland Psychological Association, Psi Chi, and was past student representative (philanthropy division 2004-05) of her current university’s counseling psychology graduate student organization (CPGSO).

**References**


Regardless of the audience or the listener, those lessons originating in the wartime theater may offer broader applicability than expected. Central to this theme is the nature of relationships and the extraordinary ties that bind, forged by times of hardship and desperation through catastrophic life experiences. The universality of those necessary survivorship skills of war is a classroom like none other. To exist in subhuman conditions and confront the second reality that one’s untimely demise has an high probability, witness and reside in the basest of human conditions, and face the most adversarial, and despicable forms of human behavior, provides lessons few would elect to learn in this manner.

There are no elective courses in surviving this prehistoric entity we call war. As psychologists and clinicians, we are responsible for treating those suffering from painful afflictions of mind and mood and developing resources that will enable self-efficacy in coping with the burdens life has placed upon them. A critical factor frequently absent from this equation is the promotion of that desperate search to fill the void, discover some kind of value, meaning, and purpose which may lead to more complete lives of satisfaction and unrestrained joy. We must become skilled in promoting growth through trauma and adversity, and cultivate the development of survivorship skills. Tough triumph over hardship is hardly a novel concept; it is the nature of catastrophic life experiences, among them the tragic psychological blows rooted in wartime service, that necessitate specialized training and a greater and more far-reaching knowledge base. The prevalence of stress-related disorders stemming from combat exposure alone and the a number of soldiers whose psychological stability has been shaken and ravaged by indescribable acts, dictates this. At the least, we must become vigilant to the fact that no one comes home from war unscathed.

There is war in my own head. Those of us who served in support of Operations Enduring Freedom and Iraqi Freedom have set foot into rooms from which we may never leave. I have been most fortunate to have experienced total immersion into an unfathomable and bottomless well, where most Americans will thankfully never be forced to descend, and have lived the depth and breadth and horror of a war where the cowardly enemy, waits to slaughter and incinerate his victims with the most cunning of guerilla warfare tactics. The results are never less than gruesome.

Desert life encompassed the usual daily fare of employing plastic bags as toilets and carrying them to “poo burning” piles, dodging fire in both directions, and breathing airborne fecal matter for months on end. My favorite “dining facilities” (euphemistically speaking) were festooned with a myriad of skylights; a daily dosage of multiple mortar attacks that made mealtime an event most assuredly to be missed. Living on stale Cheerios and Fruit Loops was preferable to dying unceremoniously at the trough. Bedtime choices often times called for remaining awake until word of pending attacks had passed or to opt for sleeping in post-mortar attack rubble piles. Always with one eye open and likely bypassing a few sleep stages, the requisite sleeping position was now and again, bedding down with both M-16 A2 rifles and 9 MM Beretta sidearms on red (round in the chamber) lying next to us on our racks (Army cots), waiting to report to our assigned sectors of fire. Entertainment came from the supremely ridiculous and profane, raucous laughter at any cost, a saving grace from the agony and torment of living only two steps from hell.

I witnessed my first solider killed in action (KIA) early last spring during my first tour of duty in the Sunni Triangle of Death. In the midst of Blackhawk helicopters plummeting to earth, hoards of casualties were off-loaded onto litters at rapid velocity, blood splattering their body armor and pooling in their Kevlar helmets, skulls crushed and separated from spines by Improvised Explosive Devices (IEDs). We bowed our heads around his unzipped body bag to show reverence for the life taken and to honor the sacrifice, the loss of only a boy not many months past his high school graduation, every heart pounding with trepidation and dread at how many more would have to fall that day...and all the days to follow.

Bradley tanks, their fuel cells punctured by the latest and most lethal forms of insurgent technology, designed to explode upon impact, transformed crew compartments into crematoriums in a matter of seconds. These enormous track vehicles, reduced to the size of banquet tables, littered the desert landscape, a constant and grisly reminder in full view of war zone inhabitants. One prefers not to fathom death by such unbearable means and struggles to scrub these images from thoughts. The sounds of rockets, mortars, and small arms fire from every conceivable type of weapon tinged the atmosphere throughout the course of every waking hour, every sleepless night, rendering alarm clocks useless. Adrenaline rose proportionately with noise decibels, though dead silence was even more unsettling. Every crash or bang, even now, remains a potential mortar or rocket attack in our heads. More times than not, we continue to wrestle ourselves away from the temptation to “hit the dirt” and dive for cover, weeks and months after redeployment back to home. Riding the wave of chaos became an inescapable and longstanding way of life. We became engrossed in profound conversation with those hungering for a listening ear, only to witness their death scenes hours later and learn of their devastating internal blast injuries and amputations by mortar or rocket attacks. Too often, we fell victim to the incompetence of appalling leadership and came to blows with an enemy inside the gates, forcing the mission to take second
chair while clashing with those in the rear who have no clue as to the sweat and toil of the battlefield. Distraught became a routine state of mind. We attended far too many tear-staining memorial services. We customarily traveled in convoys comprised of up-armored Humvees, surrounded by an extraordinary degree of force protection and with gunners loaded for bear and laden with thousands of rounds in the turrets of each vehicle. One becomes accustomed to living in mind-numbing fear and panic, unable to gear down or de-escalate from the unceasing adrenalin rush long after redeployment home. The flight or fight reaction has yet failed to permit complete adaptation and readjustment to any manifestation of what was once, ordinary life in the states. What once yielded satisfaction and reward has become mundane. Whether infantryman or psychologist, this is the legacy of the soldier and the price to be paid, a cost that divides those who went to a war where garrison (more “civilized” military installations with an abundance of amenities) broke out and those who legitimately went to war. Even now, danger lurks everywhere. More than a few of us speculate about becoming less ill at ease with the comfort of cold steel at our sides. There is an unsettling infection of guilt at having left so many suffering souls behind, at not having fulfilled the mission or of guaranteed better outcomes to unremitting combat exposure and transport back to some sense of normalcy on the home front. Now comes the endless quest to discover what constitutes the “new normal,” given that normalcy was recently comprised of sustained attacks and loss of life, intense combat, relentless heat and sand, and the most unforgiving of living conditions imaginable. Given the choice, I would not relinquish the angst or the misery, a continuous plague upon our souls. These searing images have shaken and stunned me to my core, yet they are a gift of untold proportions and remarkable magnitude.

I can no longer reside in that clueless and protective bubble of ignorance, arrogantly proclaiming pride in my military service for having lived in the comfortable trappings of pools, fast food establishments, smoothie bars, and movie theaters. I wouldn’t trade the experience for anything.

The combat zone is no longer the most improbable place for psychologists to be implanted in the wartime theater, as facilitation of access to combat stress interventions far forward in the battlefield falls within the principles of combat stress doctrine. There is no longer a front line, a rear echelon, or anyplace to draw the imaginary line in the sand. It is the categorical truth that both the requirements and needs for support are greatest among those with the highest levels of exposure to combat and unquestionably, where the greatest impact can be made upon service members from all branches of the Armed Forces, regardless of military occupational specialty or location in the wartime theater. This is also where the most glaring lessons of the war are fostered.

There is far more to this story. There are ties that cement the soldier to brother and sister soldiers in times of hardship and catastrophe that will endure for a lifetime. It steers the soldier and sailor and airman and marine and “coastie” through incomparable devastation and wreckage. Like witnessing life through a telephoto lens, unless one has lived and breathed the enormity of such life-altering experiences, one cannot truly appreciate the darkness, the crushing defeat of lost comrades, and what one must conquer within the deepest recesses of the psyche to pass through to enlightenment and wisdom. This is the revered essence of the brother-sisterhood that has stood the test of all terrible times of war that gives rise to that infinite yearning for a return to the theater of war, to keep the backs of another out of harms way and make the ultimate and final sacrifice. There simply is no greater gift than the willingness to lay down one’s life for one’s brother/sister. For those who wear the uniform, this force that often propels and surpasses the will to survive, and it may be the key for the evolution of anguish and tragedy into triumph and the essence of discovering value, significance, and purpose from the most appalling and dreadful of human conditions and war’s insanity. Perhaps the path to resilience is paved by the performance of such virtuous and ennobling deeds.

About the Author: Kathy Platoni, PsyD, LTC, US Army Reserve, has been a practicing clinical psychologist for 24 years. She has recently returned to private practice in Centerville, and a position as assistant clinical professor (adjunct faculty), School of Professional Psychology, Wright State University, Dayton, after a third voluntary deployment to active duty Army status in October, 2004. She served as commander of the 1972nd Medical Detachment (Combat Stress Control) at Guantanamo Bay Cuba from 2003-04. She then deployed to Iraq as Deputy Commander for Clinical Services, 55th Medical Company and Officer in Charge of Team Ar Ramadi, situated in the seat of the insurgency and during times of intensive combat. Dr. Platoni then returned to the Home of the Infantry, Fort Benning, Georgia to provide reintegration services due to elevated numbers of psychological casualties among combat arms soldiers. During her 26 years of both active and Army Reserve status, including a six month tour of duty during Operation Desert Storm, Dr. Platoni developed combat stress control, debriefings and crisis management programs utilized throughout the U.S. Army. Dr. Platoni also voluntarily deployed twice to New York City to provide post-9/11 disaster mental health and debriefing services to NYPD first responders. Dr. Platoni is a skilled hypnotherapist and possesses expertise in the sub-specialty areas of behavioral medicine and the treatment of chronic pain and chronic, debilitating, and terminal illnesses, to include Diplomate status by the American Academy of Pain Management.

References

More than a century ago, studies of emerging cities found the urban environment challenging to maintain emotional, spiritual and physical health. In his essay, Weber (1969) observes that amid the cacophony and bustle, cities are soulless and cold. Simmel (1969) tells us cities are ‘dehumanizing, fragmenting’ and explains the necessity for city-dwellers to learn to tune out the environment in order to survive emotionally. Depersonalization of interpersonal interactions among inhabitants of cities confuses the actors and requires them to create adaptive measures to survive.

Today, technological advances have changed the urban scene only in intensity and degree, both exponentially augmented. Brighter lights, more saturated colors, louder and more discordant sounds, invasive smells and tactile sensations compete for attention. One must somehow dissociate oneself from the crystallized spirit of the city in order to preserve one's identity. We call on the technology that has brought us to this point to insulate ourselves from these assaults. With IPod buds in our ears, Blackberrys in our hands, and cell phones attached to our belts we stay virtually connected to our personal music and news, the Internet, schedulers, e-mails, and people we need to summon instantly. In doing this, we remove ourselves from the world and this isolation prevents us from experiencing its beauty as well as its ugliness. Unfortunately, the protective layers serve more to increase the demands on us than to shield us from stress. The accessibility of means for completing tasks easily drives us to set more of these tasks than we can accomplish, keeping us perpetually in a condition of one-step-behind where we think we should be. Simply put, we place ourselves in a constant state of stress.

Allowed to run rampant, stress is a killer. It contributes to disease in all aspects of our being. It exacerbates physical and emotional pain, and expands affective discomfort into clinical depression and panic attacks. Stress-related issues bring clients to our doors, and we struggle to find the most satisfactory ways in which to treat each situation.

It is not for lack of interventions, suggestions or (again) technologically driven tools that we have not been able to set ourselves and our clients on the path to Nirvana. From exercise to meditation, time management to guided imagery, hypnosis to mind machines to biofeedback to tea to hot baths, feng shui, tai chi, chi gong, psychotropic meds, aromatherapy, balanced foods, brain-wave music, Chinese healing music, acupuncture, acupressure, a list of Empirically Proven Treatments, alternative, new age, and experimental interventions, we have the tools. And, when we use these tools at one or more at a time, stress levels are lowered. So why does stress remain such a big part of our lives?

Culture has much to do with it. In our country’s current space in history, the dominant culture largely equates...
success with achievement, and when one of the above interventions lessens our stress level, we take one or two deep easy breaths and reach for a higher rung on the ladder, and the stress returns.

Maybe what we need to do is to reeducate ourselves and our clients. In addition to using the above tools individually or in combination, we need to work on the whole being and reassess values and lifestyle change. This treatment is much more challenging. Some of the tools above, if studied and embraced fully, affect lifestyle changes, but rarely are they adopted in entirety. Lifestyle change is a big order, because, in this case, it means slowing down, relaxing, and letting go. The kind of change that I am thinking of involves acceptance, mindfulness and compassion.

Dissatisfaction with ourselves and our lives leads to depression and constant striving to be someone else. On the other hand, the idea of acceptance of ourselves and of things as they are sometimes provokes fear that acceptance will lead to stagnation, but when we take the way of acceptance we find that nothing is further from the truth. Embracing acceptance lifts a great load from our minds (as well as from our bodies and spirits) and frees us to do more of what we want to do and be more truly who we want to be.

Mindfulness allows us to become aware of ourselves and our surroundings, our interactions and behaviors. It provides the opportunity to examine ourselves quietly and without prejudice. It lets us to experience our world fully and with joy, helps us appreciate small things and sometimes transform unattractive ones. I have a friend who moved to Cleveland many years ago and discovered that her new city had many more gray days than her hometown. “Well, then,” she said, “I’ll have to notice all the beautiful shades in gray.” Today, gray is one of her favorite colors.

Compassion may be the most difficult of the three disciplines to achieve, and perhaps in part it may also be the most freeing. Frequent flares of adrenaline that accompany unnecessary anger are dangerous to our emotional and physical health and rob us of our inner peace. If we can walk the path of compassion long enough to stay calm when, say, we are cut off in traffic, then most of us will have truly changed our way of being.

When a client is open to such a change I suggest we work to identify the causes of her stress. We may find that these are related to the energy required and the frustration encountered in pursuit of her life goals. Examination of these goals might reveal that her choices have been motivated by extrinsic rather than intrinsic considerations. Reassessment may lead to the discovery of a more internally satisfying set of goals and values and help to provide a path for her task of lifestyle change.

As this approach is far from a quick fix, in addition to encouraging lifestyle change, in my own practice I use most of the tools mentioned earlier, tailoring interventions to clients’ personalities and interests.

One of my favorites is meditation. If a client tells me she has tried meditation without success, I teach her a method I think of as ‘meditation for hyperactive minds.’ I ask her to forget the ‘empty mind’ part of meditation. I suggest she sit quietly for a minimum of 15 minutes and not allow any one thought to stay in her mind for long enough to let it ‘catch,’ concentrating on the rhythm of her breath if it does so, and not worry if it comes back or if another takes its place. I tell her that her mind may be full of thoughts for the entire time she sits, but not to focus on any one of them. Often, I will do a hypnotic intervention for a client experiencing stress (if such an approach is appropriate and the client is willing). Helping someone experience relaxation is a big first step toward teaching them to de-stress themselves, and the experience itself serves as a respite. Even a few stress-free and relaxing moments lay a firm foundation for constructing a shelter from stress that we and our clients can enter at will to refresh and reconnect with our inner peace.

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Lou Sauer is a psychologist at Cleveland State University and has a small private practice. Her approach to therapy is informed by her understanding that our minds, bodies and spirits are intertwined aspects of our beings. Lou’s special interests include stress reduction work and spiritual healing. She reduces her own stress through meditation, Yoga and self hypnosis.

References


"Feeling miserable is an integral part of the normal graduate school experience" (Goplerud, 2001; p. 138).

Graduate training in psychology is fraught with stressors and challenges, and it is likely that these stressors may contribute to personal distress and possible clinical impairment. As psychologists, we encourage our clients to take care of themselves, but we do not always practice what we preach. There are stressors inherent to the role of a psychologist, but there are additional stressors that are experienced by students. One of the elements of psychology training is learning to become a therapist, so most students are actively counseling clients. Personal distress may interfere with the therapeutic process and can be potentially harmful to clients. Therefore, it is important that the stressors and resulting personal distress that graduate students experience be examined critically to determine the potential impact upon client care. While there are numerous stressors, some common themes were generated from reviewing the literature and this list is not intended to be exhaustive.

**Expectations.** Trainees experience self-imposed and other-imposed expectations about their skills and abilities. Trainees are selected for their programs based upon personal and academic qualities so they feel that they must live up to this and display no weaknesses (Cushway, 1997).

**Evaluation.** Evaluation and supervision are difficult and stressful processes for trainees to endure. “The process of psychotherapy training is so inextricably bound up with the person of the therapist that it is often difficult for the trainee to separate out the person from the body of knowledge or skill being assessed. Thus, a failed assignment can feel like a devastating personal failure” (Cushway, 1997; p. 32). Psychology training programs are competitive to gain entry into (8% acceptance rate according to Norcross, Sayette, Mayne, Karg & Turkson, 1998). Trainees are selected for their personal and academic qualities so many believe that they must live up to this and display no weaknesses so trainees may experience unrealistically high self-expectations (Cushway, 1997). Stress and difficulty in specific courses are sometimes viewed as an inability to cope in general, rather than professors realizing that this is normal and then helping students (Cushway, 1997). In addition, little consensus exists regarding the matter in which trainees should be evaluated (Forrest, Elman, Gizara & Vacha-Haase, 1999).

**Workload.** Trainees frequently experience both quantitative and qualitative workload (Nelson, Dell’Oliver, Koch and Buckler, 2001). Some programs may implement heavy workloads in order to “weed out” students (Goplerud, 2001). In addition to extensive course work, students must also participate in clinical practicums, comprehensive examinations, thesis/dissertation, teaching, and many other tasks.

**Disruption of social support.** Psychotherapy training may lead to decreased resources to invest in relationships with partners and family. Spouses of family trainees reported extreme social isolation and anger regarding program demands during the first year of training (Polson and Piercy, 1993). Family and friends may find this ironic because “the paradox is that, while the trainee’s own relationships may be severely stretched, the trainee is learning to lavish care and attention on his/her own clients” (Cushway, 1997; p. 33). Graduate students also report experiencing limited emotional support from their peers (Cahir & Morris, 1991). Some graduate students must move away from established supports for training (Cushway, 1997). When individuals outside of the graduate school environment provide this support, the possibility for role conflict exists and this may result in increased difficulties (Baird, 1969, cited by Goplerud, 2001). Support within the program is beneficial, but students must be cautious to avoid “anxiety contagion” (p. 137) during stressful periods (Goplerud, 2001).
Financial pressures. Graduate students accumulate significant debt during their training (Cahir & Morris, 1991; Nelson et al., 2001). Upon graduation, 72% of psychology doctoral students reported debt and the largest portion of those in debt owed over $75,000 (Doctoral employment survey, APA research, 2001). Many students also work part-time in order to make ends meet, and this creates a greater workload for the students (Goplerud, 2001). After five plus years of graduate training, new trainees may become distressed and discouraged by the level of starting pay that they receive.

Becoming a therapist. Trainees may be exposed for the first time to other's pain, suffering and distress (Cushway, 1997). Therapy can be an ambiguous trend is an escalation of practicum hours and training issues. The average internship can be stressful and financially draining for clinical and counseling psychology graduate students. The average cost associated with the internship application process is $1,168. Another trend is an escalation of practicum hours.

Multiple/conflicting roles. Trainees must manage many multiple and conflicting roles including: student, therapist, supervisee, supervisor, teacher, researcher, advisee, partner, parent, etc. Frequently students also experience role ambiguity due to inadequate information and lack of clarity about role expectations and evaluation procedures (Goplerud, 2001; Kuyken, Peters, Power & Lavender, 1998). Particularly problematic are the lack of clear performance criteria and the lack of indicators to assist students in differentiating important and less critical assignments (Goplerud, 2001). For example, trainees may be functioning in their role as a therapist at noon and their client may be in a crisis situation. As soon as the session is over, the trainee must switch into the student role and take a final exam. While the client in crisis feels more important to the trainee, the grade on the test may have more future ramifications in the students’ eyes since trainees must remain in good standing.

Internship. The process of applying for internship can be stressful and financially draining for clinical and counseling psychology graduate students. The average cost associated with the internship application process is $1,168. Another trend is an escalation of practicum hours.

Even though practicum hours were not found to predict internship site placement. The average number of practicum hours is 600, yet students believe that they need to acquire 1,500 or more hours to be competitive (Boggs & Douce, 2000). Student anxieties are also affected by supply and demand; more students apply to internship than there are positions available (Kelhin, Thorn, Rodolfa, Constantine, & Kaslow, 2000).

For students, the stress does not disappear once an internship spot has been successfully obtained. During the internship year, trainees experience developmental stresses as they pass through the stages of the separation-individuation process, as discussed by Kaslow and Rice (1985). Internship year represents the transition from being a student to being a professional. Multiple tasks must be managed including internship responsibilities, completing dissertation, looking for jobs, and personal life.

Dissertation. Finishing the dissertation is a particularly challenging hurdle for applied psychologists to surmount since they tend to be motivated to help people and they often do not see the value of research in directly helping others (Sumpre & Walfish, 2001). The majority of clinical and counseling psychology graduate students do not enter academic careers following graduation (e.g., Cameron, Galassi, Birk & Waggener, 1989; Fitzgerald & Osipow, 1988). Psychology graduate students are delaying finishing their dissertations due to cognitive and affective components of procrastination, and demographic, situational and interest factors (Muszynski & Akamatsu, 1991). Students who work on their dissertation during internship year are less socially involved, and more pressured and preoccupied (Denicola & Furze, 2001).

Faculty relations. Students stated that receiving feedback from specific faculty members is stressful (Cahir & Morris, 1991). Faculty members are viewed as possessing power over students since they are considered the “gatekeepers” of the profession, and occasionally, faculty abuse this power (Sumpre & Walfish, 2001). Several myths exist that hamper the faculty-student relationship: myth of unlimited faculty time/availability, myth of faculty omniscience, and myth of fixed student aims/goals throughout graduate education (Hess & Sauser, 2001).

Lack of input. Most graduate students do not believe that they have a voice in decision-making (Cahir & Morris, 1991; Goplerud, 2001). The power base of graduate students is extremely restricted and even nonexist at times, resulting in a sense of helplessness in students (Sumpre & Walfish, 2001). Graduate students frequently report the symptoms of learned helplessness including: depression, alienation, apathy, and pessimism (Sumpre & Walfish, 2001).

Random/unrelated. In addition to the stress encountered as part of the graduate school training environment, stressors unrelated to graduate school life occur, such as death of loved one (Goplerud, 2001). During the first six months of graduate training, psychology graduate students reported experiencing an average of 3.89 stressful life events and two-fifths of these events were unrelated to graduate school (Goplerud, 1980).

In conclusion, graduate training in psychology is a stressful time. Training programs need to be proactive in assisting students in managing their stress through both structured activities (e.g., stress management courses) and their implicit messages within the culture of the program. Not only do training programs have a responsibility, students must also take the initiative at preventing and combating stress. Because students are working with clients, it is our ethical responsibility to prevent this stress from negatively impacting students’ work, and to instill skills in managing stress for students to carry on in their professional lives.

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References


Don’t Answer the (Cell) Phone

By Craig S. Travis, PhD, Mount Carmel Family Medicine Residency, and Fiona H. Travis, PhD, Columbus Psychological Center

The phone can be a pretty scary thing. Don’t believe us? Just check out “Don’t Answer the Phone,” “Dial ‘M’ for Murder,” and “When a Stranger Calls.” While these may be fictional, scary, horror movies, what may be more horrific is that cell phone use is stressing us to death. We live in an immediate society, and with all this technology of the communication age, we have become conditioned to think we must not only have a cell phone and answer it whenever it rings (even if in the middle of a session; OK you don’t do it, but your patients do), but we need 5,000 minutes of talk time a month: and, if you have 5,000 minutes you better use all 5,000—even when you’re driving. We probably need all these minutes to stay connected because we are running ourselves ragged working to death.

A recent study by Chesley (2005) suggests that “spillover” from cell phone use just might be the issue. Spillover essentially means that the work family boundary line begins to blur. This was true of both men and women, although it was a double edge sword for women (women had work spillover to home and home spillover to work while men had only work spillover to home). Structural equation modeling indicated that cell phone use over time, as opposed to computer use, was associated with increases in negative forms of spillover; positive spillover was not statistically significant. Cell phone use and consequent negative spillover was linked to increased distress and lower family satisfaction. The author concludes that the evidence suggests that “technology use may be blurring work/family boundaries with negative consequences for working people.” Boundaries are important in psychology and they should be important in communication technology too. We all need down time and while cell phones and pagers keep us connected, we need time away from the stress of everyday living to recuperate. Let’s face it; we have become conditioned to answer them just like Pavlov’s dogs salivated when ringing a bell. It doesn’t matter where or when: movies, restaurants, grocery store (heck I even heard one man answer his cell phone in a public toilet). Have you ever noticed that the people using cell phones tend to talk louder than normal room conversation volume?

Simple suggestions to create a ‘cell free zone’ in your life:

• Limit the number of work calls after you punch the clock; better yet, turn it off after work hours
• Establish a designated family time when you won’t answer your cell phone
• Establish “on call” days for each working parent for emergencies so as not to over-burden one particular individual
• Share positive events; not just negative ones

In addition to work/life boundaries “spillover,” cell phones can bring increased stress by blurring extended family boundaries. Sure, cell phones can bring a family closer just as the commercials advertise, but it might mean that it brings you too close for comfort. Many young adults report that parents, their mothers in particular, feel they can call on the cell anytime (Travis, 2003). “After all, that is what it is for; so I can reach you when you are not at home or bother you on the work phone.” This dynamic occurs in newly married couples who live in another town from their parents, especially if their parents have a “family plan.” In many ways, the cellular companies have easier boundaries to follow in their rate plans than the psychological ones that get crossed by families because often family do not understand those relationship boundaries.

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Indeed, boundaries are a major issue; for instance, respect for one’s privacy. Cell phone bills can create much stress and anxiety when one spouse does not recognize a number their partner has been calling, particularly if it is a frequently called number or long duration of calls. This scenario is especially true in distrustful relationships. It is a major issue for marriage and family therapists to address. Many family dynamics can be brought to the surface via cell phone use.

When cell phone use isn’t contributing to increase family strife, it increases your risk of automobile accidents. Two studies (Stutts, Huang, and Hunter, 2002; Sodhi et. al., 2002) found that cell phone use in cars amplifies the risk of rear end collision and causes tunnel vision. In a University of North Carolina at Chapel Hill study, Stutts, Huang, and Hunter (2002) showed that drivers talking on cell phones are nearly twice as likely as other drivers to be involved in rear-end collisions. Crashes involving cell phones tended to be fender-bender types and were less likely to result in fatalities. Interestingly, the researchers found that cell phone users did not perceive talking while driving as a distraction or safety concern. Nor were they particularly supportive of legislation that would ban the use of cell phones or issue stricter penalties for cell phone users involved in crashes.

Similarly, a University of Rhode Island study involving the analysis of the eye movements of automobile drivers using cell phones determined that drivers have a reduced field of view or ‘tunnel vision’ (Sodhi et. al., 2002). The researchers used head-mounted, eye-tracking devices on volunteer drivers and concluded that driver alertness was decreased considerably when conducting cognitive tasks, such as remembering a list of items, calculating in one’s head, or using a cell phone. Tunnel vision continues well after the call is finished presumably due to the driver still thinking about the conversation. Prior to this study, the debate surrounding cell phone use while driving often involved concerns over holding the phone, thus the popularity of “hands free” devices. This study suggests that holding the phone isn’t the main issue: thinking is. The mental energy needed to focus on the conversation is distracting to the driver. Maybe that is why cell phone users are more than twice as likely to have rear-ended collisions; although they would never admit to this because they don’t see it as a problem (see above research conclusion). Not uncommon dynamics of human behavior to deny your own problematic behavior. I’ll be the first to admit I have in fact heard myself complain how other drivers are not as mindful of the road when they are talking on their phones as I am when talking on mine. After all, we do see what we want to see and create tunnel vision to our own faults. Perhaps the reality is that cell phone use and cell phone behavior is more distressing to the observer than it is for the user who denies it is a problem.

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References


Abstract
Posttraumatic stress disorder (PTSD) is a common, potentially disabling anxiety disorder that can develop subsequent to a traumatic event. Cognitive-behavioral treatments, specifically exposure-based approaches, have been identified as efficacious treatments for chronic PTSD in numerous clinical trials. Despite such strong support, exposure treatments are not typically implemented in routine clinical practice. This article reviews recent research on the implementation of exposure-based treatments for PTSD, dissemination of such treatments, and efforts to modify treatments for subgroups of trauma survivors.

Data from the National Comorbidity Survey revealed that 50–60% of adults in the U.S. have experienced at least one traumatic event during their lifetime (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). In the acute aftermath of such an event, most people will experience symptoms of distress such as intrusive thoughts about the trauma and sleep difficulties. For many, these symptoms will decline naturally in the initial weeks and months following a trauma, though a small but significant proportion (8–10%) will develop chronic posttraumatic stress disorder (PTSD) (Kessler et al., 1995).

PTSD is an anxiety disorder characterized by behavioral and cognitive avoidance of trauma-related stimuli, reexperiencing of the traumatic event through flashbacks or intrusive recollections of the event, and physiological hyperarousal (APA, 1994). Rates of PTSD vary widely with regard to type of trauma experienced (Kessler et al., 1995). Women are twice as likely to develop PTSD as men, even in response to the same traumatic experience (Breslau, Davis, Andreski, & Peterson, 1991; Kessler et al., 1995). PTSD is often accompanied by other serious psychological disorders such as depression, substance abuse/dependence, and panic disorder (Kessler et al., 1995; Breslau et al., 1991).

Fortunately, effective treatments for PTSD do exist. Cognitive-behavioral approaches, particularly those which include exposure, are among the most widely investigated for the treatment of PTSD and have strong empirical support (Foa, Keane, & Friedman, 2000). Though exposure therapy has only been applied to and examined for PTSD in the past few decades, the concepts that underlie exposure-based treatments are not new ideas. Wolpe (1958) argued that anxiety could be reduced or eliminated through the evocation of an incompatible response (i.e., relaxation) in the presence of feared stimuli. Even earlier, Breuer and Freud’s (1893) writings suggest that confrontation with painful memories may be a critical component of effective treatments after trauma: We found to our great surprise...that each individual hysterical symptom immediately and permanently disappeared when we had succeeded in bringing clearly to the light the memory of the event by which it was provoked and in arousing its accompanying affect, and when the patient had described the event in the greatest possible detail and had put the affect into words. (p. 4)

Exposure therapy typically includes an in-vivo exposure component (i.e., approaching relatively safe yet avoided trauma-related stimuli in the environment) and an imaginal exposure component (i.e., reliving the trauma memory in verbal or written form). The goal of exposure therapy for PTSD is to reduce anxiety for feared situations and memories through habituation (e.g., Resick & Schnicke, 1993; Foa & Rothbaum, 1998). Exposure-based CBT has demonstrated efficacy in numerous clinical trials, with large effect sizes in comparison to present-focused, problem-solving treatments and waiting-list control conditions (e.g., Resick, Nishith, Weaver, Astin, & Feuer, 2002; Foa et al., 2005; McDonagh et al., 2005). Such treatments also have demonstrated a significant reduction in associated symptoms of depression and general anxiety, and improvements in overall functioning (Resick et al., 2002; Foa et al., 2005).

Despite the growing evidence of their efficacy, many clinicians treating PTSD are not implementing exposure treatments in practice (Becker, Zayfert, & Anderson, 2004). Some authors have suggested that exposure treatments may be too difficult for patients to tolerate (Cloitre, Koenen, Cohen, & Han, 2002); thus, clinicians may choose not to implement exposure therapy, out of concern that patients may drop out prematurely from treatment. However, a review by Hembree et al. (2003) revealed that, across 25 controlled studies of CBT for PTSD, patients who received an exposure-based treatment were not more likely to drop out from treatment than those who received cognitive therapy, stress inoculation therapy, or eye-movement desensitization and reprocessing (EMDR). Moreover, when presented with treatment rationales, people favor exposure-based treatments for chronic PTSD over other forms of psychotherapy, such as EMDR (Tarrier, Liversidge, & Gregg, in press), or medication (Zoellner, Feeny, Cochran, & Pruitt, 2003).

Still, others have expressed concern that exposure-based treatments may actually exacerbate symptoms of PTSD, and this has been cited as another explanation as to why providers may be reluctant to implement exposure therapy (Tarrier et al., 1999). On the contrary, Foa and colleagues found that most individuals receiving exposure therapy (85%) do not experience an exacerbation in symptoms when exposure is initiated in treatment (Foa, Zoellner, Feeny, Hembree, & Alvarez-Conrad, 2002). Importantly, they also found that those who did experience a brief exacerbation of symptoms were as likely as those who did not to receive benefit from the treatment (Foa et al., 2002).

Actually, clinicians most commonly cite lack of adequate training in administration of exposure-based treatments as the primary
reason they do not use exposure in treating PTSD, as opposed to concern that patients may drop out or decompensate (Becker et al., 2004). Dissemination of and training in exposure-based treatments, then, may help to bridge this gap between research and practice. In a recent clinical trial, Foa and colleagues trained clinicians at a community-based rape crisis center in the administration of exposure therapy for PTSD, and these clinicians provided treatment to participants in the study. Data demonstrated that, after an initial training with follow-up consultation and supervision, these mental health counselors based in the community were as skilled at providing exposure-based CBT for PTSD as university-based providers, evidenced by no differences in treatment outcomes across sites (Foa et al., 2005). This provides good preliminary data to suggest that exposure-based treatments can be effectively implemented by those in practice.

Many researchers have made efforts to refine exposure-based treatments for PTSD. Several recently published clinical trials have added additional components to exposure-based treatments to treat PTSD and comorbid disorders (Falsetti, Resnick, & Davis, 2005) or made modifications to exposure treatments for use with particular subgroups of trauma survivors, such as child abuse survivors (Cloitre et al., 2002). These treatment packages have been developed in response to the complicated symptom patterns that often develop following a traumatic event, in an effort to target a broad range of symptoms beyond the PTSD criteria. Though these trials have demonstrated outcomes superior to waiting list control conditions, they have yet to be compared to a pure exposure-based treatment without these modifications and/or additional components. Thus, it is unknown whether similar outcomes would be obtained with a pure exposure-based treatment, or whether the additive components or modifications improve treatment outcome incrementally (Cahill, Zoellner, Feeny, & Riggs, 2004).

In sum, a growing body of research supports the efficacy of exposure-based treatments for PTSD, yet barriers to implementing these effective treatments still exist. Important steps toward advancing exposure-based treatments for PTSD are underway. Future research should continue to examine the dissemination of exposure-based treatments and possible ways to improve treatment outcome among those with PTSD.

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Dr. Norah Feeny is a licensed clinical psychologist and assistant professor at Case Western Reserve University in the departments of psychiatry and psychology. She specializes in posttraumatic stress disorder (PTSD) and is the director of the PTSD Treatment and Research Program. She has concentrated her research on evaluating treatments for PTSD, understanding what predicts who will develop PTSD, and finding ways to recognize pediatric posttraumatic stress disorder. Her clinical and research work has involved her in sexual assault programs, and treatment programs for anxiety and depression.

References


Continued on page 19
Adolescence is a time of many biological, cognitive, physiological, and social changes and as such, often leads to considerable life stress. Changes related to physical development, self-evaluation, and peer and family relationships can have a powerful influence on psychological well-being. In contrast to adolescent males, females react more negatively to the psychological and physiological stresses of puberty, and are therefore at greater risk for many psychological and social difficulties (Harter, 1988). In females in particular, failing to use adequate means of coping with the stressors of adolescence is associated with low self-esteem, and premature pregnancy, and increased problem behavior (Kirkcaldy, Shephard, & Siefen, 2002; President's Council on Physical Fitness and Sport, 1997 [PCPFS]). Regular physical activity can play a mitigating force, not only providing physical health benefits, but mental health benefits as well, smoothing the transition through adolescence (Covey & Feltz, 1990; Jaffee & Manzer, 1992; Jaffee & Ricker, 1993; Jaffee & Wu, 1996; PCPFS, 1997; Snyder & Kivlin, 1975). Adolescence is a formative period when many habits, particularly health habits including effective management of stress, become ingrained in the individual’s schema, and thus presents a critical time to examine attitudes regarding physical activity.

As a result of Title IX, females’ participation in sports and physical activity has nearly doubled since 1972. American females are now participating in a wider range of sports, and a broader spectrum of activities than ever before (PCPFS, 1997). The influences of sports and physical activity are far reaching, encompassing a set of independent skills that foster growth and development. Sports constitute more than just “activity.” (PCPFR, 1997, Overview of the Report section, p. 15). The resulting “multi-connectedness” of team sports enhances the adolescent’s overall health in substantial ways (Biddle, 1995; Covey & Feltz, 1990).

Benefits Associated with Increased Physical Activity
Sports participation also had a significant effect on extracurricular involvement between one’s sophomore and senior year in high school. Specifically, sports participation acted as a “social-psychological catalyst” for increasing involvement in school and community activities. Finally, the most important finding of this research was that the more that participants were involved in sports, the more they perceived themselves to be popular with other students, and thus the higher their perceived status within the social system of the school (Melnick et al., 1988). Caldwell and Darling (1999) in a study of 9,000 American high school students, identified factors that contributed to the amount of time adolescents spent using illicit substances. They found that spending more time in unstructured social settings predicted increased substance use. However, those individuals who engaged in more positive health behaviors, especially sports participation, were associated with less use of cigarettes, marijuana, depressants, hallucinogens, and stimulants; use of beer was the exception. Kirkcaldy, Shephard, and Siefen (2002) found a positive relationship between physical activity and self-image, and decreased problem behavior among adolescents. A comprehensive series of author-devised, self-report questionnaires aimed at assessing anxiety, depression, trait addiction, smoking and drinking behavior, physical health, self-perception of self-image, parental acceptance, and educational attainment, were administered to 988 German adolescent (14 to 18-years-old) males and females. A cross-sectional analysis showed that those who partook in regular “endurance/aerobic sporting activities” displayed a more favorable self-image, resistance to drug and alcohol addiction, lower depression and anxiety scores, and less social behavioral inhibition, than their less active counterparts. Perry-Burney and Takyi (2002) reported that 114 9th through 12th grade girls who played sports displayed more self-confidence and tended to have a more mature approach to peer pressure than those who did not. The athletic girls were less likely to use substances, displayed increased self-confidence, an improvement in academic achievement, and were likely to attend religious and church affiliated activities. Miller, Sabo, Farrell, Barnes, and Melnick (1998), in a study of the effects of sports and sexual behavior in 699 male and female adolescents aged 13- to 16-years, found that sports have a unique gender-specific effect on adolescent sexual activities. Specifically, athletic participation for females was associated with: (1) a significantly lower frequency of sexual intercourse, (2) significantly fewer sexual partners, and (3) a significantly older age of coital onset. On the other hand, male athletes reported opposite patterns in sexual behavior. Klein’s (1998) review of the literature also found comparable gender differences associated with athletic participation and sexual behavior. Forty-eight percent of adolescent female athletes had never had a sexual partner compared to 37% for females who did not play a sport. Further, female athletes, who were sexually active, were found to have had significantly fewer sexual partners. Additionally, female adolescents who participated in sports were less likely to have had sexual intercourse at an early age. In contrast to the females, male athletes were found to have had more sexual partners and intercourse at an earlier age than female athletes (Klein, 1998).

In summary, the period of adolescence can be a particularly stressful time and a time of high-risk behaviors. There is a strong consensus that physical activity and organized sports helps adolescents develop resilience to the stress of social pressures by promoting positive social relationship and decreased problem behavior, and general psychological functioning. Therefore, model programs for females that employs physical activity as an avenue of change need to be developed in a sound way that relies on psychological theory and research. Parents/care-givers of adolescent females should encourage the participation in physical activity to increase the adolescent female’s self-esteem and overall well-being and as a way of effectively coping with stress. Current research suggests that self-esteem is multidimensional (Harter, 1990; Marsh & Ayotte, 2003). Using this multidimensional approach as applied to athletics, it could be put forth that a talented athlete who believes that being good at sports is important, would likely benefit from increased feelings of worthiness. However, an athlete with low perceptions of competence in a domain that is highly valued (e.g., athletics) would likely experience decreased self-esteem. Given the implication of the above-mentioned multifaceted self-esteem hypotheses, it is important to recognize the possible effect on an individual’s self-esteem in specific domains. Particularly, physical activity could uniquely impact an individual’s self-esteem independent of what the individual may experience in other life experience domains. Application of these models in the field of physical activity and adolescents would indicate that physical activity, which may include athletics, may have substantial impacts of self-esteem that are closely associated with some of the goals and objectives of physical activity such as overall physical and psychological health, building team work and social concepts, and time management (Seraganian, 1993).

Therefore, extrapolating from the findings of the extant literature, which indicates that physical activity may serve as a vehicle to promote positive self-esteem in adolescence, it is possible that physical activity may serve as a mechanism to provide some resistance to the effects of significant life events and stresses that an adolescent may face. Through participation in physical activity, young females may not only realize health benefits, but more importantly they may also learn skills to help them develop into confident, successful, and mentally and physically healthy adults.

About the Author:
Amy Burleson is a 1999 graduate of St. Bonaventure University, where she played four years of Division I basketball for the Bonnies. Among her honors at St. Bonaventure, Amy was a member of the Atlantic-10 Commissioners Honor Roll, an All-American Scholar, a New York State Scholar Athlete, and was a Francis E. Kelly Program Recipient where she studied at Oxford University England. After graduating, she studied child and family clinical psychology at Argosy University-Atlanta and graduated with her doctor of clinical psychology degree in 2005. Her clinical experiences include Inner Harbour Children’s Hospital, several college counseling centers, including the United States Military Academy at West Point Center for Enhanced Performance, The Atlanta Medical Center, Kaiser Permanente Hospital, and her APA approved pre-doctoral internship at the University of Cincinnati. She is currently completing her post-doctoral psychology fellowship under the supervision of Dr. Judith Scheman, at the Cleveland Clinic Foundation, division of psychiatry and psychology, section of pain medicine. Questions and comments may be directed to burlesa@ccf.org
References


Stress has a significant impact on low income ethnic minority group members. In fact, social class and stress have been found to interact in such a way that individuals who are in the low socioeconomic status group tend to have greater levels of stress (Liu et al., 2004). This finding is particularly relevant to ethnic minority individuals, as African Americans and Hispanics are almost three times more likely to be living in poverty than European Americans (U.S. Census Bureau, 2005). These greater levels of stress suggest that the psychological well being of low income ethnic minority members may be compromised. For example, low socioeconomic status has been linked to depression (Everson, Maty, Lynch, & Kaplan, 2002). In addition to concerns regarding psychological well being, low income ethnic minority persons are also much more likely to be convicted of crimes (Lott, 2002). Based on these findings, psychologists have begun to emphasize the importance of social justice and social advocacy for low income ethnic minority group members (e.g., Fouad, 2001; Jackson, 2000; Kiselica & Robinson, 2001; Vera & Speight, 2003).

Although social justice and social advocacy are important in combating these issues, it seems that the resilience of those who are oppressed has been overlooked. Psychological research focuses so much on what we can do and are doing to help society’s oppressed groups, such as low income ethnic minority individuals, that we seem to ignore what oppressed people are doing to cope. In fact, we may not be aware of how oppressed individuals cope because those of us who are privileged (which, almost by definition, psychologists and graduate students are) may not have had to develop such strategies. As Hays (2001, p. 25) noted, “Privilege (e.g., in the form of money or powerful social connections) may prevent a person from developing the coping abilities that less privileged individuals must develop in order to survive (McIntosh, 1998).” Oppressed individuals must deal with all the stresses that accompany discrimination, lack of funds, criminal charges, and other environmental barriers everyday. An interesting question is then, how do they deal with such stresses?

To answer this question, I turn to those who are oppressed by society. Specifically, I had the opportunity to gain clinical experience through working with low income ethnic minority persons who are incarcerated or temporarily restricted to a halfway house. In doing this work, I learned a great deal about resiliency and coping with environmental barriers. I will outline some of the pathways to resilience that I have found through working with this extraordinary group of people. Although members of more affluent groups may also use these pathways, they often have more resources to draw upon and fewer barriers to overcome. Thus, I intentionally focus on low income ethnic minority members who have been involved in the criminal justice system. Because this is based on my experiences working with individuals who are oppressed, I use a first-person narrative. Finally, I will comment on what I have seen, rather than discussing relevant psychological theories related to these pathways.

Paths to Resilience
First and foremost, acceptance is a resilience pathway that appears to be important in maintaining control and hope. It is not so much acceptance of being oppressed, but rather acceptance that there is no easy way to find a job and housing, maintain economic stability, and attain services in the community that so many of us take for granted (e.g., health care, transportation, mental health services, financial aid, food, insurance, clothing, substance abuse treatment). Low income ethnic minority persons with criminal records are often forced to continue searching for jobs and facing rejection until they are able to find some agency that is willing to give them a chance. Often, they do not have the opportunity to choose between two attractive jobs in which they have interest and that offer the economic support they need, including health care benefits. I have seen the excitement and delight on their faces when they are able to secure a job, regardless of what that job is. They have accepted that the path before them is...
difficult and that they may have no choice but to find a starting point and make it work for them.

A second pathway to resilience is perseverance. A phrase that I often hear from clients is, “You’ve gotta roll with the punches.” Individuals who face many environmental barriers have learned that one of the best ways to maintain happiness and a sense of control over their lives is to deal with problems as they come up and, above all else, carry on. By continuing to persevere regardless of life’s circumstances, oppressed individuals are better able to adjust to whatever new stressors may occur. For example, I often see clients lose their jobs because of layoffs. This situation is problematic for clients in halfway houses because not only are they losing financial stability, they may also be reprimanded by the halfway house staff for being terminated from a job (regardless of the reason), and it is often stressful and upsetting for clients. Nonetheless, I see these same clients out job searching the next day. This perseverance keeps them from experiencing a great deal of distress and allows them to maintain a sense of control over their lives, which is comforting for them. They learn that their best chance for surviving in an oppressive environment is to persist in their efforts, no matter what obstacles they must overcome.

A third pathway to resilience that is evident among low income ethnic minority persons with criminal records is optimism. These individuals are often able to look at the positive aspect of any situation, no matter how terrible or depressing it may be. For example, I have worked with clients who have had their children temporarily placed with children services; have lost their job and are facing time in prison; are currently victims of domestic violence; or, do not have clothing, housing, food, or even personal hygiene products. As easy as it is to identify the inhibiting aspects of this situation, these clients can still sit before me and honestly tell me that “things aren’t that bad” and “it’s only a matter of time” before they are back on their feet and all is well within their worlds. They can identify the positive aspects in any of their circumstances and consider their environmental barriers as simply hurdles to overcome.

Finally, these resilient individuals have faith. Their faith may not necessarily be in a religious or spiritual sense, though it could be. They have faith in something, whether it be their God, their families, their self worth, or their belief that a greater good is worth the fight. Faith carries them far, even if their optimism temporarily fades or wavers. They hold on to what they believe in and allow their faith to guide them when they need it.

These four characteristics are some of the ways in which I have seen low income ethnic minority individuals involved in the criminal justice system deal with multiple stressors and environmental barriers. Their resilience is inspiring. Psychologists could learn a great deal from these survivors of oppression, and their stories can be used to inspire others. These survivors have much to offer the world, as well as psychologists’ understanding of what it means to be resilient.

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Devon Cummings is a doctoral candidate in the collaborative program in counseling psychology at The University of Akron. She received her BA in 2002 and MA in 2004 from The University of Akron. Her research, practice, and advocacy interests include offender rehabilitation, suicide in correctional environments, vocational issues of ex-offenders, social justice and social advocacy, empowerment of individuals with mental illnesses, resilience, and the teaching of psychology.

References


An Examination of the Long-Term Effects Of Child Abuse and its Connection to Child Abuse Disclosure: A Black Feminist Theory Perspective

By Candace Allen-Staten, Wright State University, School Of Professional Psychology, OPA Student Poster Session Winner, Non-Empirical Category

Abstract
Although various forms of child abuse are as prevalent in the black community as in the white community (Wyatt, 1985), the long term effects of child abuse and child abuse disclosure are rarely studied within the black community. Therefore, the present examination linked the long-term effects of child abuse in black women to complex child abuse disclosure in black women through the use of the black feminist theory. Clinical implications were presented in an effort to help clinicians better serve black women with histories of child abuse.

An Examination of the Long-Term Effects of Child Abuse in Black Women
Although various forms of child abuse (CA) are as prevalent in the black community as in the white community (Wyatt, 1985), there is a paucity of research that has examined child physical abuse (CPA) and child sexual abuse (CSA) in the black community (Abney & Priest, 1995; Bernard, 2002). More specifically, little research has been conducted on how black women’s experiences of CPA, CSA, and child abuse disclosure (CAD) contribute to the long-term effects of CA due to their membership in the two devalued groups of black Americans and women. Although women of multiple cultures were exposed to CA, black women’s experiences are unique due to the intersection of racism and sexism (West, 2002; Wilson, 1994). Therefore, the present article focuses on the impact of racism and sexism on the long-term effects of CA and CAD in black women.

Furthermore, the black feminist theory was used to conceptualize the link between CAD and the long-term effects of CA in black women.

For the purposes of this examination, several definitions are used and described below. CPA is defined as an event in which a parent or caretaker hit, kicked, punched, pushed, tied down, or broke bones or teeth, which caused bleeding or bruises to a child under 17. Spanking is only included if it resulted in bruises (Jasinski et al., 2000; Ramos et al., 2004). CSA is defined as any sexual activity (genital and breast fondling, oral sex, digital, vaginal, and oral penetration) that occurred between a child under the age of 18 and a perpetrator five years or older in which the child was unable to give informed consent (Abney and Priest, 1995; Bonnano, et al., 2003; Coffey, 1996; Greenwald et al., 1990; Jonzon & Lindblad, 2004; Ruggiero et al., 2004, Tyagi, 2001; Wyatt, 1985; West, Williams, & Siegel, 2000; West, Williams, & Siegel, 2000). CA is used as a general term, which encompasses both CPA and CSA as defined above. CAD is a description of an event as CSA or CPA, which includes the survivor’s perceptions of the event and reactions from family and friends (Brown, 1991).

Long-Term Effects of Child Abuse Among Black Women
Although CA in the black community is rarely studied, the prevalence of CSA in the black community is similar to the prevalence of CA in the dominant culture (Wyatt, 1985). In an interview with 126 black women and 122 white women about the impact of CSA, Wyatt (1985) found that 1 in 2.5 black women were sexually abused as children compared to 1 in 2 white women. However, Wyatt (1985) found that there were cultural differences in the presentation of CSA in black women. For example, she found that black women were more often abused during their preteen years, in their homes, by black male perpetrators, and by someone from their nuclear or extended families compared to white women who were more likely to be abused during early childhood years by white and multiple ethnic perpetrators.

Although black women have been abused as often as white women, it is unlikely that they will seek therapy specifically for abuse. For example, Priest (1992) used a sample of college students in which he found that 25% of black women compared...
to 12% of black men were sexually abused as children. Of those black women with histories of CSA, 19% reported receiving therapy, but only 3% received therapy specifically for CSA.

Comparison studies between black women and women of other cultures have demonstrated the urgency of studying the impact of CA on black women (Ramos, Carlson, & McNutt, 2004; Urquiza & Goodlin-Jones, 1994; Wyatt, 1985). Urquiza and Goodlin-Jones (1994) conducted a study with 243 culturally diverse women to determine the relationship between CSA and adult rape across cultures. It was found that black women were sexually abused as children and raped as adults more often than Caucasian, Latina, and Asian American women, respectively.

In order to understand the impact of CSA on black women, several researchers have conducted prospective studies (Banyard, Williams, Siegel, & West, 2002; West, Williams, & Siegel, 2000; Jasinski, Williams, & Siegel, 2000). Interestingly, these investigators all used the same sample of 113 black women who, as girls, were examined at hospital emergency rooms for reported CSA. They were interviewed approximately 17 years after the abuse.

One study found that CSA was related to adult depression, anxiety, dissociation, sexual problems, post traumatic stress disorder symptoms, and sleep disturbance (Banyard, Williams, Siegel, & West, 2002). A second study found that multiple CSA episodes by multiple perpetrators and an older age at onset of CSA were linked to alcohol abuse in adulthood (Jasinski, Williams, & Siegel, 2000). A third study found that women who were sexually abused during childhood and adulthood were more likely to be physically abused by significant others and have histories of prostitution than women who experienced CSA without subsequent assaults during adolescent or young adult years. The study also found that women who were raped during adulthood, as compared to women who experienced CSA only, were more likely to have medical problems such as repeated vaginal infections, sexually transmitted diseases, painful intercourse, and difficulty conceiving (West, Williams, & Siegel, 2000).

**Issues in Child Sexual Abuse Disclosure in Black Women**

Research has demonstrated that CA has a negative impact on women, which is further complicated by CAD. According to Browne (1991), many women are reluctant to disclose CA due to the complex nature and difficulty of disclosing it. Browne (1991) identified the first step to disclosure as the defining (accepting the reality) of the event as CA in which the definition is based on the person's perceptions of the event in dynamic relations to the reactions from family and friends about the event. Furthermore, Browne stated (1991) that intrafamilial CA produces intense and conflicting feelings related to the event, which lead to alternative explanations (denial) of the abuse. Browne (1991) identified the second step to disclosure as a decision and response in which she indicated that the decisions and responses commonly chosen are independnet coping, reevaluation of the event, reporting of the event as abuse, and denial via repression.

CAD is difficult for black women due to their devalued status as women and as black Americans in a racist and sexist society. Therefore, the intersection of racism and sexism make black women's experiences of CA and CAD unique from all other cultural groups. For example, the stereotype of the strong black woman has prevented many black girls and women from disclosing CA to avoid appearing weak. Furthermore, black women have avoided CAD in order to not be seen as unsupportive to the black men, often within her family, who are perpetrators. She is therefore caught in the dilemma of helping herself or helping her black male counterpart avoid negative experiences, such as harsher consequences than perpetrators from the dominant culture. Also, black women rarely disclose CSA due to stereotypes of black promiscuity and the associated fear that their complaints will not be seen as credible (Abney & Priest, 1995; Bernard, 2002).

Because black women tend to delay CAD and tend to be abused by family members, they are likely to meet the diagnostic criteria for posttraumatic stress disorder and depression (Ruggiero, Smith, Hanson, Resnick, Saunders, Kilpatrick, and Best, 2004). Furthermore, black women may be prone to negative reactions to CAD because they are most often abused by family members (Jonzon and Lindblad, 2004).

**Black Feminist Theory and Black Women's Victimization**

In an effort to help the reader better understand the feminist theory and the black feminist theory as well as their similarities and differences, the table below was provided prior to a discussion of CA within the black feminist framework.
According to the black feminist theory, sexual abuse is the result of men’s abuse of power against women and children. Due to society’s portrayal of black females as sex objects, perpetrators of CSA may feel justified in their actions. Furthermore, this behavior is fed by stereotypes of black men and women’s sexuality and sexual behavior. Due to society’s views of black women as promiscuous and the glorification of black men in the media for multiple black female partners, society and social service agencies may question the reality of CSA in the black community (Wilson, 1994).

The black feminist theory also states the use of sensational media contributes to society’s view that violence and CPA are the norm for the black community. Furthermore, the cultural unfairness of the justice system, the black culture’s traditional use of physical discipline, and the black community’s denial of CPA contribute to ongoing CPA and a misunderstanding of what constitutes CPA in the black community by social services (West, 2002; Wilson, 1994).

Because black women are not encouraged to disclose CPA or CSA, they tend to keep it to themselves and feel confused, guilty, and devalued (Wilson, 1994). Black women rarely disclose CPA or CSA because it is either not viewed as a major problem in the black community or it is viewed as a family problem and because they are often coaxed to move on with their lives or to be strong and get over it. Furthermore, black women are reluctant to disclose CSA because they are scared that professionals will ask them about their current sexual behaviors or will not take their disclosure of past CSA seriously due to stereotypes of promiscuity in the black community (Wilson, 1994).

Clinical Implications
Because the literature on the long-term effects of CA on black women has demonstrated that the prevalence of CA in black women is similar to the prevalence of CA in white women, more research is needed to better understand the role that culture has on the impact of CA on black women (Wyatt, 1985). Additionally, since black women rarely seek therapy for CA, it is important that psychologists working with black women assess histories of CA (Ramos et al., 2004).

Because CAD is further complicated by stereotypes about black Americans and black women, it is important that psychologists working with black women with histories of CA examine the impact that racism and sexism have on black women’s past and present experiences with CA and CAD (Bernard, 2002). It also is imperative that psychologists encourage black women to talk about the trauma of CA and of past CAD to help them more effectively cope with the long-term effects of CA (Abney & Priest, 1995; Bernard, 2002). Because black women are discouraged from talking about CA or seeking professional help, psychologists should applaud black women for seeking therapy.

About the Author:
Candace Devon Allen-Staten graduated with a master of arts degree in clinical psychology from the University of Dayton in 2002. She is currently a fifth year doctoral candidate at Wright State University, School of Professional Psychology in Dayton, and on internship at the CAARE (Child and Adolescent Abuse, Resource, Evaluation) Diagnostic and Treatment Center in Sacramento, California. Candace’s clinical and research interests are in the area of trauma, violence prevention and intervention, and black women’s issues.
References


Habit Reversal Treatment for Chronic Skin Picking in an Adult Male

By Barbara B. Beimesch, MA, 2005 OPA Student Poster Session Winner Empirical Category, and W. Michael Nelson III, PhD, ABPP, Xavier University

Skin picking (SP) is self-injurious behavior consisting of “repetitive, ritualistic, or impulsive skin picking in the absence of an underlying dermatological condition” (Deckersbach, Wilhelm, Keuthen, Baer, & Jenike, 2002, p. 361). This behavior can result in damage to the skin tissue, including scarring and infection. SP is estimated to have a 2-4% prevalence rate, beginning on average at age 15, and lasting 21 years (Wilhelm et al., 1999). However, SP has not been extensively studied and at present is not specifically described in the “Diagnostic and Statistical Manual of Mental Disorders, 4th TR edition.”

Skin picking includes, “picking, scratching, gouging, and squeezing” (Twohig & Woods, 2001, p. 217). Sixty percent of skin pickers typically pick their scalp (Wilhelm et al., 1999). Since habit reversal has been identified as a useful intervention for repetitive behavior problems, it was hypothesized to be applicable to SP (Azrin & Nunn, 1973; Miltenberger, Fuqua, & Woods, 1998). There have been four case studies where habit reversal has been used successfully for SP behaviors across the age range of 16-57 years (Deckersbach et al., 2002; Kent & Drummond, 1989; Rosenbaum & Ayllon, 1981; Twohig & Woods, 2001). The purpose of this study was to evaluate the effectiveness of habit reversal for skin picking of a participant older than in previous case studies.

Method: Participant
B.E., a 59-year-old Caucasian male, reported picking his scalp for at least 20 years, particularly when bored. Such behavior occurred anywhere when his hands were free, such as watching television. He characterized his skin picking as consisting of “digging, scratching and gouging the scalp at the crown of my head in two areas.” Approximately 10 years ago, he reported picking these areas to the extent that they bled daily. Since that time, he reported noticing the presence of two dime-sized calloused inflamed raised areas in his scalp. At initial interview, prior to the collection of baseline data, he estimated engaging in SP behaviors 15-30 times per day.

Skin Picking Scale
Prior to implementing treatment, the severity of B.E.’s SP was measured using the Skin Picking Scale (SPS) (Keuthen et al., 2001), a six item self-report instrument with satisfactory reliability. The SPS evaluates the “frequency of urges to pick the skin, intensity of urges, time spent on skin picking, interference due to skin picking, distress associated with skin picking, and avoidance due to skin picking” (Deckersbach et al., 2002, pp. 364-365). Using the SPS, the client rates each item on a 4-point scale from 0 (complete control) to 4 (no control). B.E. scored a 13 on the SPS placing him in the range of “clinically severe self-injurious skin pickers.”

Setting and Treatment Format
The treatment sessions took place in B.E.’s family room on four evenings, each one-week apart. The initial session lasted for one and the subsequent three booster sessions were each half-hour long. B.E.’s family room was a frequent SP site and was chosen in an attempt to increase his awareness of SP activity.

An A-B design was used where B.E. self-monitored his SP behaviors for one week prior to treatment initiation, for three weeks while receiving treatment, and then for an additional four days beyond the last treatment, when SP behaviors appeared stable. He was asked, without warning, to record SP behaviors again for two days approximately five and a half weeks after the final session to evaluate the stability of his diminished SP behavior.

Data Collection Procedure
B.E. self-monitored his skin picking by placing the date at the beginning of each day upon waking and recording a line every time that he engaged in SP behavior that day or night.

Intervention
The intervention was a modified and simplified habit reversal approach (Miltenberger et al., 1998). The initial hour intervention session consisted of awareness and competing response training. Awareness training involved interviewing and discussions with B.E. and having him engage in, “(a) describing the picking and its behavioral antecedents ... (b) having the participant recognize clinician stimulations of the picking and antecedent behaviors, and (c) having the participant acknowledge occurrences of his own picking or antecedents” (Twohig & Woods, 2001, p. 219).

B.E. described when and where he engaged in SP behaviors and what he felt prior to, during, and following SP. The competing response he felt comfortable performing was wiggling his toes for one minute contingent on picking or experiencing the urge to pick. B.E. practiced the competing response during each session to ensure understanding. During each weekly booster session, the participant reviewed his SP awareness level and use of the competing response procedure. B.E. was asked to describe his feelings or urges prior to or during SP to increase his awareness of SP antecedents. The participant could ask questions during treatment and was praised for his efforts.

Results
B.E. reported 134 SP behaviors, with a mean of 19.1 behaviors per day for the week prior to treatment initiation. This level of SP
behaviors was within the expected range estimated by B.E. prior to treatment. Therefore, there appears to be minimal impact or reactivity on the habit as a result of pretreatment awareness self-monitoring/awareness training during baseline data gathering. During the first week, after treatment began, SP behaviors dropped to 66 with a mean of 9.4 SP behaviors. Following the first booster session, SP behaviors dropped to 23 with a daily SP mean of 3.3. Following the second booster session, there were four total SP behaviors with a mean of 0.57. Following the third booster session there was one SP behavior for a mean of .025, including the final 3 days with no SP behaviors. After approximately five and a half weeks and with no warning, B.E. was asked to count SP until requested to stop. B.E. reported no SP behaviors for the subsequent two days. He also reported less prominent picking sites upon tactile inspection.

After treatment and follow-up, the SPS was re-administered and B.E. scored a 1, placing him in the “non-self-injurious skin picker category.”

Discussion
In this case study, skin picking was effectively suppressed using a simplified habit reversal treatment with this older participant. Although this investigation is consistent with previous habit reversal case studies for skin picking, we advise caution against generalizing these results without conducting large sample size controlled trials to systematically validate the efficacy of habit reversal cognitive behavioral therapy for SP. Habit reversal has been shown to be effective for the treatment of nervous habits, future research should extend the follow-up period regarding the target behaviors for at least another 2-4 months from the last data collection point to evaluate long-term effects.

In addition, it is important to consider additional limitations to this case study. First of all, B.E. was evaluated by the SPS and classified based upon norms from a small sample of participants not including B.E.’s age. Secondly, B.E. also did not report any adverse psychosocial difficulties often associated with SP behaviors. Thirdly, B.E. was not evaluated for co-morbid mood symptoms often observed in SP. Lastly, this investigation suggests the value of exploring various antecedents associated with the initiation and long-term maintenance of SP that may contribute to development of prevention strategies.

About the Authors:
Barbara B Beimesch, MA, is a third year PsyD student at Xavier University. She has had practicum placements with a geropsychologist and at a university health and counseling center. She also volunteers at the VA Medical Center in the PTSD Division. She recently was awarded a scholarship by the Association for Professionals in Aging. Barbara has a law degree and has worked for a large consumer products company before returning to graduate school at Xavier.

Dr. W. Michael Nelson III is a professor of psychology at Xavier University and was the faculty advisor for this project.

References


Ohio Students Honored at Science Day 2006

By: Rachel Childs, OPA Intern

On May 6, 2006, young adults came together from different areas of Ohio to exhibit their projects for the 58th Annual Science Day. Students, grades 7-12, displayed and competed with their behavioral science projects.

The projects were shown at the OSU French Field House, and were reviewed by Columbus psychologists. The amount awarded during the day totaled $675 in cash prizes coming from The Foundation for Psychology in Ohio, as well as a $25 prize from the Ohio Women in Psychology Marla Malloy Scholarship Fund.

Prizes were awarded. First place won $75, second place took home $50, and third place received $25. In addition to those taking home an award, there were many students in attendance who had presented in the preceding years also.

A special thank you to the judges (picture above from left to right) for donating their time as well as taking part in the judging process: Jeff Sherrill, PhD, Mike Witter, PsyD, John McCue, PsyD, Mary Lewis, PhD, Joseph Bene, Jr., MA, Bill Schonberg, PhD, William Friday, PhD, and James Sunbury, PhD.

2006 Science Day Winners
Congratulations to all of the 2005 Science Day Winners:

Grade 7
1st Place: Benjamin J. Hedges: “A Comparison of the Stroop Effect on Multilingual People Versus Monolingual People”
2nd Place: Emily M. Adams: “Tortoise or Hare: What Affects Human Speed?”
3rd Place: Paige A. Meacham: “Do You See What I See? Eyewitness Testimony”

Grade 8
1st Place: Gregory T. Philip: “Doossepilng cuont?”
2nd Place: Andrea E. Sieker: “What is the Effect of Caffeine in Diet Mountain Dew on Auditory, Tactile, and Visual Reaction Time?”
3rd Place: Anthony R. Savko: “Distract and Don’t React”

Grade 9
1st Place: Julia C. Philips-Roth: “The Effects of Music Genre on Time Perception”
2nd Place: Eleanor A. Young: “How Does the Brain ‘See’ Motion?”

Grade 10
1st Place: Kapil R. Melkote: “Face-ism: A Case Study of Stereotyping in ‘Newsweek’ Magazine”
2nd Place: Brian Zachary Hedges: “A Comparison of Self-Reported High Risk Behaviors in Adolescents and the Parents’ Perception of the Adolescents’ Behavior”

Grade 11
2nd Place: Tarrah A. Folley: “The Effects of Imagery Sessions and Relaxation Techniques on the Outcome of Athletic Performance”

Grade 12
1st Place: Caleb S. Hildenbrandt: “Help? The Effects of Demographic and Priming on Altruism”
2nd Place: Kathleen E. Powers: “A Study of Youth Attitudes towards AIDS”
The OP Quiz for Continuing Education

The articles selected in this issue are sponsored by the Ohio Psychological Association. OPA is approved by the American Psychological Association and OPA-MCE office to provide CE for this home study. Please complete this form in its entirety. All responses must be correct to receive 1.0 CE credit. For each question there is only one right answer. Please submit this form and payment (OPA members: $15; Non-Members: $25) by December 31, 2006 to OPA OP Home Study, 400 E. Town St. #200, Columbus, OH 43215. Pending successful completion of this test, you will receive a certificate of completion within 30 business days of receipt.

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By signing this form, I am stating that I have taken this test myself, without help from any outside sources.
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The War Room
1. Use of humor can be an effective coping mechanism when experiencing otherwise horrific circumstances or conditions.
   True          False

2. The author in a highly personal account of serving in a war zone describes a rapid return to “normal” once she returned to the United States.
   True          False

3. Strong relationships developed among fellow combatants are identified as a major source of sustenance during and after combat.
   True          False
Don’t Answer the (Cell) Phone
1. “Spillover” from cell phones refers to:
   a) a perception of being overwhelmed by too many cell phone calls
   b) a blurring of boundaries between work and home
   c) an electronic malfunction of cell phones causing problems in receiving or sending cell phone calls

2. The authors caution readers that stress from using cell phones can blur extended family boundaries.
   True False

3. Contrary to popular belief, cell phone use is not related to increased risks for traffic accidents.
   True False

Resilience Among the Overlooked and Understudied: A Personal Perspective
1. The four different “pathways to resilience” that the author believed helpful for clients with coping were:
   a) faith, resilience, determination, persistence
   b) perseverance, acceptance, optimism, faith
   c) acceptance, assertiveness, faith, optimism

2. Clients the author worked with were ethnic minority members with histories with what system?
   a) mental health
   b) legal
   c) health

3. The identified “pathways to resilience” are unique to the minority group described in the article as oppressed.
   True False

Promoting Resilience in 21st Century Disaster Victims Using Evidence from Trauma Survivors
1. There are relatively few studies about resilient children.
   True False

2. Peri-traumatic risk factors include the quantity of multiple traumas in the past, history of psychiatric problems and personality characteristics.
   True False

3. Which characteristic was found to moderate the impact of traumatic experiences have on an individual?
   a) persistence
   b) readiness
   c) hardiness

“If You Let Me Play…” Helping Female Adolescents Develop Resilience to the Stress of Social Pressures Through Physical Activity and Structured Sports
1. Studies of the effects of sports participation and sexual behavior of adolescents show gender differences with male athletes being sexually active at an earlier age than female athletes.
   True False

2. Male adolescents react more negatively than female adolescents to stress during puberty and are at greater risk for psychological problems.
   True False
3. The author refers to a longitudinal study of female adolescents that found that sports participation was associated with (pick two):

   a) decreased interpersonal problems
   b) higher academic performance
   c) higher self esteem
   d) a sense of self-mastery

**An Examination of The Long-Term Effects Of Child Abuse and its Connection to Child Abuse Disclosure**

1. The prevalence of child abuse is different in black and white women.

   True   False

2. A major point made by the author was that female women rarely report child abuse because of stereotypes of black women being promiscuous and fearing that they will not be believed.

   True   False

3. One of the studies cited in the article found that black women compared to white women, reported more sexual abuse during preteen years than early childhood years.

   True   False

**An Update on Exposure-Based Treatments for PTSD**

1. The goal of exposure therapy for PTSD is to reduce anxiety for feared situations and memories through: (pick one)

   a) avoidance
   b) cognitive restructuring
   c) habituation

2. The most common reason clinicians do not use exposure-based treatment for PTSD is (pick one)

   a) concern that patients may decompensate
   b) concern that patients may prematurely dropout of treatment
   c) clinicians lack adequate training in such treatment

3. Men and women are just as likely to develop PTSD in response to the same traumatic experience.

   True   False

**Habit Reversal Treatment for Chronic Skin Picking in an Adult Male**

1. The results of this one case study were consist with previous one case studies using a habit reversal intervention.

   True   False

2. The purpose of the study was to evaluate the effectiveness of a habit reversal for skin picking for what type of participant compared to previous studies? (pick one)

   a) younger
   b) different gender
   c) older
3. The Skin Picking Scale used in the study has how many items?
   a) 5  
   b) 6  
   c) 7  
   d) 8

A Traditional Approach to Making Life Easier
1. Technological advances such as cell phones and Internet have helped to protect us from stress.
   True  
   False

2. The author outlined three “disciplines” for dealing with stress. Which is not one of them?
   a) optimism  
   b) compassion  
   c) mindfulness  
   d) acceptance

3. What is the author’s favorite relaxation tool to use with clients?
   a) hypnotic intervention  
   b) guided imagery  
   c) medication  
   d) mediation

New Members
Welcome to the following new OPA members, approved by the Board of Directors on June 3, 2006:

Laura M. Abood, PhD (reinstatement)  
Diane P. Castelli, PhD (reinstatement)  
Danette Y. Conklin, MEd  
Arturo Corrales  
Paul A. Deardorff, PhD (reinstatement)  
Kirsten E. Delambo, PhD  
Richard J. Duval, PhD (reinstatement)  
Cynthia M. Favret, PhD (reinstatement)  
Melissa A. Foti-Hoff, PsyD  
Jo-Ann M. Giordano, PhD (reinstatement)  
Jessica L. Grayson  
Brian J. Hall, MA  
Kristin A. Hoff, BS  
Dionne L. Hollis, PhD  
Kimberly E. Hunter, PhD  
Lorena L. Kvalheim, PsyD  
Nicole A. Leisgang, PsyD  
Lisa K. McCarthy, PsyD  
Leslie E. McClure, PsyD  
Albert F. Painter, PsyD (reinstatement)  
Lisa R. Stines, PhD (reinstatement)  
Carol D. Sweis, PhD  
Janita L. Trujillo, MS

Congratulations to the following new OPA Emeritus Members, also approved on June 3, 2006:

Dorothy M. Haverbusch, MA  
Aurelia Evangeline Norton, PhD
Tenure-track Assistant Professor: The Department of Psychology at Xavier University invites applications for an Assistant Professor in a tenure-track position in Clinical Psychology to begin Fall 2007.

Applicants must have a doctoral degree in clinical psychology from an APA-accredited program. An Ohio license or license eligibility is strongly preferred. We are seeking an individual with clinical interests in adults with severe mental disorders. Consideration will also be given to candidates with clinical interests in children/adolescents. A commitment to excellence in both undergraduate and graduate teaching and a record of empirical research are necessary. Duties include teaching graduate and undergraduate courses, thesis and dissertation supervision, developing a continuing research program, and participating in department and university service. Clinical supervision of graduate students may also be part of faculty responsibilities.

Xavier University is a Catholic institution in the Jesuit tradition with over 6500 students. The Department of Psychology has 16 full-time faculty members who teach in the undergraduate and graduate programs. These include a five-year APA-accredited Psy.D. program in clinical psychology (practitioner-scientist model), two-year master's degree programs in industrial-organizational and general experimental psychology, and a well-established, liberal arts-based undergraduate psychology major. Some faculty members also supervise clinical doctoral students at the Psychological Services Center on campus, which serves as our training clinic.

Applicants must submit a cover letter describing their teaching philosophy and experience, research interests and accomplishments, and clinical experience. Also include curriculum vitae, any reprints, and three letters of reference (sent directly by the recommenders) to Christine M. Dacey, Ph.D., ABPP, Chair, Department of Psychology, Xavier University, 3800 Victory Parkway, Cincinnati, OH 45207-6511 or email. To ensure optimal consideration, applications should be received by November 3, 2006, but the search will continue until the position is filled. For more information, visit the Department of Psychology on Xavier's Web Site at Xavier University has a strong commitment to diversity and, building upon recent success, seeks a broad spectrum of candidates including women and minorities.

Save the Dates!

October 25-27, 2006
OPA’s 2006 Annual Convention “Stress in the 21st Century: Promoting Health and Resilience”

Keynote Address “Health Care for the Whole Person” by Dr. Ron Levant, APA Past President
Plenary Session “Survivorship in the Wartime Theater and In Times of Catastrophe” by LTC Kathy Platoni, PsyD

Earn 20 credit hours! Network with colleagues! Bid on great items at the first Foundation for Psychology in Ohio Silent Auction!

Updated information available at www.ohpsych.org.

Online registration begins in late August; paper registrations will follow.