**Title:** The Role of Psychologist in Rehabilitation Pediatric Center: An analysis of neurological conditions and family functioning  
**Author(s):** Alicia Maldonado

**Abstract**  
This paper examines the role of psychologists in a pediatric rehabilitation setting. Pediatric Rehabilitation centers seek to restore and make adjustments into the functioning of children with physical and neurological conditions. This accomplished through a multidisciplinary team of medical doctors, occupational, speech and physical therapists. The recent emphasis of integrated care by the American Psychological Association (APA) encourages the psychological care in medical settings. Through the services provided by psychologists the families of children seeking rehabilitation can receive mental health treatment and family training. We will cover disorders of the neuromuscular, neurological, and musculoskeletal systems and the role psychologists play within the rehabilitation process.

**Title:** The Impact of Childhood Sexual Abuse on Mental Health  
**Author(s):** Brianna Thor

**Abstract**  
Based on statistics from the National Sexual Assault Hotline (NSAH), the number of children who experience sexual abuse or assault at the hands of an adult continues to be a high and concerning rate (RAINN, 2020). Multiple studies have identified that victims of childhood sexual abuse (CSA) were likely to experience mental and emotional problems (Allen et al., 2014). The current review of literature will highlight some of the effects of sexual abuse on childhood mental health. Additionally, recommendations for future research will be provided.

**Title:** Anxiety Presented in Adolescence  
**Author(s):** Breyanna Sanders

**Abstract**  
Since anxiety is a natural and necessary emotion that can signal worry, anyone can experience it. When these feelings are exaggerated, it becomes unhealthy and it is important to understand how anxiety presents in adolescents. In young adults, anxiety-related issues share some common factors: the anxiety that the individual experiences are fearful and interferes with the adolescent's ability to enjoy their life and perform necessary tasks. The purpose of this paper is to explore the symptoms, etiology, prognosis, and treatment of anxiety in adolescents.

**Title:** Schizophrenia: Diagnosis, Contributing Factors & Treatment  
**Author(s):** Julia Rondinella

**Abstract**  
Schizophrenia is a very complex psychological disorder that can cause impairments in many aspects of a person’s life. It is characterized by a spectrum of emotional and cognitive
dysfunctions including delusions and hallucinations, disorganized speech and behavior, and inappropriate emotions. The purpose of this paper is to explain the disorder including bio-psycho-social factors of this disorder, symptoms, etiology, prognosis, and treatment implications.

**Title:** The History and Evolution of Spirituality and Mental Health  
**Author(s):** Julia Rondinella

**Abstract**  
Although spirituality is a major part of the human person, the role it should play in the field of psychology is still up for debate. While some psychologists consider it to be a vital part of the healing process, others believe it has less value. History has seen a shifting back and forth in this perspective. The purpose of this paper is to explain the history and evolution of spirituality and mental health. Religion and spirituality still have a stigma when being discussed among psychologists, it is important to understand the evolution of this practice throughout history.

**Title:** Psychosexual Development in Adolescents with Autism Spectrum Disorder (ASD)  
**Author(s):** Carl C. Papandrea

**Abstract**  
In recent years, the psychosexual functioning of those with ASD has become increasingly studied, particularly in early childhood and adolescence. The concept of psychosexual development can be traced back to Freud’s psychosexual stages, (e.g. oral, anal, phallic, latency and genital), though this paper will utilize a more current and broad perspective of psychosexual development which is part of Erik H. Erikson’s Psychosocial Theory. The focus of this paper will be on current research regarding the psychosexual development and functioning of individuals diagnosed with Autism Spectrum Disorder (ASD) and ideas for future researchers.

**Title:** Cognitive and Affective Issues Related to Detainment (Prison/Juvenile Detention)  
**Author(s):** Carl C. Papandrea

**Abstract**  
Prisons are bad for mental health and time serviced places inmates at increased risk for cognitive and affective issues, both during and post-release. This paper looks into the cognitive and affective impact of being involved in the prison/juvenile detention system. It looks into the psychological impact being involved in this system can have on a person’s mental health. As well as treatment approaches to combating the psychological changes that effect prisoners during detainment and once released.

**Title:** The Effects of Self-Efficacy Counseling on Juvenile Offenders  
**Author(s):** Samantha Tisi

**Abstract**  
The purpose of this proposal is to examine the effects of a self-efficacy counseling intervention on juvenile offenders. It will follow a true experimental design with participants sharing the characteristic of being incarcerated youth. Self-efficacy is anticipated to be a predictor of goal-setting thoughts and behavior with a positive correlation. Experimental groups one and two will
receive two levels of intervention from the same therapist, with a control group receiving counseling without a self-efficacy focus. Longitudinal techniques will be implemented in both groups along with the control in order to compare surveys, questionnaires, interviews, and self-reports on individual experiences. It is predicted that the significance level will be below or at .05%. Future research might attempt to replicate these projected results with a mentoring program intervention, possibly intended for youth recently released from juvenile detention centers, in place of a traditional therapy.

Title: Observation of Self-Efficacy Development
Author(s): Samantha Tisi

Abstract
This observation examines the development of self-efficacy over time. The goal of this observation is to explore how an individual’s levels of career decision-making self-efficacy (DV) might relate to the developmental stage (IV) that they are in (i.e., age). Subjects were selected from four age brackets, and all of them signed and received an explanation of the informed consent form. Forms were administered to parents for adolescent participants. The age groups explored include adolescence (ages 10-17), emerging adulthood (ages 18-25), early adulthood (ages 26-39), and middle age (ages 40-65). The Career Decision Self-Efficacy Scale (CDSE), developed by Taylor and Betz (1993), aims to apply Bandura’s theory of self-efficacy to career decision making. Concepts within each developmental period include identity versus role confusion, intimacy versus isolation, and generativity versus stagnation. Each of the participant’s demographic, cultural, ethnic, and religious beliefs or practices related to different upbringing experiences may account for variation in results.

Title: The Physiology of Abuse: An Overview of the Physiological Effects of Childhood Abuse and Neglect
Author(s): Anthony J. Ferrer

Abstract
Trauma, abuse, and neglect can have devastating and life-altering effects on the developing brain (Teicher et al., 2017). There are hundreds of thousands of cases of child maltreatment reported each year in the United States (Child Trends, 2020). The continued call for action against child maltreatment remains strong and increased knowledge of the effects from abuse and neglect may aid in the prevention, as well as, provide assistance to those who have already experienced trauma. The current review of literature seeks to highlight the most current and applicable research on the physiological effects children experience as a result of abuse and neglect. Clinical considerations that are applicable and digestible for counseling professionals unfamiliar with complex neurological and physiological processes will be reviewed in detail.

Title: Integration of Science and Practice: Borderline Personality Disorder
Author(s): Ashley Del Rio

Abstract
Borderline personality disorder (BPD) is a very prevalent personality disorder, affecting up to 6% of the population. BPD is often described as intense emotions and dysfunctional
interpersonal relationships and behaviors. People with this disorder are seen as reckless and impulsive with no feelings towards others, just wanting attention. It is assumed that they cannot maintain strong healthy romantic relationships, and when in relationships- romantic or platonic- they are insecure, demanding, and sexually promiscuous. This paper outlines the symptomatology, etiology, prognosis, and treatment implications for this disorder.
The Role of Psychologist in Rehabilitation Pediatric Center:

An analysis of neurological conditions and family functioning

Alicia Maldonado

St. Elizabeth University
Abstract

This paper examines the role of psychologists in a pediatric rehabilitation setting. Pediatric Rehabilitation centers seek to restore and make adjustments into the functioning of children with physical and neurological conditions. This accomplished through a multidisciplinary team of medical doctors, occupational, speech and physical therapists. The recent emphasis of integrated care by the American Psychological Association (APA) encourages the psychological care in medical settings. Through the services provided by psychologists the families of children seeking rehabilitation can receive mental health treatment and family training. We will cover disorders of the neuromuscular, neurological, and musculoskeletal systems and the role psychologists play within the rehabilitation process.
The Role of Psychologist in Rehabilitation Pediatric Center:

An analysis of neurological conditions and family functioning

Having a baby can be an exciting and confusing time for many parents. As families envision their new life as parents, it is safe to say that they do not prepare themselves with the possibility of their child being born with a disability. Parenting a child with a disability can add psychological barriers to the child and their caregivers. Pediatric Rehabilitation Centers help to improve the child’s functioning and their caregiver’s role in said functioning. This paper looks to cover the disorders that affect the neuromuscular, neurological, and musculoskeletal systems and the role psychologists play within the rehabilitation process.

Rehabilitation is the “process of restoration after injury of disease to maximize an individual’s ability to function in a typical manner” (Swaiman, 2012). Within pediatric rehabilitation, the focus remains on the child’s functioning and the role caregivers play in their improvement (Alexander et al., 2015). Since children are in the earlier stages of their development it is the therapist’s goal to assist in developing their abilities and help them adapt to their environment given their disabilities (Bode et al., 2004). Several disorders are prominent and treated in the field of pediatric rehabilitation which includes: cerebral palsy, spina bifida, acquired brain injuries, spinal cord injuries, brachial plexus palsy, autism-related motor issues, limb deficiencies and gait abnormalities. This paper will focus on a psychologist's role in cerebral palsy, spinal bifida, autism-related motor disorder, sports injuries, and muscular dystrophy.

Symptomology
Cerebral Palsy is a term used for a group of abnormalities within an individual that is permanent and non-aggressive. Their presence leads to disorders in movement and posture (Pearce, 2018). According to the Institute of Health and Care Excellence, it is the most common physical disability in childhood. Pearce (2018), explained that abnormalities in Cerebral Palsy can occur in the neonatal period or during infancy. The disorder is characterized by spasticity, impairments in movement, muscle weakness, ataxia, and rigidity (Koman et al., 2004). Its appearance in infancy may cause babies to lose their balance, affect their ability to walk and the positioning of their limbs. Motor delays last throughout the lifespan and can progressively worsen; however, intellectual delays will remain consistent and not progress. The symptoms of Cerebral Palsy fall within a spectrum where they can be so severe that the child passes away during childhood or has symptoms so mild that intervention is not needed (Zhakupova et al., 2019).

Another disorder that is treated within the field of Pediatric Rehabilitation is spina bifida. Spina bifida is a disorder of the central nervous system (CNS) where the spinal cord fails to fully develop or close while in the womb. The disorder is characterized by disabilities in the area of cognition, motor, and language (Fletcher, J. M., Barnes, M., & Dennis, 2002). Autism Spectrum (ASD) is a neurological disorder which is identified by impairments in communication and social interactions (American Psychiatric Association, 2013). Although ASD is not commonly treated in a pediatric rehabilitation center, repetitive and stereotyped motor movements may necessitate rehabilitation.

Like ASD, Traumatic Brain Injuries can fall within a spectrum from mild to severe. Sports Injuries are the leading cause of brain injuries in children (Glass et al., 2015). Traumatic Brain Injuries (TBI) can lead to post-traumatic amnesia, neurological deficits, vomiting, headaches, dizziness, disorientation and changes in mental status (Yeates et al., 2012). Lastly, we look at Muscular Dystrophy (Duchenne and Becker), a neuromuscular
disorder that is comprised of different diagnoses correlated with genetic conditions (Rasmussen et al., 2012).

**Etiology**

The disorders which are typically treated in pediatric rehabilitation centers are organic diseases, taking place during the prenatal or the neonatal periods. The disorders are characterized by neurological dysfunction which had a direct effect on motor, memory, learning, behavior, and communication. Traumatic Brain Injuries (TBI) are the exceptions where the disorder can be acquired after birth and at any stage of childhood. Cerebral Palsy is an umbrella term for a group of diseases which can occur during the embryonic stage of development (Zhakupova et al., 2019). According to Zhakupova, (2019) the disorder can also occur during the baby's first year of life, for example, if there is trauma during the prenatal period or during the delivery, Cerebral Palsy can occur. In premature babies, if weight continues to decline it will also increase the likelihood of Cerebral Palsy. The data in the study show those with Cerebral Palsy were 69.7% likely to be born with mothers between the ages of 18 to 30 and 73.1% of mothers were previously pregnant. Additionally, amenia during pregnancy (60.7%) and those who received reproductive assistant (e.g. invitro fertilization and fertility treatments) to become pregnant (41.1%) were also likely to increase the chances of the disorder. After birth, genetic disease or viral infections can cause malfunctions in the baby’s brain as well as a lack of oxygen causing irreversible damage.

Spina Bifida is a birth abnormality that occurs during the prenatal period when the spinal cord does not fully close or develop (Panda et al., 2019). Its cause is due to a lack of folic acid in the mother’s body during the prenatal period. Spina Bifida occurs in 1 to 3 out of 1,000 live births and can co-occur with hydrocephalus, due to the spinal cord being compromised it also affects the brain and skull (Adzick, 2013). Spina Bifida can be diagnosed in utero giving parents the ability to choose the course they which to take regarding delivery. Choices for treatment can
include a planned delivery, termination of the surgery, surgical correction, or therapy during the neonatal period. Due to the awareness surrounding Spina Bifida and an increase in technology chances of children surviving into adulthood have increased from 20% in the 1950s to 80% in the 1980s (Malheiro et al., 2017).

Muscular Dystrophy can be categorized by two subtypes Duchenne muscular dystrophy (DMD) and Becker Muscular Dystrophy (BMD) (Peay, et al., 2018). Muscular Dystrophy is a neuromuscular genetic disorder caused by a mutation of the dystrophin gene caused by the X chromosome (female). The dystrophin gene produces dystrophin proteins which structure the cells in the skeletal and heart muscles. Cases of DMD and BMD are more likely to occur in males with DMD being more prominent (11 in 100,000) than BMD (2 in 100,000). Though DMD tends to have more severe symptomatology, severity ranges for both disorders (Andrews et al., 2018).

Unlike many of the other disorders where etiology can be detected in the neonatal period, Autism Spectrum Disorder (ASD) is not detected until symptoms appear. Despite not having a concrete explanation for how it occurs, researchers are aware that it is not caused by psychological impairments (due to parent maltreatment) or trauma (Ritvo et al., 1984). Researchers continue to look at genetic factors as a reason for causality. For example, recessive genes such as Phenylketonuria (PKU) or hemophilia can cause structural abnormalities in the brain which affect neurotransmitters and neureceptor pathways. Traumatic Brain Injury (TBI) is a non-degenerative brain injury which can be acquired from a hit to the head or a penetrating injury that interrupts brain functioning. Etiology of TBI can be due to a gunshot wound, car accident, sports accident, or shaking a baby to name a few. However, it may be difficult to detect TBI in children because the brain is still in the stages of development which may lead to changes in symptoms as the child ages and can interrupt brain functioning (Shen et al., 2020).

**Prognosis**
The prognosis of care in the pediatric rehabilitation setting depends on the symptomatology of the disorder and its severity. Pediatric Rehabilitation Centers employ a multi-disciplinary team of specialists which include speech therapists, occupational therapists, medical doctors, and psychologists (neuropsychologists). The focus of this section will be on the role psychologists play within the rehabilitative treatment. Psychologists have their place within the confounds of early intervention, family training, therapy, psychoeducation, and neuropsychological assessment. Within Cerebral Palsy, a psychologist can provide neuro-psych testing which can assess for motor, cognitive, language, visual-spatial awareness, executive functioning, and memory (Straub & Obrzut, 2009). Since children with cerebral palsy have several areas of deficiencies, neuropsychological testing has its place in helping to develop a baseline for treatment and identify target areas to improve child development. In addition to their neuropsychological roles, a psychologist can be utilized to examine quality of life and psychological well-being.

In a study by Wiley and Renk (2007) on quality of life, concerns were addressed with parents of children with cerebral palsy. Quality of life was determined by psychological well-being, social functioning, and levels of discomfort (pain) one experiences. Children with Cerebral Palsy can be limited in their ability to communicate; therefore, parents may assume their child is in discomfort causing higher levels of stress, depression, and anxiety in mothers. Since parents have the ability to gauge their child’s quality of life, it becomes apparent that the child’s quality of life is correlated to parental levels of depression, stress and anxiety. In addition, parents who endorsed a belief in fate/chance, lack of control over their child’s behavior, and the child’s control over the parents' life were directly related to psychological symptomatology. However, when parents were given a protocol for the treatment of their child’s Cerebral Palsy symptoms it led to feelings of competence and control of their child’s quality of life. In contrast, parents who took an authoritative role in parenting had a higher level of
anxiety. These parents sought control over their child without having positive interactions which in turn put them at risk of psychological symptoms.

In a 2016 study from Uganda (Bannink et al.,) looked at the cognitive abilities of pre and primary school children with Spina Bifida. The study shows that those cognitive abilities and socio-economic statuses (SES) were correlated. Poverty was seen as contributing to poorer cognitive function than children with higher SES. This indicates that parents with the financial means can stimulate their child in their cognitive functioning. Whereas schools in lower SES areas may lack a supportive school environment, fail to have the proper materials/equipment, and have poorly trained teachers. Bannink’s study used psychometric and neuropsychological testing on children with and without Spina Bifida. The results found that children enrolled in a school setting had better cognitive outcomes. This demonstrated that despite the cognitive impairments of children with Spina Bifida, those that are enrolled in school can reap benefits than those that are not enrolled. Furthermore, those from higher SES statuses were more likely to have social support and have the means to provide further care to their child.

In another study, the psychosocial adjustment of children with Spina Bifida was compared to a group of children with minor acute illness. Those with Spina Bifida was found to have some maladjustment (Uwe-Martin Zurmohle, et al., 1998). Specifically, boys between the ages of 6 and 11 were seen to score higher on immaturity scales whereas girls scored higher on depression withdrawal. Utilizing the Child Behavior Checklist, children with spina bifida have lower levels of social competence when compared to their able-bodied peers. Interestingly, children with Spina Bifida who were in mainstream schools had higher IQs than those within a private school setting. This may be correlated to the mother’s attitude to compensate for her child’s physical limitations with academic achievement. If the child is from an affluent area than there may be provisions in place that allow the child to be mainstreamed rather than sent out of district. The study found a downside to being mainstreamed which was that children with Spina
Bifida were more likely to have lower self-esteem than their able-bodied peers. Older boys were more worried about their incontinence and future careers as they get older. As children with Spina Bifida continue to experience longer lifespans their psychological care and role as adults need to be fostered for overall well-being.

Those with Autism Spectrum Disorder (ASD) are 80% more likely to experience motor dyspraxia, though this may not always be identified in a routine neurological exam. However, children with motor delays at the age of two indicate the possibility of ASD or a neurological condition (Sokhadze et al., 2016). Controlling movement every day requires one to have the ability to reach, grasp, walk, and gaze in a particular direction. These movements are planned, initiated, and adjusted which can be difficult for those with a neurological condition. For children with ASD, typical movements such as running jumping and ball throwing can be difficult and lead to low self-esteem and frustration (Stins, 2018). Children with ASD are also likely to have balance deterioration due to sensory processing. The poor development in balance can cause anxiety issues due to falling or poor motor performance with children who have ASD.

As a psychologist, the development of programs that target anxiety symptoms in ASD could help to improve the functioning of stereotypes and motor dyspraxia.

Studies on Traumatic Brain Injuries (TBI) looked at behaviors in a preschool setting and maternal distress. TBI in preschool-age children was more likely to result in internalizing and externalizing behavior such as defiance and aggression (Gagner and et al, 2018). These behaviors must be addressed since preschool behavior is indicative of future behavior in school, peers, and mental health concerns. Concerning maternal distress, mothers are more likely to become stressed being protective of their child if they’ve been in a car accident or hurt by a caregiver which caused a TBI. This may cause externalizing behaviors of the mother towards the child. Therefore, the child could be responding to their maladaptive behaviors in response to their mother. Another indication of maternal distress is their perception of their child’s pain. However, because children at the preschool age do not have the linguistics to communicate
their symptoms such as irritation or a headache, this may lead to further behavioral concerns which cause maternal distress. As it pertains to TBI, the psychologist needs to be present for both child and caregivers. Symptoms of TBI can become worse as the body is developing and changing as it does with typical children. However, those with TBI may show heightened behaviors that affect the caregiver and their relationship. It is necessary to make sure the child is being given coping and social skills and that the family is trained on the techniques being utilized.

Similarly, mothers with children who have Duchenne Muscular Dystrophy (DMD) and Becker Muscular Dystrophy (BMD) are experiencing some psychological distress in the care for their child. A study by Peay et al., (2018), focused solely on the psychosocial needs and facilitators of mothers caring for children with DMD and BMD. It found that caregivers did not always cope with challenging emotions, death with the uncertainty about the future of their children, and fears of the syndrome itself. This was especially true in the earlier stages of the diagnosis. In addition to the well-being of caregivers, the physical demand of caring for someone with DMD and the children’s psychological behaviors could also affect the mother’s well-being. Improvement in caregiving was associated with having support from a partner/family member and them knowing how important it was to provide the best care for the child. Pleasurable activities, social support, and exercises were also reported to increase well-being. Those who did well reported faith and spiritual beliefs as well as support from care facilitators.

**Pharmacological Intervention**

The conditions researched were all biological in nature as such medication may be implemented by medical doctors to help with symptomology. However, to address common mental health concerns, such as anxiety, depression, and attention medication may be prescribed that targets psychological aspects. For example, in Cerebral Palsy medication may be given a
Dopaminergic drug (CP Group). Dopaminergic medication is used to increase dopamine in the body and helps those to control muscles and reduce rigidity. Additionally, Benzodiazepines such as Valium may be prescribed as a relaxant to ease additional conditions in Cerebral Palsy.

In TBI injuries, children experience a range of symptomology. However, anti-anxiety medication is most likely to be prescribed to reduce feelings of nervousness and fear. Stimulants can also be utilized to increase alertness and attention that may be lost due to the injury. Anti-depressants may be prescribed to treat symptoms of depression and mood instability. Though there is not a specific medication prescribed for motor-related disorders in ASD, Risperidone is an approved medication for those on the spectrum (Alli, 2018). Risperidone is an antipsychotic which helps by improving thinking, behavior, and moods.

**Conclusion**

Children learn through their ability to move and it’s how they socialize with other children. Something as simple as swinging, playing with a ball, hide and go seek, and racing are the benchmark of children’s play. However, for children with neurological disabilities, these opportunities are not always available. When they can engage in play, they may compare their abilities to normal developing children. Their ability to interact with peers, physical limitations, and discomfort may lead to psychological symptoms. Caregivers who are aware of their child’s experience may bring them levels of distress. Additionally, being a caregiver to a child with a disability is often unexpected resulting in depression, anxiety, and difficulty balancing the role of a caregiver with their own personal well-being. In addition to physical limitations, neurological conditions can affect language and verbal abilities for the child, leading to maladaptive behaviors. How can children share with their caregivers what is wrong when they lack the ability to communicate? For children with linguistic impairments, they rely on their caregiver to be in tuned with their need and want, causing the caregiver to spend more time in the caregiver role. However, to prevent caregiver burnout it is important that the quality of the life of the
caregiver is not being neglected but instead taken into consideration. Children with disabilities spend more time with their parents than their peers making their parents emotional well-being influential in their mental and overall health.

The field of psychology has a role in ensuring that the family of a child with a disability is getting the psychological care they need to provide the best care for themselves and their child. Additionally, neurological testing can be completed by a psychologist and provides a baseline for treatment and can help guide their care in targeted areas. As children with disabilities age, counseling psychologists could look at the vocational needs of the adolescent to help them with employment. I hypothesize that being able to work while disabled brings a sense of purpose, pride and normalcy to their life. Lastly, social justice concerns are implicated throughout this paper. Having high-quality health insurance and the financial means to make accommodations as needed can lead to higher levels of cognitive abilities in children with disabilities. However, those from lower SES areas have concerns regarding the price of accommodations to the child’s environment if their insurance does not cover it. School systems in poorer areas may not have the ability to help children within the public school and they are therefore transferred out of the district with children who have a spectrum of disabilities. We have to be aware that familial care and pediatric centers are models for multi-disciplinary familial care.


The Impact of Childhood Sexual Abuse on Mental Health

Brianna Thor

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Abstract

Based on statistics from the National Sexual Assault Hotline (NSAH), the amount of children who experience sexual abuse or assault at the hands of an adult continues to be a high and concerning rate (RAINN, 2020). Multiple studies have identified that victims of childhood sexual abuse (CSA) were likely to experience mental and emotional problems (ie. Allen et al., 2014). The current review of literature will highlight some of the effects of sexual abuse on childhood mental health. Additionally, recommendations for future research will be provided.

*Keywords: child mental health, sexual abuse, mental illness*
The Impact of Childhood Sexual Abuse on Mental Health

Childhood sexual abuse (CSA) can be defined as sexual acts done by an adult against a nonconsenting adolescent (RAINN 2018). According to Springer (2007), CSA is likely to occur more than once to a child victim throughout their childhood and even into adulthood. Based on statistics from the National Sexual Assault Hotline (NSAH), 1 in 9 girls and 1 in 53 boys under the age of 18 experienced sexual abuse or assault at the hands of an adult (RAINN, 2020). Stats from the NSAH also states 98% of known sexual abuse cases victims knew their attackers (RAINN, 2020). CSA is one of the largest injustices faced in the U.S today. Children who experience CSA are more likely to experience future mental illness. Some of these illnesses include Major Depressive Disorder, Anxiety, PTSD, suicidal thoughts, and tendencies just to name a few (Springer et al., 2007).

Multiple studies have been conducted on the impact childhood sexual abuse has on the mental health of a victim. Allen and colleagues (2014) reported varied levels of mental illness between age groups being interviewed and what mental illness if any, the subjects were affected by after experiencing CSA. An example of the varying mental illness participants experienced includes anxiety, depression, and post-traumatic stress disorder (PTSD), schizophrenia, and other mental anguish in adulthood. These researchers explained that groups who had experienced CSA were more likely to experience mental and emotional problems compared to a control group (Allen et al., 2014). Although this study has brought more attention to the problem of CSA, regular studies should be conducted to keep statistics up to date.

More recent studies, such as Hailes and colleagues work in 2019, have been conducted; however, the focus was not centered around the mental health of the participant, rather, other
factors not pertaining to specific mental illnesses. It is important to note that their study did find victims of CSA are at a higher risk of experiencing PTSD and Schizophrenia in their lifetime (Hailes et al., 2019). One problem which could ultimately affect the findings of this particular study is the method in which the participants were selected. Rather than creating a survey or interviewing willing participants, the information was obtained from a database then interpreted.

While Hailes and colleagues (2019) gave proper insight into what mental illnesses and other factors could affect a person after experiencing CSA, a review done by Lindert and colleagues (2014) gave more in-depth knowledge on the rate of depression and anxiety in CSA victims. These writers completed an in-depth review of literature was completed (Lindert et al., 2014). Lindert and colleagues (2014) showed an influx in all countries the mental effects on victims of CSA. However, information from other studies was published as early as 1998 which can, in turn, cause unreliable information to today’s population (Lindert et al., 2014).

Similarly, to the aforementioned review of research, Spataro and colleagues (2004) also compiled a well-reviewed meta-analysis of previously completed research. Researchers gathered information from a database known as the Victorian Psychiatric Case Register (VPCR; Spataro et al., 2004). The VPCR is a comprehensive and reliable source of mental health cases that details what the cause was. The register, established in 1966, highlights an overview of the overall upcurve in Child Sexual Abuse related to mental health (Spataro et al., 2004).

**Stipulations**

A disadvantage of finding research that addresses the effects CSA has on mental health is the limited number of studies conducted within the past five years. This caused the conclusions of those studies to not be relevant in today’s age. Statistics on mental health have been known to rise over the years since not many individuals understood mental health in the 20th century
compared to the 21st century (A.P Association, 2019). In the past five years alone it is suggested that mental illness has risen to very high numbers and no one knows how many of these mental health cases are related to CSA (RAINN, 2020).

Another disadvantage when attempting to find proper numbers is whether or not the victims feel as though they are safe enough to speak up. While a study can give more insight into exactly how many children experience sexual abuse, the population will never know the exact number because of the fear the victims face. Since not all children have the safety of someone to share this information with, the number of people who experience mental health issues due to prior victimization of CSA is difficult to determine.

**Future Research**

After examining multiple studies pertaining to mental illness following CSA, future studies should have a more in-depth criterion in obtaining its results. For example, Spataro and colleagues (2004) used the VPCR as their only way of retrieving evidence. Although only using secondary information can have perks in retrieving information easier than more traditional research studies, controlled studies can provide further insight into the severity of illness within CSA victims. Future studies should consider using both methods to obtain information. Retrieving information from both sources can give a better insight into why CSA causes an increase in mental illness. Having the ability to obtain secondary information with first-hand accounts can give a broader, more accurate number of how many children experienced CSA and subsequently struggle with mental illness.

Studies should also be conducted on a yearly basis to keep proper statistics of the matter. This can be done through searching hospital records specifically for emergency room visits and psych ward entries. Searching emergency room visits for possible sexual abuse cases gives
insight on an estimated number of cases. Psych ward entries can help the mental health side of the study because doctors are required to keep records of their patients’ meetings. Making this a yearly occurrence can give more up-to-date insight on just how severe childhood sexual abuse affects one’s mental health.
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Anxiety Presented in Adolescence

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ANXIETY DISORDER

Anxiety Presented in Adolescence

Anxiety is when a person's body has a normal and natural response to stress. The person may feel fear or apprehension about what may come; for example, if someone is going on a job interview, they may feel nervous or fearful about their interview performance. One may notice, when they are worried and feeling anxious their body begins to tense up and thoughts become fixated on the thing that you are concerned about. When a person experiences anxiety, they can find it difficult to concentrate on anything but the situation they are concerned about, which can make it hard to sleep or even decrease appetite (American Psychological Association, 2020).

Many people think that anxiety is harmful, but it can be useful. For instance, if an individual has a deadline for an upcoming paper, it might motivate them to work twice as hard, so they will not fail. Even though anxiety can be useful, there are times when being too anxious can get out of control. If one is so worried that they cannot complete their paper to the extent that it prevents them from completing their paper, then the anxiety is no longer useful. When feelings of anxiety last longer than six months and begin to interfere with daily functioning in life, than this might indicate an Anxiety disorder, which is a type of mental disorder (Curcio & Corboy, 2020). Stigma and anxiety disorders: A systematic review. Stigma and Health, (pp126).

An anxiety disorder can differ from nervousness to excessive fear, making it is one of the most common mental disorders. Nearly one in three of all adolescents from ages 13 to 18 will be diagnosed with an anxiety disorder with the numbers increasing.

When discussing anxiety it is important to become aware that there are several types of anxiety disorders such as generalized anxiety disorder, panic disorder, phobias, social anxiety disorder, and separation anxiety disorder, obsessive-compulsive disorder, and PTSD post-traumatic stress disorder. All anxiety disorders have a common factor in that they the individual
experiences anxiety, it related to what is happening around them. (American Psychological Association, 2020).

Since anxiety is a natural and necessary emotion that can signal worry, anyone can experience it. When these feelings are exaggerated, it becomes unhealthy and it is important to understand how anxiety presents in adolescents. For some adolescents, anxiety can become a chronic state which can interfere with their ability to attend school, perform their best academically, participate in extracurricular activities, and make friends. The anxiety that they feel can lead to uneasiness and may develop into panic attacks or phobias. The presentation of anxiety disorders varies from in adolescents. Many adolescents experience a normal amount of apprehension in certain situations, such as an upcoming test for school. Most adolescents experience an overwhelming sense of fear and dread, they can't stop thinking about the situations that make them fearful, and reassurance doesn't help. In these cases, children become fixated on their thoughts of worry and have a hard time functioning in their normal life such as, going to school, and falling asleep. In Adolescents, the feelings of being fixated is the main symptom which separates normal worrying from an anxiety disorder. When this occurs, it is necessary for the adolescent to seek psychological intervention.

In young adults, anxiety-related issues share some common factors: the anxiety that the individual experiences are fearful and interferes with the adolescent's ability to enjoy their life and perform necessary tasks. The anxiety can be as confusing to the individual themselves as well as their parent or guardian (Muris et al., 2017).

**Symptomatology**

The signs and symptoms of anxiety can vary from person to person, feeling anxious the body is on high alert and looking for any possible danger, activating the "fight or flight" response
ANXIETY DISORDER

(American Psychology Association, 2020). There are many symptoms of anxiety such as rapid heartbeat or breathing, nervousness, feelings of danger, panic, weakness, OCD, and PTSD. Someone experiencing anxiety should seek help when the worrying interferes with their life, becomes up or is difficult to control. If someone who has anxiety is also susceptible to a physical health condition such as a cardiovascular disease or is having suicidal thought, they should seek emergency treatment immediately. The more concerning issue is that the person's anxiety may not go away on their own and may become worse over time, so the person must seek treatment, (American Psychology Association, 2020).

Anxiety is likely to cause sleep-related problems. Sleep disruption in adolescents may cause issues with their physical and mental health. Sleep-related problems might result in nightmares, difficulties falling asleep, waking up unexpectedly or refusal to sleep alone. These problems with sleep can persist into adulthood which places the individual at risk for subsequent emotional dysregulation. Sleep-related problems can also affect young adults' attention problems and aggressive behavior (Caporino et al., 2017). In addition to anxiety causing sleep related problems, anxiety is comorbid with eating disorders in adolescents between ages 8-13 and 14-17. More than half of individuals with an eating disorder such as Anorexia, Bulimia, and Binge eating have anxiety. In addition to the stress anxiety causes, it is common for it to be comorbid with depression (Schaumberg et al., 2019). At age 10, anxiety disorder symptoms predict eating disorder symptoms and diagnoses in adolescence. *Journal of Child Psychology & Psychiatry*, 60(6) (pp686). The reason anxiety and depression present comorbidly is an overlap and interaction of symptomology such as feeling worry which lead to feeling down or sleepy.

When focusing on the symptomatology of anxiety amongst adolescents, we must be aware that these symptoms vary and generally include fear and restlessness, with some
adolescents describing feeling nervous or stressed. Ways to identify when a young adult may experience anxiety is by looking at their social setting. Anxious adolescents may appear dependent, withdrawn, uneasy and may seem overly emotional. Some worry may include being preoccupied with losing control or unrealistic concerns about their social life (Peterman, et al., 2019). Young individuals who suffer from anxiety often experience physical symptoms such as, muscle tension, cramping, stomach pains, headaches, or body pain. You may also notice them blushing, sweating, trembling, or hyperventilating. Another physical change that may occur will be the way their body looks or feels, based on social acceptance. Some adolescents may appear shy if they have anxiety. Adolescents who are dealing with anxiety may deny their fears or worries, and engage in risky behavior such as drugs or compulsive sexual behaviors (Peterman et al., 2019). When people experience anxiety, they may blame themselves and feel embarrassed because of their consistent worry believing that their anxiety is a sign of weakness. Because these are the issues that adolescents are presented with it may be harder to detect exactly what is troubling them. Adolescent years can be considered one of the most stressful times affecting school performances and social life. It is important to recognize that anxiety may have a role in these types of behavior.

**Etiology**

There is not an exact cause. It is not developed by a single factor but a combination of things can develop it. Some factors that may play a role in the cause of anxiety are personality factors, physical health, and difficult life experiences. Many mental health conditions are genetic, and it is important to know the family history. People with anxiety may have a genetic predisposition towards anxiety which can then be passed down from generations, though this is not always conclusive (Greene et al., 2013).
Personality is not always thought of as contributing to one’s personality. However, those who have certain personality traits are more likely to have anxiety, such as perfectionistic thinking, being timid, low self-esteem, low frustration tolerance, and those needing control. If these personality traits began during childhood, they may affect the individual as they age (Barlow & Kennedy, 2016).

Stress is one of the most common causes of anxiety. Triggers that can be included are environmental factors such as work stress, relationship problems, traumatic events, abuse, or grieving the loss of a loved one. Alongside stress, physical illness can be caused by stress and anxiety such as hypertension which leads to weakening of the heart, high blood pressure, or asthma. Physical conditions can then mimic anxiety such as an overactive thyroid which can explain the feelings of anxiety. Mental health is also a common cause for experiencing different types of anxiety disorders such as depression, (Barlow & Kennedy, 2016). Drugs are a common way people try to manage anxiousness but this may lead the person to develop a substance use problem alongside anxiety. (Dyer et al., 2019).

As previously mentioned, adolescent years can be stressful leading one to have feelings of anxiety. During the adolescent stage, females are more likely to feel stressed as the result of placing high expectations on themselves. For instance, most teens want to do well academically in school and have expectations of attending a university. While this may be their focus, they may also be working part-time jobs, involved in sports or participating in school clubs. With so much pressure along with balancing hobbies or activities in their social life, they may experience stress and have little time to decompress, leading to sleep deprivation and ultimately causing anxiety. Hormones can also play a factor in the presentation of anxiety in children. If the individual is feeling anxious, upset, sad, or angry without because this may be a result to
hormonal changes. Teenage boys who are dealing with testosterone and girls who deal with menstruation lack experience and maturity to deal with hormonal changes making them at risk for stress and anxiety (Peterman et al., 2019). Hormonal changes are not the only bodily change that causes anxiety, brain development is also a cause for anxiety. During these years an adolescent brain has not fully developed until their mid-twenties. When a teenager is expected to take on adult responsibilities, but they do not have the skills to care for themselves, leading to frustration and raising their anxiety level (Pattwell et al., 2013). Parents can also influence adolescent anxiety, if they do not recognize the balance in their need for acceptance and challenging authority. When the parent disapproves of their child this can cause frustration, stress, or sadness. Lastly, during the adolescent stages social life is important and both positive and negative attention can raise anxiety. The need of wanting to fit in with your friends or being bullied and being afraid to attend school all coincides with anxiety (Peterman et al., 2019).

**Prognosis**

Anxiety in each age group from children to adults are more commonly presented in women and occurs earlier in women than in men. Women are also more likely to be diagnosed with a psychiatric disorder than men such as co-occurring anxiety and depression. Studies have shown there is a difference in brain chemistry, specifically the fight or flight response which is more activated in women’s brains than mine. Women also continue to stay activated longer than men, due to estrogen and progesterone that women produce, (Lloyd et al., 2017). Other than estrogen causing anxiety in women, the neurotransmitter serotonin is a big part and may be a response to stress and anxiety. Evidence suggests that the female brain does not produce serotonin as quickly as it would for a male brain, and women have low levels of corticotropic-releasing factor which is a hormone that produces stress that then makes women much more
vulnerable than men concerning stress-related disorders. The coping strategies that men and women use can also play a role during stressful situations. For example, if a woman is faced with a stressful situation they may ruminate about the situation increases their anxiety but men decide to take the active role when trying to cope (Lloyd, Klinteberg, & DeMarinis, 2017). Besides women lacking in their coping strategies. Women are also more likely to experience mental and physical abuse more than men which is also linked to anxiety. Women that have experienced sexual abuse at any age may have abnormal blood flowing to the hippocampus which involves our emotional processing (McCarthy-Jones, & McCarthy-Jones 2014).

Black men are also more likely to experience anxiety since they are not taught how to process and talk about their emotions. This then leads to feelings of isolation, anger, resentment, and this causes them to "shut down" in their relationships with family and friends. Because black men are unaware of how to handle their heightened emotions the resentment they carry may lead to aggression and violent behavior, Whitaker, J. A. (2018). There is a struggle on how to be vulnerable when sharing their emotions. Black adolescent males who grow up and are considered "sensitive" are more likely to be ridiculed for sharing their emotions, black men overall are prized about their physical appearance but not their emotions. Black men are told to “man up” even at the young ages and they are taught not to cry about things but to shake it off. African American males are more likely to not seek help or talk about their emotions, resulting in releasing emotions negatively (Whitaker, 2018). Overall, the American population is less likely to seek treatment for mental disorders and can use religion as a way of healing.

**Treatment**

Now that we know all our information about anxiety and that it is the most common mental disorders, we should also be aware that anxiety is treatable. Several effective treatments
can lead people to a normal and productive life. Cognitive-behavioral therapy or better known as CBT, focuses on understanding the individual's perception of thoughts by changing their maladaptive thoughts to more adaptive thoughts. The therapist may help the client develop coping skills to help them deal with their anxiety (Lee et al., 2019). Talk therapy is also useful in understanding why the individual is having the thoughts that they are having. Dialectical behavioral therapy or DBT is another form of CBT this type of therapy encourages the client to accept and change where they are in life and be motivated to improve while mindfulness is practiced. Another form of therapy is exposure therapy when the therapist will expose the client to a situation that they fear. The goal is to eliminate the client from being fearful of the situation. For adolescents dealing with anxiety, group therapy may be a great start. This helps others relate to one another, and group therapy can be seen as an alternative for those who may not be able to afford one on one therapy. The individual feels supported by their peers to share their experiences and can receive or offer advice to others. Hypnosis has also been suggested to clients, the goal of hypnosis is to have the person in a relaxed state by having them breathe, the therapist will use guided imagery or muscle relaxing techniques these techniques can reduce anxiety symptoms (Lee et al., 2019).

While therapy is an important part of treatment to help those, who have an anxiety disorder, prescribed medications are also a part of. The most common medication used to treat anxiety are SSRIs which are prescribed as antidepressants. These medications block nerve cells in the brain from reuptake and leave enough serotonin available. Another medication used to treat anxiety are Benzodiazepines which helps with sleep, relaxation, and mood changes (Strawn et al., 2018)
Meditation is also beneficial in treating anxiety as it allows focus our thoughts and redirects them. Meditation should be practiced in an environment without any sensory distraction. There are many forms of treatment for anxiety disorders that are safe and effective. It is very important that when an individual is experiencing any signs or symptoms of anxiety for more than six months that they seek treatment. For adolescents who struggle with the conditions of anxiety, others need to be aware of the non-verbal signs and symptoms displayed when an adolescent has anxiety.

**Biopsychosocial**

The biological factors of anxiety are based on genetics and brains functioning. It is based on what is passed down genetically which is considered our "personality type" which informs us of how people respond during stressful situations. The biological factors have to be in place for anxiety to be presented. Research shows that at birth we have temporal differences. For example, some babies may have more sensitive temperaments to stress than others, and these differences can remain as the child gets older, which then causes the individuals to be more prone to developing a anxiety disorder (Greene et al., 2013).

The psychological factors of anxiety are our thoughts beliefs and perspectives about our experiences, as many psychological factors predict vulnerability to anxiety. Perceived control which defines itself as the person's ability to perceive control during a stressful event and the degree of their perception is important. When a person has a negative perception, they expect negative outcomes. Perception can be developed not only through the person but can be influenced, for insistence family style. If a parent is overprotective then the child might view the world as dangerous. Loss of something, separation, or trauma are also influencers of perception.
Due to lack of control of thoughts and emotions, it's hard for the person to control their perception (Greene et al., 2013).

Social factors that play an important role in anxiety are the effect of the individual’s ability to socialize or communicate with others. The person may feel fear interacting with others, avoid conversations or public speaking with poor verbal communication skills, low self-esteem and self-critical. There is also a fear that if they don't interact or communicate with others then they have a fear of being judged (Greene et al., 2013). Social factors are also influenced by the person's parents, if the parent is overprotective and encourages the child to believe that other people are harmful or cruel then this will lead to a negative perception of social relationships. Another social factor is rejection where many times when an individual has been rejected by loved ones, they tend to develop a fear that if they try to create relationships with others, they may witness the same rejection, causing a lack of confidence in building relationships.

Conclusion

Overall, we understand that anxiety is normal for people to experience. It is in our nature as humans to feel fear and have a natural response to danger. But we understand that too much fear can be considered an issue if it interferes with the person's daily life. Adolescents are the primary age group that experiences anxiety, though they experience high levels of stress adolescents who have higher expectations from family and peers feel pressured to wear many hats. Adolescents experience many signs and symptoms of an anxiety disorder. They may feel sad, tired, increased heart rate and breathing, or physical symptoms such as body aches and pains. While these symptoms are common, adolescents may feel ashamed or embarrassed that they are dealing with these emotions due to fear of being judged by peers. They may not express their fear but instead express anger outburst. The reason that anxiety is common during the
adolescent stage is because of hormonal changes. Young males develop testosterone and young females begin to start menstruation, and since the individual is still in the process of maturing it may be difficult to understand their feelings.

There are many causes of anxiety such as biology and genetics, Family members who struggles with anxiety disorder may or may not be passed down from generation to generation. Adolescents who have anxiety confront many issues that may be the main cause of their consistent fear. Parental disapproval leaves adolescents to feel the need to have their parent’s approval. When their parents disapprove of their child it causes stress. Many adolescents also have high expectations and are hard on themselves regarding academic achievement, and peer relationships. This can also play a major role in the adolescent dealing with different stressors on how to be accepted by others. With these issues, adolescents may result in drug use to avoid feelings of anxiety.

Anxiety is most seen in women and during the years of 13-18 years of age females are experiencing an increased risk of anxiety. Women are more likely to stress more than men and ruminate over their stressors. Young African American males are also more likely to experience anxiety due to the expectation of being a man and not being too sensitive, another cause of their anxiety are negative stereotypes that are projected onto them.

Adolescents must seek help when they feel extreme fear. The signs and symptoms can cause serious effects on the individual and may lead to suicidal thoughts or behaviors. During the adolescent stage, it may be difficult for them to communicate how they feel because of embarrassment. Group therapy can be an effective form of treatment for adolescents. The person will feel supported by their peers and can connect with others who also face the same situations.
There are several different ways to treat anxiety disorder and each treatment is effective in helping the client to become less vulnerable to anxiety and live a healthier lifestyle.

Overall, we have looked at all aspects of anxiety and were able to understand what it is and what causes it. We can identify the signs and symptoms and understand how different people may present different forms of anxiety. We should understand that anxiety does not limit nor label a person and these individuals can make the change in themselves when they reach out for help and guidance. If you witness someone who is experiencing anxiety it is also important to pay attention to their presentation and be sure to offer support in helping them seek treatment.
References


Schizophrenia: Diagnosis, Contributing Factors & Treatment

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Schizophrenia: Diagnosis, Contributing Factors & Treatment

Schizophrenia is a very complex psychological disorder that can cause impairments in many aspects of a person’s life. This disorder is commonly spoken about, but also very misunderstood. The word schizophrenia is derived from the Greek words “skhizein” meaning split and “phren” meaning mind. Due to this, people commonly assume this disorder involves having split personalities, similar to multiple personality disorder. In today’s society, people tend to use the word schizophrenic when someone is acting “crazy”. This contributes to the misunderstanding about this disorder and what it entails. The way mental disorders, specifically schizophrenia, are portrayed in the media also contributes to this assumption. People who have schizophrenia in movies or books are commonly misrepresented, especially when characters are driven by violence. Although these assumptions are not true, there are many other obstacles that accompany this diagnosis. Schizophrenia is characterized by a spectrum of emotional and cognitive dysfunctions. This includes delusions and hallucinations, disorganized speech and behavior, and inappropriate emotions. The spectrum for symptoms of schizophrenia range from not present to severe. For a diagnosis of schizophrenia to be made, there must be at least two or more negative, positive and disorganized symptoms present. With the wide variety of symptoms, schizophrenia can be represented in many different ways. This is another aspect that causes confusion when discussing schizophrenia. A person who is wearing a tin foil hat to prevent interaction with aliens may have a diagnosis of schizophrenia, but a man sitting completely still on a bench staring off into the distance may also have the same diagnosis. There are many contributing factors to the diagnosis of schizophrenia, like biological, social, and psychological influences. These influences heavily impact how schizophrenia is characterized by person to person.
Symptomatology and Etiology

Schizophrenia spectrum disorder contains many different facets, but they all share the feature of reality distortion. The first psychologist to make significant progress when researching schizophrenia was Emil Kraepelin. He identified three very important symptoms that are still notable today. This includes catatonia, which is the alternation between immobility and excited agitation, hebephrenia, which is silly and immature emotionality, and paranoia, which consists of delusions of grandeur or persecution (Barlow, Durand & Hofmann, 2018). He stated that these three symptoms fall under the dementia praecox. This classification means that there is an early onset and could indicate “mental weakness.” This was the earliest distinction made between psychotic disorders and manic depression. Although much progress has been made since, some of these features are seen in many of the symptoms that are used in a diagnosis from the DSM V.

The DSM 5 has listed the diagnostic criteria for schizophrenia which indicates that “A. Two or more of the following, each present for a significant portion of time during a 1-month period. At least one must be (1) (2) or (3): 1. Delusions, 2. Hallucinations, 3. Disorganized Speech, 4. Grossly disorganized or catatonic behavior, 5. Negative symptoms (diminished emotional expression)” (American Psychiatric Association, 2013). Other symptoms include “B. For a significant portion of the time since the onset of the disturbance, level of functioning in one or more major areas, such as work, interpersonal relations, or self-care, is markedly below the level of achieved prior to the onset, C. Continuous signs of the disturbance persist for at least 6 months, D. Schizoaffective disorder and depressive or bipolar disorder with psychotic features have been ruled out” (American Psychiatric Association, 2013, p. 99). It is important to be sure of a diagnosis before assigning it, due to the stigma that is associated with schizophrenia. It has
been misrepresented in many ways by the media and society often devalues individuals with this diagnosis. Many find it difficult to maintain a job or personal relationships. Even with technological advances, the full recovery rate of schizophrenia is one in seven (Barlow, Durand & Hofmann, 2018).

**Biological Factors**

It has been recognized that individuals with schizophrenia have varying symptoms and causes. Biology must always be considered when discussing mental health because genetics carry many disorders through lineage. Schizophrenia is one of these disorders with genetic considerations, though it has been a debate. The general consensus was that genetics make some individuals vulnerable to schizophrenia (Barlow, Durand & Hofmann, 2018). To test genetic vulnerabilities, there have been some studies done on families. The findings were interesting and provided very important information. Having a parent with schizophrenia gives a child a 17% chance of also developing schizophrenia. Children who have parents with severe schizophrenia were more likely to develop the disorder, although it may be characterized in different ways. Even if both parents are paranoid, this does not indicate that the child will have the same fate. The child may also have schizophrenia, but it can be presented in different ways, such as catatonia. Adoption studies were also done to test the genesis of schizophrenia, and it was shown that non-biological children with a schizophrenic mother have a 5% chance of also developing this disorder, when compared to the general public with a 1% chance (Barlow, Durand & Hofmann, 2018). This shows there are many different contributing factors to how mental disorders develop and persist.

Twin studies have also largely contributed to this topic. One of the most intriguing studies done on this disorder focused on quadruplets who were all diagnosed with schizophrenia.
The “Genain” quadruplets were all raised in the same environment and were biologically similar, yet each sister expressed their schizophrenia in very different ways. The age of onset, symptoms, and their outcomes all varied among the four sisters. For example, one of the sisters was a habitual masturbator and suffered from more social impairments than the others. The same sister was also the first to experience the symptoms of schizophrenia, whereas one of her other sisters was not hospitalized until many years later. The study showed how regardless of having the same genetic make-up and shared environment, schizophrenia can develop differently for different people.

It can be seen that the biology must be having an impact on how this disorder evolves. Researchers have been looking extensively into finding a marker gene, which would indicate where in one’s DNA the disorder is originating. They believe that there is a “carrier” for a schizophrenic gene that has the possibility of being inherited by future generations (Barlow, Durand & Hofmann, 2018). For example, the 22nd chromosome is suspected due to its role in metabolizing dopamine. Further studies have been done on this theory and it has been recorded that dopamine is important for the genesis of psychosis (Radulescu, 2009). The same study also showed that specific areas of the brain are also a factor of psychosis, specifically, the amygdala, the hippocampus and parts of the prefrontal cortex. If there is an impairment in these parts of the brain, this could be contributing to the symptoms and also have an impact on the treatment of this disorder (Radulescu, 2009). The limbic system is very complex, which contributes to why schizophrenia is difficult to understand.

Other studies have been performed to determine exactly where the symptoms are originating from within the brain. Brain imaging was done to shed light on this phenomenon, and some interesting facts were discovered. The brain was scanned while participants were
hallucinating and the Broca’s area was most active during this time. This finding was interesting because the Broca’s area of the brain is responsible for speech production, not comprehension. If the individual is hearing voices, one might assume that there is an issue in the Wernike’s area of the brain, which involves language comprehension. This has led to the idea that the people who are hallucinating are not hearing the voices of others but are unable to distinguish the difference between their thoughts and their own voices. This supports the idea that individuals with schizophrenia have issues with metacognition. A possible explanation for this is called “emotional prosody comprehension.” Prosody is a term used to explain our spoken language, in regard to pitch, amplitude and pauses (Barlow, Durand & Hofmann, 2018). An example of this is when someone asks a question and the inflection of their voice goes higher. We are able to understand that they are asking a question based off of their tone of voice and inflection. It has been seen that those with schizophrenia who experience auditory verbal hallucinations have deficient emotional prosody and are unable to make these distinctions. This could also contribute to the confusion between their inner voice and external stimuli.

**Psychological Factors**

Psychological issues have a large impact on schizophrenia. As seen, comprehension can be impaired which may lead to cognitive issues or deficits. If a person cannot comprehend context of conversation or be aware of their own internal thoughts, many aspects of their life may become impaired as well. There are many ways that psychological distress can be identified in an individual. The distinction between the differences in the symptoms experienced with schizophrenia is very important. There are positive, negative, and disorganized symptoms. The positive symptoms include delusions and hallucinations, which is commonly seen among schizophrenic patients; between 50% and 70% experience delusions and hallucinations or both
Delusions are described as a belief that would be seen by most members of society as a distorted reality. There are two more common types of delusions, one being of grandeur and the other being of persecution. Those who experience delusions of grandeur, believe that they are famous or powerful. Delusions of persecution is the idea that someone is out to get them, which can be very disturbing. People who have these delusions will avoid certain situations because they believe they are being followed or watched. This causes a disruption in their social lives. Hallucinations are described as experiencing sensory events without any input from the environment. They may be experiencing intrusive thoughts, but believe it is originating from somewhere else, rather than inside their minds. This can have a significant impact on the mental health of an individual. Worry is also a common side effect from experiencing hallucinations, and can cause meta-worrying, which is worrying about their worry. This increases the depressive and anxiety symptoms in these individuals. Both delusions and hallucinations are considered positive symptoms because something is being added into their perception. For example, the belief that aliens are coming to Earth can manifest from their own cognition causing an increase in their anxiety. Others may believe that they hear their deceased loved ones speaking to them, which is a positive sensory experience.

There are also negative symptoms that are a possibility with schizophrenia, which indicate the absence or insufficiency of normal behavior. An example of this is avolition, also referred to as apathy. This is the inability to initiate and maintain activities, which will limit the interaction a individual has to the world and society. Another negative symptom is affective flattening, which happens to be very common. In fact, one quarter of people with schizophrenia experience this. Affective flattening is the lack of expression when one would normally expect them to. This is detrimental because nonverbal communication is very important when
interacting with others. Picking up on and sending social cues is an important aspect when creating and maintaining friendships. Schizophrenia has the ability to change the cognition and affect of an individual, which can lead to further psychological issues.

Disorganized symptoms may also be present in an individual who suffers from schizophrenia. Unfortunately, this symptom is not extensively researched, and it is not fully understood. These symptoms include erratic behaviors that may affect speech, motor behavior and emotional reactions. An example of this is disorganized speech, which is a major communication issue. This can be represented as jumping from topic to topic or speaking illogically. It may be difficult to hold a conversation with an individual with schizophrenia because of this. Tangentiality is often an issue, where the individual will go off on a tangent unrelated to the topic of discussion. Another disorganized symptom is inappropriate affect, which means that the reaction of the individual does not match the context of the conversation or situation. Common examples are laughing or crying at inappropriate times, which could prevent connections to others. This is a direct effect that schizophrenia has on affect and how the individual can have difficulties in presenting themselves in public.

Social Factors

Social aspects of one’s life also has a large impact on how their lives will unfold. As mentioned earlier, the media has stigmatized schizophrenia and has correlated it with violence. A study that was done indicated that “the majority of characters with schizophrenia in English language movies between 1990 and 2010 were portrayed as violent, with more than one third depicted as murderers and one fourth as suicidal” (Owen, 2012). Although it is possible that someone may become angry and violent, it is not the standard expression of schizophrenia. This attributes to the reason why schizophrenia is still seen much differently in society. This is a
contributing factor to how schizophrenia has been used to describe someone who is acting “crazy” or “out of sorts”. When the media portrays these individuals as having a serious mental disorder, society will follow suit, and this contributes to the stigmatization of mental health. Another reason could be that schizophrenia is so complex, that the diagnosis itself is controversial. In some cultures, they believe that schizophrenia does not really exist, and it is a derogatory term for those who exhibit unusual behaviors (Barlow, Durand & Hofmann, 2018). Other cultures, like native Chinese, believe that when one develops schizophrenia, it is because they did something evil in another life. The belief is that schizophrenia is seen as a punishment for their wrong doings in another life (Barlow, Durand & Hofmann, 2018). The way they treat this disorder also varies widely, where they believe that ancestral worship will help cure this disorder. Either way, schizophrenia is universal and affects all racial and cultural groups that have been studied thus far. It is universal in its prevalence, but the symptoms and characterization still have an impact on how it is presented. Many societal factors contribute to this, including politics and economics. People who suffer from schizophrenia in Africa may not have appropriate healthcare to access any treatment options. People in America with this diagnosis also encounter difficulties when seeking treatment. If insurance does not cover the treatment, it can be very expensive. The annual cost of schizophrenia in the United States exceeds 60 billion dollars (Barlow, Durand & Hofmann, 2018). This is also taking into account family caregiving, lost wages, and treatment, because all of these aspects are impacted by a schizophrenia diagnosis. It can be debilitating for the individual and the family of the individual as well.

Although schizophrenia does not discriminate against race or culture, it could be debated that health care professionals do. In a recent study, the aim was to test the disparities between
ethnicities and the diagnosis between mood disorders and schizophrenia. It was seen that people of Hispanic origin were three times more likely to be diagnosed with schizophrenia (Hamilton, Heads, Meyer, Desai, Okusaga & Cho, 2018). In another study, Caucasian women were more likely to be diagnosed with a mood disorder, despite the fact that they were experiencing significant psychotic episodes (Hamilton et al., 2018). Due to this, a study was done to test the disparities in hospitals when it comes to diagnosing. This study was conducted in Texas, where there is a higher population for African American and Hispanic individuals. It was seen that schizophrenia was over diagnosed in African Americans and under diagnosed in Caucasians (Hamilton et al., 2018). Schizophrenia is a very polarizing disorder. It causes many disruptions in a person’s life and the stigma of that diagnosis will follow that individual for a very long time. Another very interesting finding was that when there was an interpreter present for the intake assessment, Hispanic individuals were less likely to receive a diagnosis of schizophrenia (Hamilton et al., 2018). This leads to the assumption that there may be a language barrier when individuals come into the hospital, leading to the misdiagnosis of schizophrenia. This is very important because this could be happening in many different parts of the country. As mentioned, living in America with a diagnosis of schizophrenia is very expensive. Receiving this diagnosis can cause a significant amount of stress on a family or individual. Treatment options are not as readily available due to its complexity and being misdiagnosed can cause further issues for that person.

**Psychosocial and Psychopharmacological Treatment**

The treatment of schizophrenia can be tedious because there is not one singular solution to help. The most appropriate approach to treating schizophrenia is to start treating each symptom. Antipsychotic medication has been seen to help some individuals, but this treatment is
sometimes seen as controversial. Some researchers argue that some antipsychotic drugs will increase dopamine, which is the neurotransmitter that is assumed to increase psychotic episodes (Radulescu, 2009). Although this may be true for some people, some medications have the ability to significantly decrease the amount of hallucinations and delusions experienced. It has been seen to help with managing psychotic episodes, which leads to a better quality of life. Considering that schizophrenia has such a large spectrum, it is expected that not all treatment options work for every individual.

Another form of therapy treatment that has been seen to make significant improvements is skills training. In a skills training treatment, the patient is prompted to relearn social skills, like basic conversation and relationship building. This can be done by participating in role play, where the clinician and the patient act out possible scenarios. This helps the patient to visualize how these interactions will play out when done in a real social setting, which will help with creating friendships or maintaining employment. This extends further, so the individual can reacclimate with the community and be conscious of their actions and behaviors. The skills training will help them show initiative by taking charge of their own lives and schedules, by helping them identify when a relapse is imminent, or learning how to manage their medications. This will help the individual build a stronger cognition, meaning they will be learning and understanding their diagnosis and actively preventing any future incidents. Developing a better self-awareness will help the person live a full and independent life. Another psychosocial treatment process is cognitive remediation, which focuses on improving cognitive processes, like attention, memory and executive functioning. Changing the cognitive processes helped change the behaviors of these individuals and prepares them for functioning in society. All of these types of treatment have been seen to be effective, but it is very important that the patients are
consistent and dedicated to the treatment process. The typical length of time that individuals with schizophrenia stay on a regular treatment plan is 18 months (Barlow, Durand & Hofmann, 2018). This shows how it can be difficult to stay on a regiment when dealing with a significant mental disorder. The support of family and friends is one of the most important aspects when discussing remission or recovery. It is crucial that family and friends do what they can to help the individual stay on a treatment plan so they can see progression in behavior and cognition.

**Prognosis**

Considering how complex and difficult schizophrenia can be, there are many studies that cover the topic of treatment and what will be most efficient. One study that was done was very enlightening because it was a longitudinal study testing how treatment helped individuals with schizophrenia. This study was conducted over the span of one year and extended into eight countries to see how treatment outcomes vary in different parts of the world. Schizophrenia is not considered curable and will likely be present for the individual throughout life, but can be managed. Although there are approaches to manage this disorder, many patients will still experience positive and negative symptoms, and 10% of patients will have a relapse while in recovery (Haro, Altamura, Corral, Elks, Evans, Krebs, Zink, Malla, Méndez, Bernasconi, Lalonde & Nordstroem, 2018). It was also estimated that two-thirds of patients still experience positive symptoms two years after the initiation of medication for treatment and approximately one-third will continue to experience these symptoms six years after the initial diagnosis (Haro et al., 2018). As mentioned earlier, the most effective way to treat schizophrenia is by treating the symptoms. Although this has worked for many individuals, the ultimate goal has recently changed to help these patients achieve full recovery.
In the study done by Haro and colleagues, the results were very telling. Despite the fact that 35% of the participants were in symptomatic remission at baseline, only 7% were in recovery after 12 months (Haro et al., 2018). This shows how difficult it can be to treat individuals with this disorder. Because of its lengthy remission time, many people will stop treatment. Some may not have the financial capacity and others may feel that treatment will not work and do not want to continue. Over the course of the 12 months, participants also did not have a reduction in the persistence of negative symptoms, and it has been seen that it usually takes about three to five years after the first psychotic episode to stabilize. Again, this is a lengthy amount of time, but these symptoms can be relieved with proper treatment. If individuals are not committing to their treatment plan, then there is a high likelihood of relapse. The study shed light on how important it is to commit treatment. The individuals who did so were able to reach remission after 12 months. It also showed how treatment approaches vary among different people and the right approach will help those individuals reach recovery. Committing to the right treatment will help these individuals reach their full potential. Schizophrenia has a negative connotation, but it is manageable. The people who have this disorder will have many obstacles, but it has been seen that people can overcome these. With the right treatment, understanding, and support from family and friends, these individuals are able to live a fulfilling life.
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The History and Evolution of Spirituality and Mental Health

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The History and Evolution of Spirituality and Mental Health

Although spirituality is a major part of the human person, the role it should play in the field of psychology is still up for debate. While some psychologists consider it to be a vital part of the healing process, others believe it has less value. History has seen a shifting back and forth in this perspective.

When this topic is discussed, it is important to remember what each term means. Spirituality and religion are two different things. “Spirituality is generally understood as the thoughts, feelings, and behaviors an individual engages in search of a relationship with the sacred; religiousness is generally defined as those spiritual thoughts, feelings, and behaviors that are specifically related to a formally organized and identifiable religion’’ (Pargament and Saunders, 2007, p. 904; Foster, Bowland & Vosler, 2015, p. 193). Spirituality defined in this way shows how it is more of a personal experience. It may stem from a specific religion, but it is personal to the individual and does not follow a specific set of rules. Religion is more about following the teachings of a specific dogma and having guidelines for how to live one’s life. Not being a part of a specific religion does not mean that one cannot be a spiritual being. Having a strong connection to the self and the soul can have an extraordinary impact, and some may say that those experiences are religious to them. Believing in oneself and a “higher being” can provide a person with a unique type of power. It can encourage the person to be a better version of themselves and to observe their lives objectively. It does not need to be a specific organized belief, but it can be. Many times, spirituality and religion go hand in hand, which is why they are commonly described as being the same experience. This leads to misconceptions among society, meaning that spirituality can be seen as following a specific religion. Spirituality is about
connecting to oneself and having the capacity to reflect on one’s life while striving to become a better person. Introspection leads to self-discovery and spirituality can help people with this feat.

Psychology - the study of the psyche - was not recognized as a legitimate field until the 19th century. This science continues to evolve; most recently with the use of technology in studying the brain. However, the ancient Greeks began studying the mind many years before. While Aristotle was the first philosopher to mention spirituality specifically, he studied under Plato for many years. Plato set the foundation for spirituality to be an important part of existence. He believed that everyone has a soul; therefore, we have an innate ability for introspection and reflection. He was a dualist in this respect, meaning that the body and the soul are both important for how we gain our knowledge. Aristotle took this belief, and he expanded on it. Aristotle believed that everything had a purpose. This could be seen as spirituality because he also said that everything has a soul. If something has a soul, then it must have a purpose. He mentioned the hierarchy of souls, which includes the vegetative soul, the sensitive soul, and the rational soul. The vegetative soul resides in plants; the sensitive soul in animals; and the rational soul is what humans are born with. The rational soul provides the functions of the vegetative and sensitive soul, but also provides the ability to think and have rational thoughts. The human person is able to interpret experiences and use them to better themselves. While plants and animals are mostly focused on procreating and growing, humans can think logically and use reason to determine our actions. This relates to spirituality because it provides the opportunity for introspection. Humans can look at situations and decide what is good and what is bad; and use those lessons to change behaviors and become better persons. Aristotle believed that with this rational soul, it was impossible to dissect the body from the mind. Essentially, because souls exist within the body, the soul and the body are one.
After Aristotle, more psychological foundations began to move away from introspection and spirituality, and began to focus on concrete ideas. In the middle ages Neoplatonism began to emerge. Philo was a philosopher who promoted this school of thought. In fact, he was often referred to as the “Jewish Plato.” Philo took the teachings from the Bible and used them as a foundation. He described the body as being created by the earth, and the soul as being a part of God. Though bodies are considered lowly, humans have a divine nature deriving from our soul, inherited from God. According to Philo, all knowledge also comes from God. This leaves two options for the human experience. If a person focuses on the flesh and living experiences, then development goes in a downward direction. If a person strives to live a divine life, then the development goes in an upward direction. By growing upward, we strive to gain knowledge and become divine, like God. Sensory experiences provide little insight as to how we gain knowledge and develop into divine beings. Philo depended more on the teachings in the Bible rather than the spirituality that accompanies God and his teachings.

St. Paul discovered this theory and began to expand on it. His foundation followed the teachings of Plato and Philo, which then caught the attention of Constantine. Constantine began to follow the church teachings and declared Christianity as the official religion of Rome. In the years following, there were debates on the semantics of the church. Questions were raised to determine if God the Father was superior to Jesus the Son; or did they have equal status; or was Jesus simply an exceptional individual? (Henley, 2019, p. 72). This put a stronger emphasis on the practice of Christianity, rather than the spiritual connection to God. This was a time when Christianity was becoming an integral part of society. Those who did not follow the official religion of Christianity were often executed. This is where the diversion between spirituality and religion can be seen to emerge. When one focuses only on the semantics and rules of a religion,
the spirituality component can become lost. The irony was that the people who were promoting a religion that encourages love for all, were executing people who did not agree. If spirituality was the driving force at this time, as opposed to the enforcement of a particular dogma, perhaps peace would have been encouraged.

One of the pioneers for spirituality in psychology was Kierkegaard. Soren Kierkegaard was born to a very religious family in the 1800’s and grew up with very strong faith. When his father admitted to having an affair, this changed Kierkegaard’s view of religion. Although he had turned his back on Christianity, while in school he began to explore his faith in a spiritual way. Kierkegaard slowly began to accept the Christian faith again, but on his own terms. The Christianity that he accepted was not rooted in the institutionalized church. Kierkegaard believed that the strongest relationship with God was one that was rooted in a personal connection. He believed that the church could not tell someone how to relate to God. It was an innate personal experience that was based off of the person’s own free will and willingness to connect to God.

Kierkegaard focused more on the emotional side of an individual, rather than the logical or rational side of the human experience. He believed that people began to pray reflexively, rather than allowing Christianity to touch them and influence their experience emotionally. Kierkegaard was the first philosopher to make a distinction between religion and spirituality. He believed that people in his society were being forced to practice a religion, rather than following their heart and intuition to believe in God. Reflexively saying a prayer wasn’t enough for Kierkegaard, whereas he encouraged people to truly connect with God and themselves. He believed that spiritual truth cannot be taught by a book or specific dogma; truth must be experienced. He believed that the more we tried to logically understand God, the further one was from comprehending him. In his book entitled Fear and Trembling (1843), Kierkegaard makes an
interesting analogy. He discussed the story of Abraham being called to kill his son Isaac at the
top of a mountain as a sacrifice. There is a great paradox between faith and religion, where one
may know God exists, while also knowing that He cannot be fully comprehended. Abraham had
faith, knowing that God would not lead him in the wrong direction, even though he loved Isaac and
did not want him to die. Abraham was still willing to sacrifice his son in order to abide by
God’s will. Kierkegaard believed that this is how Christianity should be practiced. Instead of
being forced to practice the rules set in the Bible, he encouraged people to live their lives with
faith in God and to be spiritual beings. Having a strong faith and connecting with God on a
spiritual level was more important that following the traditions and rituals set by the church.

Although since Kierkegaard there were many psychologists who rejected spirituality and
religion, Freud is important to look at because of his heavy influence on the field of psychology.
Many people see Freud as being the “father of psychology” and his work is still being
implemented today. His view on religion and spirituality was vastly different from Kierkegaard,
but they both had similar religious experiences. For Kierkegaard, he saw his father as the
ultimate Christian. He tried to follow his father’s footsteps in their religion but was devastated
when his father admitted to being an adulterer. This completely changed his worldview of
religion but was able to still find his spiritual self by rejecting religious dogma and focusing on
his personal relationship with God. For Freud, he was raised in a Jewish family during the Nazi
regime. This in turn made him quite critical of any religion. He believed that religion was an
illusion made by man to gain control over the sensory world. He also believed that it was
unwelcoming, harsh and unloving toward those who are not members of a specific religious
group. Freud’s experience as a Jewish boy during the Holocaust could have had an influence on
this belief. His early experiences of religion were clouded with hate and suffering. He witnessed
individuals being pulled from their families to be executed because of their religious affiliation. He also stated that those who believe in a specific religion use it as a way to achieve their ultimate wishes and desires. They use the label of “sin” to validate their guilt about certain situations, which he saw as a weakness. Freud thought of religion as a distraction from what the real human experience should be and discouraged following a religious dogma. Due to Freud’s adverse relationship with religion, he rejected it. Kierkegaard had a similar experience, but his spirituality was never lost. He believed that he could have a strong connection to God, regardless of his religious affiliation and that his spiritual connectedness gave him a stronger sense of self.

Other psychologists disagreed with Freud and believed that spiritual and existential experiences are important to how people interpret their lives. Ludwig Binswanger was a psychologist in the 1900’s who began to forge the field of existential psychology, which to some degree, also incorporates spirituality as a part of the human existence. He explained that there are three different types of existence. Umwelt, meaning “the world around,” which covers our environments, the second is Mitwelt meaning “the with world,” which is our interactions with other humans, and Eigenwelt, meaning “the own world,” meaning the person’s private and subjective experiences. Including all of these aspects of an individual will help understand their overall life experience. The Eigenwelt may involve spirituality as a key component. To fully understand a person means to learn how they view their lives in that moment. If this includes spirituality for a client, then spirituality should be discussed to help the client resolve any possible issue they may encounter.

Although spirituality could be derived from the works of Binswanger, he focused on existentialism. Viktor Frankl was the first psychologist who was able to integrate existentialism with spirituality. Frankl had a similar experience to Freud, where he was a Jewish man living in
during the time that the Nazi regime had taken place. In his book, *Man’s Search for Meaning* (1984), he recounted his experience of his time spent there. He was sent to a concentration camp and suffered great duress while there. He was tortured and beaten by the Nazi’s. He witnessed the brutality and degradation that surrounded him. Frankl was forced to work in extremely cold weather environments without proper shoes or coats. Most of Frankl’s family was also taken to concentration camps. His mother, father and wife had all perished in Auschwitz. In his book he reported seeing other Jewish men and women dying everyday due to starvation or disease, while others were selected at random to be executed. Rather than turning away from his spirituality and religion, Frankl observed the survivors around him. He noticed that those who had something to live for, did in fact survive. The individuals that believed they were living with a purpose were more likely to survive. This led him to founding “Logotherapy” which is therapy that incorporates meaning making. He noticed that when people have something to live for, they live a happier life. Even during the suffering, Frankl believed that he would survive and escape Auschwitz alive. He encouraged others to find meaning in the suffering that they endured. They can survive when they find a meaning. Without meaning, people tend to fill their time with hedonistic pleasures. Having a meaning and making meaning out of difficult situations help people develop emotionally, spiritually, and psychologically.

Some may also strive for Suprameaning, which Frankl defines as the ultimate meaning in life. It is a spiritual kind of meaning that depends on a greater power outside of personal or external control. A quote from Frankl states, “When we are no longer able to change the situation, we are challenged to change ourselves” and many people feel they can achieve this through spirituality. Taking a step back from the worldly view of oneself and truly reflecting on their wants and needs can provide a new perspective. It could help provide the tools for a person
to make positive life changes. As mentioned, sometimes religion and spirituality are used intermittently when they have different definitions. Meaning in life can be used as a way of generalizing spirituality. Meaning in life refers to one having a purpose and value of significance. Being in touch with oneself and knowing which direction one’s life is going, can provide a sense of spiritual connectedness. Although these are all very notable psychologists and there has been more recent research, spirituality is still not a very common topic to discuss. Many psychologists will stray from this topic because they assume it involves discussing religion. Psychologists today have been doing more research on how to properly define spirituality so that it can be utilized in helping individuals.

Lisa Miller is in a newer wave of psychologists who strive to revolutionize spiritually. In her book *The Spiritual Child* (2015), she explains the clear link between spirituality and health. Further, she shows that children who have a positive, active relationship to spirituality are “40% less likely to use and abuse substances, are 60% less likely to be depressed as teenagers, are 80% less likely to have dangerous or unprotected sex and have significantly more positive markers for thriving including an increased sense of meaning and purpose, and high levels of academic success” (Miller, 2015). One of the most important factors that Miller brings to light is her definition of spirituality, where she is referring to a relationship with a higher power, whether that be nature, God, or the universe as a whole. The universe is a source of spirituality for many people. It does not require a link to an institutionalized religion. Contrary to popular belief, spirituality is a very important part to the majority of citizens in the United States, and it has been reported that 95% of Americans believe in God (Plante, 20009). With a such a large percentage, it is impossible to believe that spirituality is still not incorporated when discussing mental health when it could have a positive impact on a client’s wellbeing.
Many studies have been done more recently to clarify the importance of spirituality among individuals. Leeson et al (2015) conducted a study examining the spirituality and quality of life among women who were in hematopoietic stem cell transplantation to help treat their cancer diagnosis. Before treatment began, a sample of these patients were given a questionnaire to assess psychological adjustment and quality of life through spirituality. The questionnaires were also used at a six month follow up and a 12 month follow up to see if spirituality had a lasting change or not. The results indicated how spirituality can help these patients remain resilient during this difficult time. Many of the patients reported of having a more positive experience undergoing treatment and was seen to be stable among participants. At a six month follow up, the participants reported to having a higher level of meaning and peace in their lives, higher physical and functional well-being, and lower levels of depression and fatigue. The fascinating aspect of this study is that it is done on women who were facing imminent death and fear. They were receiving treatment for cancer, but treatment is never guaranteed to help enter full remission. During a time of great stress, spirituality was a source of empowerment which helped their overall health as well.

In another more recent study, members of the LGBT community were studied in regard to their spiritual resilience. Recent research has shown that “LGBTs are at increased risk for major depression, eating disorders, generalized anxiety disorder, poor self-esteem, alcohol dependency, drug dependency, and comorbid diagnoses” (Foster, Bowland & Vosler, 2015). There are also physical maladies that the LGBT community is susceptible too, like cancer, diabetes, and cardiovascular disease. This is a community that is notably discriminated against, especially from some religious institutions. Society has been making great strides to help the LGBT community be treated as equals, but there is still progress to be made. This study was
conducted by asking 27 gay and lesbian Christians to partake in interviews over the course of 10 months. The results showed that when gay and lesbian Christians are actively engaged in supportive faith communities, they demonstrate higher levels of psychological well-being, especially when they experience acceptance from other lesbian and gay Christians. Other studies have shown that the process of self-identifying and publicly identifying as gay or lesbian was a spiritual milestone. They reported that they “better understood themselves as children of God, created in God’s image” (Foster, Bowland & Vosler, 2015). This study also addressed their meaning-making process. Many reported developing existential questions such as, “Who am I? Did God create me this way? How can I continue participation in a faith community and be gay?” These questions led the participants to reflect on their lives and how what the meaning of life means to them. They also took the time to read Bible entries and apply the teachings to their own situations. Many found that the Bible and its teachings had a profound impact on themselves and their spiritual selves. By interpreting God’s words to help them with their own situations, showed how they can still incorporate God into their lives. It helped them identify their resilience, which allowed them to grow personally as well as spiritually.

As research on spirituality in psychology has been expanding, more interesting information has come about. In particular, there has been research on the impact that spirituality has on those who have attempted suicide and survived. A study done by Dransart (2018), 50 suicide survivors were interviewed about their lives after the attempt, mainly inquiring about their spiritual and religious experiences. Suicide is a very sensitive subject, especially when considering religion. Many religious institutions see suicide as unforgivable. For example, many Christians believe that when someone commits suicide, they eternally live in hell. This can be a state of contention for many individuals who are suffering from a mental illness. Suicide has
become an epidemic among middle aged women. The suicide rate has been slowly increasing over the years. Spirituality may be a key factor in enforcing change. The study showed that “spiritual or religious issues play an important role in the process of reconstruction for survivors, notably in meaning-making and responsibility-clarifying processes, in forging a continuing bond with the deceased and in honoring their life and memory” (Dransart, 2018, 152). Not only was spirituality important for those who had attempted suicide, but it was also seen as important for their family members healing as well. Many reported that family members turned to spirituality to help them navigate such a difficult time. Spirituality helped them find meaning in the suffering and believing that it would be resolved. In comparing religion and spirituality, more spirituality was practiced among the survivors. There were some aspects of religion that were very beneficial to the healing process. Many sought refuge from a minister at a church and felt reprieve, but the overall consensus showed that making meaning out of the experience and connecting to oneself had the largest benefit on their recovery process. Many stated that their suicide marked the beginning of their spiritual quest.

This topic is particularly important because there is still more progress to be made. Religion and spirituality still have a stigma when being discussed among psychologists. Some believe that it has the potential to help many individuals, and others believe it is inappropriate. One of the biggest issues would be making sure that clinicians do not impose their own beliefs onto a client in a therapy session. It is a valid concern, but at the same time it should be a setting where the client feels comfortable enough to discuss any issue they may have. If this involves spirituality and meaning making, clinicians need to be educated on how to handle these situations. With the growing research on its positive impact, there may be more acceptance among practitioners. It is always important to allow the client to approach the subject first. By
providing a safe space, the client will be able to do so. As mentioned, spirituality can be represented in many ways. Some may believe in God and have a strong foundation in Christianity. Some others may believe that spirituality stems from nature and the universe. However the client represents themselves spiritually, it is our duty as clinicians to help them in any way we can, which involves being accepting of spirituality in a psychology setting.
References


Psychosexual Development in Adolescents with Autism Spectrum Disorder (ASD)

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Psychosexual Development in Adolescents with Autism Spectrum Disorder (ASD)

The focus of this paper will be on current research regarding the psychosexual development and functioning of individuals diagnosed with Autism Spectrum Disorder (ASD). In recent years, the psychosexual functioning of those with ASD has become increasingly studied, particularly in early childhood and adolescence. The concept of psychosexual development can be traced back to Freud’s psychosexual stages, (e.g. oral, anal, phallic, latency and genital), though this paper will utilize a more current and broad perspective of psychosexual development which is part of Erik H. Erikson’s Psychosocial Theory. Psychosexual development and functioning in this review will explore appropriate and inappropriate behaviors (obscene gesturing, touching or hugging another person, exposing body parts or disrobing, and/or masturbating in public), intrapersonal and interpersonal aspects, current educational and treatment programs, social justice, familial and legal concerns, along with diagnostic tools and criteria.

Interpersonal (i.e. psychosexual socialization) and intrapersonal (i.e. psychosexual selfhood) aspects, per Dekker et al. (2017) could be the basis for overall healthy psychosexual functioning in adolescents. Early adolescence is an important developmental period because of the many changes and challenges adolescents face. For example, the need to fit in with peers and/or the physical changes due to puberty. The skills and knowledge needed for healthy sexual development include awareness of social and cultural rules and appropriate social skills. This leads to the following questions: Are adolescents with Autism Spectrum Disorder at risk for unfavorable healthy sexual development more so than their typically developed peers? Are they more at risk to fall victim or delinquent? What types of programs, if any, are out there to assist adolescents with ASD in their development of psychosexual functioning? Are these programs
evidenced-based and effective? If not, are there any programs being developed or that have already been developed to address these issues?

Prior research on this topic has for the most part focused on inappropriate or problematic behaviors. For example, some individuals that exhibit autistic traits tend to excessively think about sex, masturbate in public or stalk others. Either as the victim or perpetrator, some individuals have also been involved with sexual offenses (e.g. Dekker et al. 2014; Dewinter et al. 2013; Hellemans et al. 2007; Sevlever et al. 2013; Stokes and Kaur 2005; T Hart-Kerkhoffs et al. 2009). There is a general consensus in the field of psychology that those diagnosed with ASD have similar sexual needs, desires and interests in romance as their typically developed peers, however their learning styles differ.

**Current Research**

In a case study by Griffin-Shelley (2010), an adolescent boy whom is diagnosed with Asperger’s Syndrome sexually offends against a family member. This case study poignantly highlights the lack of knowledge, understanding and treatment/educational programs there are for such a vulnerable population. As the young boy makes his way through the legal system, a significant amount of time is lost regarding his rehabilitation. Though Asperger’s Syndrome has been removed from the DSM-V, the symptoms in which mark such a diagnosis still exist under the Autism Spectrum Disorder umbrella.

The identified issues in this case study are far too common and have been either misunderstood or overlooked for years, particularly in youth with ASD. Now, more than ever, research is beginning to look at the struggle’s adolescents with ASD face regarding psychosexual functioning. Griffen-Shelley (2010) eloquently paints a picture of what treatment providers and
professionals are struggling to appropriately address, while youth, families and the community are being put at unnecessary risk. Griffen-Shelley (2010) does not victim blame or minimize the offenses, nor does it place blame on any one single entity. To give you a better sense of this youth’s struggles, below is a snippet of a psychological evaluation done by one of the treatment providers involved in the case:

“The client truly feels like a “stranger in a strange land,” and unlike severely autistic children, however, he longs for some sense of interpersonal connectedness. He cannot understand why he is so odd and why people react to him the way they do, and he feels frustrated because he does not know how to change his situation. He sees people enjoying their relationships, is old enough to have a vague sense of the pleasures of intimacy and sex, and because he does not experience these himself he also feels deep resentment and occasionally great hostility, even or perhaps especially toward those who are most present in his life: his immediate family (which includes the family friend that he victimized)” (Griffen-Shelley, p.49, 2010).

The case study mentioned above is one that is reoccurring in today’s society, where an individual is receiving therapeutic interventions that are inappropriate to address their needs. Also, ways to prevent, or avoid such instances are not being utilized or have not yet been developed. Research and treatment professionals have responded by attempting to better understand the issues presented and ways in which to make improvements regarding treatment and educational programs. For instance, a study was conducted that explored the longitudinal relation between childhood autistic traits and psychosexual problems in early adolescents (Dekker et al. 2015). The study utilized parent-reports to investigate the longitudinal relation
between autistic traits in childhood and psychosexual problems in adolescence. Researches questioned whether children who exhibit autistic traits were more or less likely to develop psychosexual problems in adolescence. It is an established fact that individuals with ASD struggle with appropriate social skills, which later could lead to problematic and maladjustment behaviors (Jenson, 2010), though less is known about their psychosexual functioning. Kumagami and Matsuura (2009) and Maniglio (2012) and T Hart-Kerkhoffs et al. (2009) did find relationships between severe psychosexual problems and diminished social competence, which implies adolescents with ASD may be more prone to psychosexual problems. Dekker et al. (2015) investigates this potential relationship by utilizing a large general population sample and parent-report questionnaire. Dekker et al. (2015) hypothesized that autistic traits in childhood are related to psychosexual problems in adolescence.

The results confirmed that reduced social skills effected psychosexual functioning and the change in autistic traits in general predicted psychosexual problems in adolescence. Also, limited social interaction and problems with appropriately adjusting one’s behavior to social situations were related to increased thoughts about sex and inappropriately touching oneself too much. Dekker et al. (2015) also suggest a link between lower IQ and psychosexual problems.

Dekker et al. (2017) then studied how cognitively-able adolescents with ASD compared to their typically developing (TD) peers in regard to psychosexual development and functioning. To compare groups, Dekker (2017) developed and reviewed the usage of the Teen Transition Inventory (TTI). Unique to this study is that the TTI utilizes both self and parent-report measures, whereas in prior research, much of the information obtained was from either former or latter measures independently. Utilizing both measures is valuable because it provides
researchers with a more complete picture of those being studied. In addition, earlier research focused on adolescents with ASD alone.

Dekker (2017) utilized prior research to divide psychosexual functioning into three domains. The first of which is psychosexual socialization (interpersonal), which includes social interactions with peers, parents, siblings and the media. The second domain, psychosexual selfhood (intrapersonal) includes self-esteem, perception, competence, and overall knowledge. The third domain, sexual/intimate behavior, includes a range of sexualized behaviors and experiences, both appropriate and inappropriate.

The results of their research found significant differences between ASD and TD adolescents in all domains of psychosexual functioning, specifically in the areas of psychosexual socialization and selfhood. Regarding psychosexual socialization, both parent and self-reports suggest that adolescents with ASD are less likely to exhibit appropriate social skills, which leads to a lack of acceptance by peers. Considering psychosexual selfhood, Dekker (2017) found no differences in sexual preference between ASD and TD adolescent participants, though suggest more research is needed in this area. There were also no differences found in the amount of sexual desires between the groups. Parent reports did show a significant difference around body image, though the self-reports did not. Dekker (2017) believe this can be attributed to adolescents with ASD struggling to understand social interactions, causing them to be less bothered by their physical appearance. Both parent and self-reports did show adolescents with ASD show lower perceived social competence. In the domain of sexual/intimate behavior though, differences were found in the parent-report’s only, suggesting that results will differ depending on which measure is utilized in any given study. For example, parent and self-reports differed around inappropriate and appropriate sexual behaviors, in that parents perceive
adolescents with ASD to exhibit less sexual behaviors, however, self-reports did not show a significant difference.

The overall findings of Dekker (2017) suggest that adolescents with ASD struggle in their psychosexual functioning development. By including three psychosexual domains, Dekker (2017) provide readers with a better view of psychosexual functioning as a whole, and, by including a comparison, were able to directly compare levels of functioning amongst ASD adolescents to TD adolescents. Dekker (2017) conclude that social impairments in adolescents with ASD contribute to the differences seen in the psychosexual functioning between the two groups. Dekker (2017) suggest that the limited development of appropriate psychosexual functioning in adolescents with ASD could lead to other issues of psychological functioning e.g. frustration or loneliness. In addition, difficulties in psychosexual functioning could lead to sexual victimization or delinquency. Dekker (2017) conclude that targeted interventions to improve psychosexual functioning are important and can reduce the risks and vulnerabilities inherently faced by adolescents with ASD.

de Graff, Vanwesenbeeck, Woertman & Mees (2011) completed a literature review of the effects parenting had on adolescents’ sexual development in western societies. Though this article does not specifically review research about adolescents with ASD, it is important to discuss because of its implications for parents of adolescents with ASD and the development/need for treatment/educational programs to promote healthy psychosexual functioning. de Graff (2011) examines the associations between differing parenting styles and psychosexual development in adolescents. With most young people in western societies having at least one sexual experience during adolescence, the role parents play in the individual differences must be considered. de Graff (2011) review both sexuality-related parenting and
general parenting styles, focusing on three dimensions: support, control and knowledge. Higher levels of parental support were correlated with a delay in first sexual intercourse, greater usage of contraceptives, increased positive feelings regarding sexuality, and higher levels of competence in sexual interactions. In regard to control, or rules/supervision/decision making, it was found that both too much control and a lack of control can be detrimental. de Graff (2011) did find that when parents had clear and fair demands of their children, there was a delay in first sexual intercourse and less unwanted sexual experience. They also postulate that greater levels of support and balanced control create psychologically healthy young people. Finally, with regards to knowledge, de Graff (2011) rationalize that parental knowledge of a child’s whereabouts, needs, strengths, and overall functioning, play an important role.

As clearly stated above, research has established a need for improving psychosexual functioning in adolescents with ASD. In a pilot study, Dekker et al. (2014) responded to this need by developing the Tackling Teenage Training (TTT) program (Boudesteijn et al. 2011), which consists of “18 individual sessions in which a variety of psychosexual topics are discussed (i.e. psycho-education) alternated with exercises (e.g. behavioral rehearsal) and is specifically tailored to the needs of cognitively able adolescents with ASD. The TTT program aims to improve all domains of psychosexual functioning (i.e. sexual behavior, sexual selfhood, and sexual socialization), with a particular focus on obtaining theoretical as well as practical knowledge (e.g. explicit explanation of often implicit rules and practicing conversational skills)” Dekker (2014).

Dekker (2014) used a pre/post training design to determine whether or not knowledge increased in adolescents with ASD after exposure to the TTT program. In a sample of thirty 11-19 year old adolescents with ASD, Dekker (2014) showed that overall psychosexual knowledge
increased with the usage of TTT program. In addition, younger adolescents and those identified as having more difficulty learning the program showed higher levels of psychosexual knowledge after being exposed to the TTT program. Moreover, the parents perceived their children as being able to transfer this newly learned psychosexual knowledge into their day to day lives.

Visser et al. (2017) expanded on the pilot work done by Dekker (2014) and further examined the effects of the TTT program on (a) cognitive outcomes and (b) behavioral outcomes. Visser (2017) conclude that all participants benefited significantly from the TTT program by showing improved knowledge, social responsiveness, improved psychosexual functioning and decreased problematic sexual behaviors; while also supporting the pilot program’s findings that usage of the TTT by younger adolescents with ASD was even more effective.

The issues highlighted above can at times lead to significant traumatic events where youth end up victimized or offending against others. Offending can then lead to being labeled as a juvenile sex offender (JSO), which in itself can have detrimental effects. Sutton et al. (2013) identified sexual offenders with ASD in a state detention facility for adjudicated youth and discuss why suggesting a relation between ASD and sexual offences is unfitting, though concur the struggle’s individuals with ASD experience may lead to victimization and/or offending. Sutton (2013) confirm there is a high prevalence of ASD traits in JSO youth and that further examination is needed. Moreover, it behooves those involved in the treatment and care of JSO youth with ASD to expose them to treatment that is specifically tailored to their learning styles, while also providing sufficient supervision.

Baarsma et al. (2016) conducted an eight year follow up study regarding sexuality and ASD symptoms in JSO. Although JSO research has increased over the years, questions
surrounding the psychosexual functioning and mental health of JSOs remain unanswered, especially questions around the role of ASD traits and diagnoses. Evidence suggests that adolescents with heightened psychosexual problems exhibit autistic traits, though the likelihood of committing a sexual offence cannot be predicted by autistic traits alone (Maniglio, 2012). Baarsma (2016) found that ASD symptoms in JSOs persist over time. It is important that not only treatment providers, but juvenile justice officials be alert to autistic traits in JSO. This could lead to courts favoring dispositions that include treatment interventions instead of punitive punishments such as detainment. Those involved in the youth’s care, along with the courts, can initiate treatment that improves social skills and educates JSO youth utilizing programs such as the Tackling Teenage Training (TTT). In turn, this should reduce the already low recidivism rates of JSO youth. Also, Baarsma (2016) research again highlights the fact that JSO youth with ASD may also be vulnerable to sexual assault themselves.

Conclusion

Mack et al. (2010) establishes that having ASD contributes to relationship problems with peers, in that ASD youth struggle to make, maintain, and keep friendships amongst peers. Murphy and Young (2005) similarly found ASD youth struggle even more in this area due to the complexity and importance placed on peer relationships during the adolescent years. These peer relationship and social problems may then lead to other psychological issues, which can be linked to problems with delinquency (Marshall, 2010). If ASD adolescents are less likely to develop friendships, then they can be less likely to learn and develop their psychosexual functioning in an appropriate manner through peer or other social sources. Adolescents with ASD learn and develop psychosexual knowledge at a slower rate than their typically developed peers, due in part by their unique learning styles. Both academic and treatment settings are currently
exploring alternative ways to provide psychosexual education to adolescents, while considering their unique needs. Historically, sex education offered in most academic settings focuses on the physical parts of sexuality rather than psychosexual functioning. Additionally, sources such as the media and internet where adolescents obtain psychosexual knowledge provide incorrect depictions of romantic relationships and distorted viewpoints which can lead to the development of inappropriate and incorrect psychosexual knowledge.

Initial literature demonstrates that psychosexual functioning in adolescents with ASD can be improved through tailored educational programs such as the Tackling Teenage Training. Programs tailored to the learning styles of adolescents with ASD should also support the development of more general social skills. As reported in Dekker (2017), typically developed peers generally exhibit increased levels of psychosexual knowledge as compared to adolescents with ASD. This lack of understanding, or inability to obtain knowledge at the same rate as their typically developed peers is why specific programs need to be developed.

Future research should continue to focus on the development and improvement of psychosexual functioning in adolescents with ASD through tailored treatment and educational programs. Current research clearly presents a problem which society would benefit from exploring further: the link between ASD and JSO. Is our justice system working properly by implementing punitive measures such as the detainment of adolescents with ASD if there aren’t adequate programs to teach them the necessary skills? Are these youth able to control these urges, and if so, how can treatment providers and professionals assist in developing these necessary skills during childhood and adolescence? Could the development of peer to peer psychoeducational programs for adolescents with ASD work? It is clear that further research and exploration in this area is warranted.
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Cognitive and Affective Issues Related to Detainment (Prison/Juvenile Detention)

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Cognitive and Affective Issues Related to Detainment (Prison/Juvenile Detention)

Introduction

The negative impact imprisonment has on a person’s mental state is well documented. From concentration camps to prisoners of war, and now our current system of corrections in the United States of America. When imprisoned, one must adapt his or her way of thinking in a dysfunctional manner, alter their behavior, and attempt to regulate their emotions differently. No two people are alike and not everyone will be affected in the same way, but only few would be unaffected from extended periods of detainment. Similarities in cognitive and affective changes amongst individuals who have been detained will be discussed in this paper, along with identifying some etiological causes/historical perspectives, while also reviewing evidenced-based treatment modalities.

Etiology

To say that prison or detainment is the cause of a clinically-diagnosable psychological disorder would be wrong, as discussed by Haney (1997) in his “Psychology and the Limits to Prison Pain.” Being detained or held in prison won’t make an individual mentally ill alone, though there is a general consensus, even amongst skeptics like Bonta & Gendreau (1990), that extended periods of detainment can cause long-lasting cognitive and affective changes.

Prison or detainment as we know it today began in the 19th century. It was at this time society began to perceive criminals as being purely evil. Take for example Cesare Lombroso’s biological theory of a born criminal type, which he elaborated on in "Crime, Its Causes, and Remedies" (Lombroso, 1911), the 3rd volume of his larger work "Criminal Man."

During the 19th century, the concept of psychological individualism was popular in American society and what it implied, or so the nation believed, was that a deficiency within an individual
was the cause of social deviance. To change this, it was believed that a change had to be made to an individual’s personal characteristics. Thus, grew the idea of a prison science, or penology. Zebulon Brockway was one of the most influential figures in the development of penology and professed toward the end of the century that prison science is working and is in unity with the true science of our common human nature (Brockway, 1898).

The first half of the 20th century brought about further connections between prison policy and psychology. An individual’s release from prison was based on their personal transformation; juvenile courts focused more on the character of youth than the offense; and probation officers were created to observe and intervene in a prisoner’s life once released (Haney, 1997). With these new changes, the mental state, or an individual’s psychology would help determine a prisoner’s fate. Within prisons, prisoners were being classified, evaluated, graded, and separated according to the results of these methods. Practices such as “quarantines” were utilized upon entry and for the first time, mental health professionals such as Psychiatrists and Psychologists were staffed within a prison, albeit only a few for hundreds of prisoners. Barnes (1921) discusses a significant step in the early 1900s at Sing Sing Prison in New York, where a psychological clinic was created inside the prison, though explains that their presence was more for diagnostic purposes than treatment. If a treatment recommendation was made, the prison didn’t have an appropriate way to implement such services. The goal of rehabilitation was up against the need to maintain order and punishment. What appeared to be a step in the right direction changed in the 1970s; psychological influence was removed from within the study of prison systems and policy debates (Haney, 1997). This was at a time when new theories in psychology were emerging that would have challenged the prison systems status quo. Martinson (1974) reinforced the belief that rehabilitation did not and could not work. His article “What Works?” is forever
connected to the demise of rehabilitation practices within prisons. Judges became the authority that brought about justice through pain and punishment. Sentencing guidelines for prisoners became mandatory and harsh, removing from the system any concerns for social justice. In the 1980’s the idea professed by Lombroso (1911) that criminals were biologically different resurfaced in research such as “Genetic Influences in Criminal Convictions” by Mednick et al., (1984) and Samenow (1984) “Inside the Criminal Mind.”

Throughout the 1980s, 1990s, and 2000’s the number of prisons and prisoners grew drastically. Kaeble & Cowhig (2018) show us that the population under the control of the U.S. Corrections Systems in 1980 was 1,842,100 and in 2016 was 6,613,500. As the numbers increased, overcrowding was necessary, most times housing two to three inmates in a cell originally built to house only one. In addition, the abandonment of rehabilitation programs helped further the declining mental health of inmates. Prisons were described as dangerous and frightening places (Rideau & Wikberg, 1992). Unfortunately, much of the debate on the psychological effects of detainment focused on the amount of harm done rather than any positive changes made (Haney, 1997). Of additional concern is the continued increase in the number of racial disparities amongst those detained in the U.S. In 2016, 60% of the people in prison were people of color, where black men are six times as likely and Hispanic men 2.7 times as likely to be detained as white men. For black men in their thirties, one in every twelve is in prison on any given day (Bonczar, 2003).

**The Psychological Impact of Incarceration**

As seen above, the history of utilizing detainment to discourage, punish and/or rehabilitate criminals has been around for centuries. Now that we have seen how we got to where we are today, let’s explore the cognitive and affective changes inmates experience in both subtle
and more extreme situations. Terms often used to describe those observable changes are “institutionalized” and “prisonization,” which involve adapting ways of thinking, feeling, and acting. These adaptations are a normal response to being placed in an abnormal, or unnatural setting.

Prisons can be overcrowded, violent, lack meaningful activities, and provide inadequate health services. When entering prison, inmates are forced to adapt to strict routines, loss of privacy, and subjected to limited material possessions, which can be unpleasant and difficult for new inmates. The changes inmates are forced to make to extremely harsh and dangerous environments, eventually becomes natural. The effects of these changes or the speed in which they occur differ amongst individuals and can be seen in youth that enter out of home treatment facilities. This can occur quickly in younger individuals that have not yet formed the ability and/or expectations to control their own life. Some of the cognitive and affective changes, or psychological adaptations seen in detained individuals include: dependence on institutionalized structure and contingencies; hypervigilance, interpersonal distrust and suspicion; emotional over-control, alienation, and psychological distancing; social withdrawal and isolation; incorporation of exploitative norms of prison culture; a diminished sense of self-worth and personal value; and post-traumatic stress reactions to the pains of imprisonment (Haney, 2001).

In more extreme instances, Bonta & Gendreau (1990) found the following: signs of pathology in inmates that were incarcerated in solitary confinement for periods up to a year; higher levels of anxiety after eight weeks in jail than after one; increases in psychopathological symptoms can occur after 72 hours of confinement. Death row inmates exhibited symptoms ranging from paranoia to insomnia, increased feelings of depression and hopelessness, to feeling powerlessness, fearful of their surroundings, and emotionally shattered. As a result, suicide rates
are high among inmates, though have fallen somewhat since the 1980s. In 1983, the suicide rate was 129 per 100,000 inmates in local jails and 47 per 100,000 in 2002 (Mumola, 2005).

Although anyone who enters prison is at risk of maladaptive cognitive and affective changes, some are more vulnerable than others because of personal characteristics or special needs. Those at higher risk include the mentally ill and developmentally disabled population, along with those subjected to “supermax” or solitary confinement (Haney, 2001). Those suffering from mental illness and/or developmental disabilities represent the largest number of disabilities amongst prisoners. In fact, in 2000, 20% or more of the prison population suffered from a psychological disorder and/or developmental disability (Beck & Maruschak, 2001) and as of 2012, 3 in 10 state and federal prisoners and 4 in 10 local jail inmates reported having at least one disability (Bronson, Maruschak, & Berzofsky, 2015).

**Treatment Approaches**

A specific focus of society and those involved in the decision-making within the prison system should be on how these psychological changes effect prisoners during detainment and once released. The consequences of the psychological effects on individuals returning to society are profound. Prisoners that become institutionalized cannot be expected to return to a normal way of living after having become adjusted to and dependent upon the strict order of a prison. Parents being released cannot be expected to organize their child/children’s lives in an autonomous manner, which is necessary. Those who have become hypervigilant and distrusting will struggle in re-establishing or developing new relationships. The hardening mentality one has to adopt within a prison will alienate the individual from others, reinforcing their diminished sense of self-worth and personal value. Which is why programs such as the following need continued support.
Huynh, Hall, Hurst, & Bikos (2015) evaluated a Positive Re-Entry in Corrections Program (PRCP), which focused on teaching inmates skills that facilitate re-entry into the community utilizing positive psychology principles. Inmates in the 8-12 week program participated in weekly lectures, discussions, and were given homework assignments. Results showed significant, positive change in inmate outcomes measured by gratitude, life satisfaction, and hope over time. Feingold, Fox, & Galovski (2018) assessed the effectiveness of evidence-based psychotherapies (EBPs) for trauma-related distress in individuals with serious mental illness who have been diverted from jail to receive community-based treatment services. Results provide evidence for the effectiveness of such treatment in an outpatient setting for those with serious mental illness, implying that diversion programs that utilize EBPs are effective. Jungersen, Walker, Kennedy, Black, & Groth (2019) assessed the effectiveness of The Survivor Therapy Empowerment Program (STEP) in incarcerated individuals. STEP is a 12 unit, manualized, tri-partite psychoeducational program focused on trauma and its effects. Results indicate that STEP is a beneficial treatment approach for both male and female inmate survivors of various traumas. In recent years, work programs have been adopted within the prison system. One study in Spain looked at the effects of prison work programs on the employability of ex-inmates. Results show that even with a prison work program, reintegration into the labor force is difficult, though 43.6 percent of ex-inmates find a job once released from prison (Alós, Esteban, Jódar, & Miguélez, 2015).

**Conclusion**

Prisons are bad for mental health and time serviced places inmates at increased risk for cognitive and affective issues, both during and post-release. Those most often detained are our most vulnerable population, individuals suffering from severe and persistent mental illnesses
and/or developmental disabilities. Becoming institutionalized leads to a dependence on an
institutionalized structure and contingencies, hypervigilance, interpersonal distrust and suspicion,
emotional dysregulation, alienation, social withdrawal and isolation, diminished sense of self-
worth, and post-traumatic stress reactions. Evidenced-based treatment interventions within the
prisons and diversionary programs have been shown to work. Research should continue to focus
on the effectiveness of diversionary programs and the benefits of rehabilitation.
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The Effects of Self-Efficacy Counseling on Juvenile Offenders

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Abstract

The purpose of this proposal is to examine the effects of a self-efficacy counseling intervention on juvenile offenders. It will follow a true experimental design with participants sharing the characteristic of being incarcerated youth. Self-efficacy is anticipated to be a predictor of goal-setting thoughts and behavior with a positive correlation. Experimental groups one and two will receive two levels of intervention from the same therapist, with a control group receiving counseling without a self-efficacy focus. Longitudinal techniques will be implemented in both groups along with the control in order to compare surveys, questionnaires, interviews, and self-reports on individual experiences. It is predicted that the significance level will be below or at .05%. Future research might attempt to replicate these projected results with a mentoring program intervention, possibly intended for youth recently released from juvenile detention centers, in place of a traditional therapy.

Keywords: self-efficacy, career self-efficacy, juvenile justice system
The Effects of Self-Efficacy Counseling on Juvenile Offenders

Self-efficacy is one’s belief in one’s ability to succeed in specific situations or accomplish a task (AllPsych Dictionary, 2018). Previous research has indicated the significance of self-efficacy and the effect it can have on approaching challenges and accomplishing life goals. What people believe they can do has shown to have a monumental effect on their abilities. According to Albert Bandura’s “An Agentic Perspective on Positive Psychology,” people who have an awareness of self-efficacy are typically able to bounce back from failure and approach conflict with alternative solutions rather than worry of what might go wrong (Bandura, 2008). Previous research has investigated links between self-efficacy and incarcerated youth.

Review of Literature

Perceptions of the Legal System and Recidivism

There is no national estimate of juvenile recidivism, according to the Office of Juvenile Justice and Delinquency Prevention (PJUDP), due to how these justice systems vary from state to state (Sickmund & Puzzanchera, 2014). However, Kalist, Lee, and Spurr (2015) documented a link between juvenile delinquency and adult crime. Abate and Venta (2018) researched the perceptions of the legal system and recidivism by investigating the mediating role of perceptions of chances for success in juvenile offenders. They considered the perceptions of future success to be a mediator with race and ethnicity as a moderator. The participants (n = 1354) consisted of incarcerated youth, aged 14 to 19. Individuals were 86% male, 20% White, 41% Black, 34% Hispanic, and 5% Other. All participants shared the trait of having been adjudicated of a serious offense (i.e., all felony offenses but not less serious property crimes). They also excluded misdemeanor weapons and sexual assault charges. Participants were administered modified versions of procedural justice inventories with agreeable or disagreeable statements such as, “she
or he treated me the way I expected he or she to treat me.” All measures of youth perceptions were collected through Likert-style scales (e.g., strongly disagree, somewhat disagree, somewhat agree, strongly agree). “We hypothesized that juvenile offenders who did not recidivate at 6-month follow-up would demonstrate (a) increased positive perceptions of procedural justice, (b) increased perceptions of legal legitimacy, and (c) decreased legal cynicism compared with those who recidivated” (Abate & Venta, 2018). Their results indicated that for Black and Hispanic incarcerated youth, but not White, beliefs on the possibilities of success facilitated the relationship between beliefs about the justice system and rate of reincarceration. Both researchers intended for their results to serve as future support in the development of interventions aiming to prevent youth from engaging in criminal activity.

**Belief in a Prosocial Self**

Bandura (1991) maintains that individuals with higher self-efficacy levels are more likely to challenge themselves to achieve goals and commit to them. Cuevas, Wolff, and Baglivio (2017) investigated whether incarcerated youth’s beliefs in their abilities predict positive aspirations. While prior research has examined a link between self-efficacy and crime, there appeared to be a research gap on how these variables are related to continued criminal behavior and the involvement of the justice system (Cuevas et al., 2017). They sought to more specifically explore a juvenile’s belief in his or her own ability to live a prosocial life and whether those beliefs could predict future aspirations. Conventional aspirations were described as behavior deemed acceptable, traditional, and mainstream (i.e., in regards to setting career goals). Their sample consisted of juvenile offenders (n = 12,955) who completed a residential placement program in Florida. Connections between self-efficacy and aspirations were explored. This study implemented a structural equation model in order to measure demographics and risk factors
among the participants. Results specified that individuals with higher levels of prosocial self-efficacy also reported higher prosocial future ambitions. This research concluded that interventions in juvenile justice locations should target attitudes and beliefs in connection to a prosocial identity (Cuevas et al., 2017).

**Adolescent Goal Setting**

Carroll et al. (2012), explored the relationship between setting goals and self-efficacy. “Juvenile offending is one of the most serious contemporary societal problems, with data clearly demonstrating its significant negative impact on educational, health, financial, vocational, and judicial systems” (Carroll et al., 2012, p. 431). Participants included a matched sample of 88 adolescent delinquents (18% female), 97 at-risk (20% female), and 95 not at-risk (20% female). High school students were categorized as at-risk or not at-risk based on the Western Australian Legislative Assembly (WALA, 1992) which consists of checklist specifications. Goal commitment and goal types were also measured. Commitment was measured with a Hollenbeck adapted, nine-item, Likert scale. The Goal Types Scale (Carroll, 1995) required participants to order up to eight life goals based on significance.’ Findings indicated that delinquent youth reported the least amount of goals and the least challenging goals. They were found to have lower commitment to their goals along with lower academic and self-regulatory self-efficacy levels. Data was examined utilizing discriminant functioning analysis. Youth that reported high delinquency related goals and low educational and interpersonal goals were likely to belong to the delinquent group (Carroll et al., 2012). “Setting clear achievable goals that enhance self-efficacy and reputational status directs the energies of adolescents into socially conforming or non-conforming activities” (Carroll et al., 2012, p. 431).
Along with financial and educational difficulties that many youths in the juvenile justice system face, there are also distressingly high rates of mental health struggles. Krezmien et al. (2008) reported up to 80% of incarcerated youth are living with psychiatric illnesses, and those numbers are overwhelmingly larger in comparison community-based youth. Youth with physical and mental health conditions are more likely to remain incarcerated for longer amounts of time, and those conditions are likely to be worsened by being incarcerated. Pennebaker and Chung (2011) examined links between written self-disclosure and increases in positive psychological developments. Greenbaum and Javdani (2017) developed an intervention designed specifically for underserved youth within the justice system. They implemented a writing-based program called WRITE ON, which is an acronym for Writing and Reflecting on Identity To Empower Ourselves as Narrators. The model was designed to include information pertinent to youth development, trauma experiences, and research-based therapeutic paradigms. The program consisted of a six-week group-based mediation meeting twice per week. Choices of writing prompts were also delivered throughout the intervention, for example, “Imagine you wrote an autobiography of your life up to this point in time, and then you opened the book to a random page. Write that page” (Greenbaum & Javdani, 2017, 2.4.2). All data collected were measured in terms of positive or negative mental health outcomes. Results showed that individuals exhibited high satisfaction levels, and the WRITE ON intervention produced significant increases in resilience ($p < 0.01$). Their results suggested a need for a much larger trial exploring the efficacy of the WRITE ON program.

**Career Guidance**

Fernandes and Bance (2015) studied the route adolescents take from career indecision to career decision. Two focus groups were conducted with 14 participants in each group. The
sample consisted of an even number of males and females. A questionnaire was developed for the purpose of this study by the researchers. Interview-style questions allowed for open-ended responses. Semi-structured interviews were held for follow-up inquiries. Sessions were audio recorded to capture every aspect that transpired. Analyses consisted of grouping responses into a thematic framework (i.e., interests, mass meanings, phenomenological expression). “The basic purpose is to acquire firsthand personal and realistic information from the adolescents-respondents” (Fernandes & Bance, 2015, p. 137). Their results from the focus groups emerged into personal factors affecting decision making (i.e., anxiety, lack of information, lack of confidence, varied interest, career fear, uncertainty). Results also appeared to fit into categories of environmental factors along with personal factors. The three major themes that categorized the results were factors affecting adolescents in decision making, internal and external factors regarding career indecision, and accessing assistance regarding career indecision. This study demonstrates the various needs of adolescent guidance in general when it comes to indecision, and that illustrates further the need for a more specific needs-based intervention for the incarcerated youth population. Prevention is vital, however, there is a strong need for intervention within these institutions in wanting to reduce rates of recidivism.

Researchers Allen and Loretta (2014) sought to more specifically enhance career counseling with the juvenile justice population. Specific needs of juvenile offenders outlined in this study include career decision-making skills and career maturity. The focus variables were on self-efficacy and career maturity. Maturity was conveyed as awareness, exploration, and decision making. Participants included 22 individuals who completed a 12-week intervention. Long-term residents were the only youth eligible for participation. Ages ranged from 12 to 17 and consisted of both males and females. It was hypothesized that the intervention would improve career self-
efficacy and career maturity. The Career Decision Self-Efficacy Scale (CDSE) was administered in order to collect pretest and posttest data. The counseling integrated into this study’s treatment program included cognitive behavior therapy (CBT), due to the theoretical foundation of behavior being grounded in an individual’s perception. Results indicated that there was no significant pretest difference between the control and treatment groups. In comparing the groups’ scores on the two dependent variables, “the result was significant for the two tests indicating that one or both of the dependent variables were significantly different” (Allen & Loretta, 2014, p. 35). This study helped exploit the limitations in research regarding at-risk youth and career guidance intervention programs.

Not only is research lacking for interventions designed for incarcerated youth, but there is also a neglect of recognizing specialized needs (SEN) within that population. Gutman and Schoon (2017) investigated adolescents with special educational needs and their career aspirations. This particular research compared early career aspirations of students with SEN to students without SEN. They wanted to see if there were greater opportunities for one group over the other and possibly less barriers to future goal-setting and employment. Gutman and Schoon considered the related factors during analyses (2017) (e.g., previous academic ability, self-concept, motivation, parental expectations). They also made sure to address a measure on uncertainty. The adolescents included in the sample (n = 139) attended mainstream schools, excluding SEN exclusive schools with students diagnosed with much more severe needs (e.g., severe physical, emotional, and intellectual disabilities). This study serves as an example of how specific needs change the foundation of the intervention which is an additional aspect that should not be overlooked within the justice system.
Conkel-Ziebel et al. (2018) tested an integrative contextual career development model (ICM) with adolescents from high-poverty areas. “Learning to set viable career choice goals motivates young people to proactively pursue their career dreams and moves them toward establishing greater vocational identity and confidence in their career pursuits” (Lapan, 2004). Whether or not a family is considered to be in poverty, young people face challenges within these concentrated areas. Schools can have more dropout rates with less local jobs available. Lack of experience and networking can lead to unemployment. Researchers in this study sought to better the understanding and development of career decision-making of youth in these areas. Measures included collecting data on career exploration, person-environment fit, social readiness, self-regulation, and emotional support. Goal-setting skills were considered a main focus. It was hypothesized that the ICM skills would positively predict the ICM outcomes (i.e., academic achievement, self-efficacy, vocational interests, etc.) (Conkel-Ziebel et al., 2018). Participants (n = 220) consisted of 129 males and 91 females from one public school in a high-poverty area in the Midwest. The mean age was 16.33. “School profiles indicated that 87% of the students were from low-income families as indicated by their enrollment in the National School Lunch Program” (Conkel-Ziebel et al., 2018). Results did show that the vocational skills were interrelated along with the outcomes, however, the two groupings were not multicollinear. Their findings exposed a stronger need to examine the development of a juvenile’s ability to recognize where and how to get help (i.e., acquiring emotional and instrumental support). This might start with fostering parental guidance and awareness on how to do so.

**Parental Support**

Ginevra et al. (2013) investigated parental support in adolescents’ career development and examined both the parents’ and children’s perspectives. They grounded their research in the
social cognitive career theory (SCCT) of Lent, Brown, and Hackett (2000). It focused on the specific role that the parents play in terms of their support and the influence it may have on adolescents’ career self-efficacy and decision-making skills. The research included 94 youth, 30 of which were males and 64 females, residing in what they described as an industrial economy (i.e., large and small companies throughout the area). The ages of the participants ranged from 16-19 years old. All individuals were attending high schools that held within school activities centered around career preparation. They were administered three questionnaires. The Ideas and Attitudes on School/Career Future (IASC, 2003) evaluated different levels of decision-making. The Career Decision-Making Self-Efficacy Scale-Short Form (CDMSE-SF, 1996) measured the individual’s beliefs on his or her ability to succeed at and complete tasks. The Social Provision Scale (SPA, 1984) was implemented as well in efforts to measure youth perceptions of parental support. The parents were administered a separate questionnaire entitled, My Children’s Future (Nota et al., 2012), to measure their perceptions of the support they deliver to their children. Data analysis included the computation of means, standard deviations, and intercorrelations. T tests were computed to measure for any participant differences across different groups. “Moderate and positive correlations were observed among mothers’ perceptions of support and adolescents’ perceptions of parental support, and moderate correlations with career self-efficacy and career choice were also found” (Ginevra et al., 2013, p. 8). They also found a strong correlation between fathers’ perceptions of the support they feel they positively provide with weaker adolescent’s perceptions of parental support. “Although the relationship among fathers’ perceptions of support and career self-efficacy was not significant (p = .06), we decided to include fathers’ perception of support in the further analysis because it was in the hypothesized direction” (Ginevra et al., 2013, p. 9). These findings highlight the significance of parental
involvement in adolescent career planning. The level of parental support plays a role in an adolescent’s future, but so does the adolescent’s perception of what that role truly is. Future research might examine the discrepancies between those adolescent perceptions and the parental perceptions further.

Walker et al. (2015) researched a more specific interest of peer partner support for justice-involved parents. The sample was comprised of adults found waiting in a court lobby for their children’s juvenile court hearings. They were approached in the morning 30 minutes before the hearings began. A perceived flaw of this study is that only English-speaking adults were eligible to participate. Researchers conducted baseline surveys just prior to a video recruitment presentation. The survey was redistributed within the first week as a follow up procedure. Individuals who participated were given $5 gift cards upon completing the first survey and $10 gift cards upon completing the follow up survey. Examples of agreeable or disagreeable statements included in the survey are, “The court is out to get my child,” or, “I am scared about how this process will turn out” (Walker et al., 2015, p. 447). This study evaluated self-efficacy on behalf of the parents involved in the juvenile justice system. Scales intended to measure the parents’ experiences were not found, so the researchers developed a scale for the purpose of this study to, “measure a sense of efficacy in being able to navigate the juvenile court processes” (Walker et al., 2015, p. 447). Results entailed that court mistrust did not differentiate between genders, ethnicities, or prior exposure from initial information collected. They utilized a linear regression model to evaluate participation and levels of mistrust of legal system processes. This model designated independent variables as conditions and mistrust with the dependent variable being the mistrust score. Participants present at the beginning of the study, but failed to participate further, exhibited higher levels of mistrust. No other statistically significant
differences were found. There was a nonsignificant decrease in mistrust found to be associated with the video perceptions. Family involvement and commitment is associated with positive mental health results. However, this research features the point that very little is known or studied regarding family involvement with the juvenile justice system.

**Method**

**Participants**

Participants will be selected from the same juvenile detention center at random. This study will utilize a sample (n = 150) containing approximately an even number of individuals divided into three groups. All groups will receive counseling services. The first group will receive a 6-month intervention. The second group will receive a 12-month intervention from the same psychologists. The third group will receive counseling services, without a focus on self-efficacy, at the same rate as the experimental groups. As possible variables for future areas to study, race and educations levels will be randomized. Each participant will be eligible for participation based on length of stay being at least six months, and they will be selected at random. Researchers will inform all participants that there will not be any compensation prior to agreeing to participate in this study. The purpose of this is to inhibit any possible financial or privilege-based incentives that could result increased levels of participation. Analyzing the results sufficiently will mandate accurate measurements of self-efficacy levels.

**Variables**

The dependent variable for this proposed study will be the effects of the efficacy counseling on juvenile offenders. The actual level of engagement in goal setting behavior will also be measured for comparison. However, individuals may choose to partake or refrain from behavior at different rates, so what will be tracked more specifically will be each participant’s
self-report of self-efficacy. Measurement will include check-in dates and times, log entries for attendance at intervention sessions, completion and submission of questionnaires, and filming appointments for interviews. The independent variable, self-efficacy, will be manipulated through this experiment while compared to individuals receiving counseling without a focus on efficacy. Instructions will be given by the researcher to all participants at the same time to avoid any differentiation.

Materials

Essential materials to apply in this study will consist of journal entry records, either written or electronically submitted (e.g., online or mobile uploads). Participation must be tracked along with comprehensive accounts of therapy sessions. Video footage of the interviews will also be collected with camera equipment in order cross reference data over time. Frequent self-report surveys and assessments will be crucial in monitoring the levels of self-efficacy. How each of the individuals feel about their own capabilities for potential and success will need to be consistently measured and documented. Questionnaires will need to include topics such as goal orientation and perception of self.

Procedure

This proposed study will implement a quantitative measure with supplemented qualitative measures (i.e., group and individual counseling, open ended interview settings, taped sessions with consent for future reference, collected observational data, and archival data). The intervention program will include factors of Cognitive Behavior Therapy (CBT), grounded on theory that an individual’s behavior is mediated through individual’s perceptions, as cognitions play an important role in how people feel. Comprised of 50 items designed to evaluate the method adolescents and adults use to approach career development tasks, the Career Maturity
Inventory (CMI) will be implemented before and after the intervention. The goal will be to determine whether any differentiation occurs between the experimental groups. A supplemental longitudinal technique will be added to both the intervention and control groups. Due to therapy effectiveness relying on the strength of the relationship between the therapist and client, any form of therapy will be an acceptable intervention, as long as it is standardized among the experimental groups with a focus on self-efficacy development. All participants will be required to disclose their experiences and mental health states through journal entries and psychological assessments. This will aid in the analysis of efficacy measurements over time and the examining of results for composing future research. All participants will still be required to document their trials and tribulations at homogeneous times, and all will be held to the same check-in times and interview stage commitment. Focus groups grounded in self-efficacy will require reliance on the participants’ interaction with one another in order to produce the data. This will allow for personal and group feelings, opinions, and perceptions, and it will save time and money in contrast with individual interviews. Focus groups will be held for parents and siblings as well in order to further explore what previous research has supported involving juvenile delinquents (Walker et al., 2013).

**Projected Results**

The goal will be to obtain the mean and standard deviation of each of the group’s self-efficacy levels prior to, during, and after the intervention. Column charts will be created to best present the group means. A t-test will need to be included in the statistical analysis of the findings. The hypothesis is that self-efficacy is indeed an influencer of juvenile offenders’ behavior. Isolating one demographic will allow for a more accurate view of extraneous variables. It is predicted that the significance level will be below or at .05%. Self-efficacy is believed to be
a predictor of future ambitions and aspirations. Age and length of sentencing is also believed to affect the results, which is why it must be standardized for this study and possibly manipulated in a future one. Stronger self-efficacy beliefs are projected to be associated with positive outcomes, such as increased academic achievement, greater athletic performance, and happier romantic relationships. It is projected that they will provide a broader range of information, investigate complex behavior, and help identify changes. This study aims to discover how this population might differ in beliefs on this topic and why the individuals participating hold the certain opinions that they do. Investigating usefulness of current research effectiveness in action will help to better analyze the results from surveys, questionnaires, etc.

Discussion

Results may suggest potential solutions to problems identified, inform decision-making, strategic planning and resource distribution. Adding human dimension to impersonal data will deepen the understanding between the variables and help to explain statistical data. It will provide useful material such as quotes for public relations publication and presentations. Limitations include supplemented Appendices A and B, as they were adapted from prior research for the purpose of this study and therefore have lower validity and reliability. Limitations regarding the focus groups include disagreements and irrelevant discussion which can distract from the main focus. The groups can be hard to control and manage and complicated to analyze. It can be difficult to encourage a wide variety of people to participate. Some participants may find a focus group too intimidating or off-putting of a setting. Participants may also feel pressured to agree with the dominant view, similarly to conformity experiments such as Zimbardo’s (1971) prison experiment. As focus groups are self-selecting, they may not be
Suggestions for Future Research might include more specific targets within a treatment program for self-efficacy. Perhaps measures can be taken to address academic, problem-solving, and self-regulatory self-efficacy in an isolated format. Exploring the influence of self-efficacy on psychological and physical health and well-being would be beneficial along with academic and vocational success. Other research interests with this study might incorporate comparison data to counseling interventions preventing recidivism in adolescent middle-class suburban settings (i.e., to exploit the strong need for more specialized justice system programs). A closer look at juvenile offenders’ psychiatric disorders being under-identified and under-treated would be helpful following this study as well. This data could supplement studies looking at rates of recidivism and incarcerated youth perceptions. From Bandura’s (1997) publication, *Passages Beyond the Gate*, “If self-efficacy is lacking, people tend to behave ineffectually, even though they know what to do” (p. 425).
Appendix A
Interview Script Sheet for Filmed Sessions

Interviewer ID: ___
Interviewee ID: ___
Video Session #: ______
Date: ______________

Open-Ended Questions:

1. What are some goals, both short and long-term, that you have set for yourself in the past month?

______________________________________________________________________________
______________________________________________________________________________

2. Of the goals previously mentioned, which have you met and not met?

______________________________________________________________________________

3. What do you believe to be the reason for having met or not met those goals?

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

4. What short and long-term goals do you plan on setting for yourself in the future?

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

5. How do you plan ensure that you accomplish said goals?

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

6. What deterrents, if any, do you anticipate experiencing in the pursuit of these goals?

______________________________________________________________________________
7. How can you prepare for said deterrents if and when they occur?

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________
Appendix B
Self-Analysis Questionnaire

Participant ID: ___
Date: ______________

Questions:

1. On a scale from 1-10, with 1 being the weakest and 10 being the strongest, rank your ability to set goals for yourself:

    1  2  3  4  5  6  7  8  9  10

2. On a scale from 1-10, with 1 being the weakest and 10 being the strongest, rank your ability to accomplish said goals for yourself:

    1  2  3  4  5  6  7  8  9  10

3. On a scale from 1-10, with 1 being the weakest and 10 being the strongest, rank your ability to maintain a positive mindset:

    1  2  3  4  5  6  7  8  9  10

4. On a scale from 1-10, with 1 being the weakest and 10 being the strongest, rank the strength of your self-esteem:

    1  2  3  4  5  6  7  8  9  10

5. On a scale from 1-10, with 1 being the weakest and 10 being the strongest, rank how successful you feel at this moment:

    1  2  3  4  5  6  7  8  9  10

6. On a scale from 1-10, with 1 being the weakest and 10 being the strongest, rank your potential for success in the future:

    1  2  3  4  5  6  7  8  9  10
References


Observation of Self-Efficacy Development

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Abstract
This observation examines the development of self-efficacy over time. The goal of this observation is to explore how an individual’s levels of career decision-making self-efficacy (DV) might relate to the developmental stage (IV) that they are in (i.e., age). Subjects were selected from four age brackets, and all of them signed and received an explanation of the informed consent form. Forms were administered to parents for adolescent participants. The age groups explored include adolescence (ages 10-17), emerging adulthood (ages 18-25), early adulthood (ages 26-39), and middle age (ages 40-65). The Career Decision Self-Efficacy Scale (CDSE), developed by Taylor and Betz (1993), aims to apply Bandura’s theory of self-efficacy to career decision making. Concepts within each developmental period include identity versus role confusion, intimacy versus isolation, and generativity versus stagnation. Each of the participant’s demographic, cultural, ethnic, and religious beliefs or practices related to different upbringing experiences may account for variation in results.

Keywords: self-efficacy, career self-efficacy
Observation of Career Decision-Making Self-Efficacy Development

Rationale and Description

Self-efficacy is one’s belief in one’s ability to succeed in specific situations or accomplish a task (AllPsych Dictionary, 2018). Previous research has indicated the significance of self-efficacy and the effect it can have on approaching challenges and accomplishing life goals. What people believe they can do has shown to have a monumental effect on their abilities. According to Albert Bandura’s “An Agentic Perspective on Positive Psychology,” people who have an awareness of self-efficacy are typically able to bounce back from failure and approach conflict with alternative solutions rather than worry of what might go wrong (Bandura, 2008). Unlike Watson and Skinner, Bandura’s theories do not maintain that an individual is passively shaped by their parents and other socializing mediators (Seligman, 2018). Instead, his theory emphasizes reciprocal determinism, which is the development of humans occurring as a “continuous reciprocal interaction among the individual’s biological and psychological characteristics and cognitions, his or her behavior, and his or her environment” (Seligman, 2018, p. 44). While Skinner maintained that the environment was the lead influencer, Bandura claimed that people make choices to adapt within certain environments. “Whether you are trying to lose 10 pounds or get an A on a test, Bandura and colleagues have shown, your success depends greatly on whether you have a sense of self-efficacy concerning your ability to achieve your goal” (Seligman, 2018, p. 44).

Review of Relevant Literature

Belief in a Prosocial Self

Bandura (1991) maintains that individuals with higher self-efficacy levels are more likely to challenge themselves to achieve goals and commit to them. Cuevas, Wolff, and Baglivio
(2017) investigated whether incarcerated youth’s beliefs in their abilities predict positive aspirations. While prior research has examined a link between self-efficacy and crime, there appeared to be a research gap on how these variables are related to continued criminal behavior and the involvement of the justice system (Cuevas et al., 2017). They sought to more specifically explore a juvenile’s belief in his or her own ability to live a prosocial life and whether those beliefs could predict future aspirations. Conventional aspirations were described as behavior deemed acceptable, traditional, and mainstream (i.e., in regards to setting career goals). Their sample consisted of juvenile offenders (n = 12,955) who completed a residential placement program in Florida. Connections between self-efficacy and aspirations were explored. This study implemented a structural equation model in order to measure demographics and risk factors among the participants. Results specified that individuals with higher levels of prosocial self-efficacy also reported higher prosocial future ambitions. This research concluded that interventions in juvenile justice locations should target attitudes and beliefs in connection to a prosocial identity (Cuevas et al., 2017).

Adolescent Goal Setting

Carroll et al. (2012) explored the relationship between setting goals and self-efficacy. “Juvenile offending is one of the most serious contemporary societal problems, with data clearly demonstrating its significant negative impact on educational, health, financial, vocational, and judicial systems” (Carroll et al., 2012, p. 431). Participants included a matched sample of 88 adolescent delinquents (18% female), 97 at-risk (20% female), and 95 not at-risk (20% female). High school students were categorized as at-risk or not at-risk based on the Western Australian Legislative Assembly (WALA, 1992) which consists of checklist specifications. Goal commitment and goal types were also measured. Commitment was measured with a Hollenbeck
adapted, nine-item, Likert scale. The Goal Types Scale (Carroll, 1995) required participants to order up to eight life goals based on significance.’ Findings indicated that delinquent youth reported the least amount of goals and the least challenging goals. They were found to have lower commitment to their goals along with lower academic and self-regulatory self-efficacy levels. Data was examined utilizing discriminant functioning analysis. Youth that reported high delinquency-related goals and low educational and interpersonal goals were likely to belong to the delinquent group (Carroll et al., 2012). “Setting clear achievable goals that enhance self-efficacy and reputational status directs the energies of adolescents into socially conforming or non-conforming activities” (Carroll et al., 2012, p. 431).

Along with financial and educational difficulties that many youths in the juvenile justice system face, there are also distressingly high rates of mental health struggles. Krezmien et al. (2008) reported up to 80% of incarcerated youth are living with psychiatric illnesses, and those numbers are overwhelmingly larger in comparison to community-based youth. Youth with physical and mental health conditions are more likely to remain incarcerated for longer amounts of time, and those conditions are likely to be worsened by being incarcerated. Pennebaker and Chung (2011) examined links between written self-disclosure and increases in positive psychological developments. Greenbaum and Javdani (2017) developed an intervention designed specifically for underserved youth within the justice system. They implemented a writing-based program called WRITE ON, which is an acronym for Writing and Reflecting on Identity To Empower Ourselves as Narrators. The model was designed to include information pertinent to youth development, trauma experiences, and research-based therapeutic paradigms. The program consisted of a six-week group-based mediation meeting twice per week. Choices of writing prompts were also delivered throughout the intervention, for example, “Imagine you wrote an
autobiography of your life up to this point in time, and then you opened the book to a random page. Write that page” (Greenbaum & Javdani, 2017, 2.4.2). All data collected were measured in terms of positive or negative mental health outcomes. Results showed that individuals exhibited high satisfaction levels, and the WRITE ON intervention produced significant increases in resilience ($p < 0.01$). Their results suggested a need for a much larger trial exploring the efficacy of the WRITE ON program.

Career Guidance

Fernandes and Bance (2015) studied the route adolescents take from career indecision to career decision. Two focus groups were conducted with 14 participants in each group. The sample consisted of an even number of males and females. A questionnaire was developed for this study by the researchers. Interview-style questions allowed for open-ended responses. Semi-structured interviews were held for follow-up inquiries. Sessions were audio recorded to capture every aspect that transpired. Analyses consisted of grouping responses into a thematic framework (i.e., interests, mass meanings, phenomenological expression). “The basic purpose is to acquire firsthand personal and realistic information from the adolescents-respondents” (Fernandes & Bance, 2015, p. 137). Their results from the focus groups emerged into personal factors affecting decision making (i.e., anxiety, lack of information, lack of confidence, varied interest, career fear, uncertainty). Results also appeared to fit into categories of environmental factors along with personal factors. The three major themes that categorized the results were factors affecting adolescents in decision making, internal and external factors regarding career indecision, and accessing assistance regarding career indecision. This study demonstrates the various needs of adolescent guidance in general when it comes to indecision, and that illustrates further the need for a more specific needs-based intervention for the incarcerated youth.
population. Prevention is vital, however, there is a strong need for intervention within these institutions in wanting to reduce rates of recidivism.

Researchers Allen and Loretta (2014) sought to more specifically enhance career counseling with the juvenile justice population. Specific needs of juvenile offenders outlined in this study include career decision-making skills and career maturity. The focus variables were on self-efficacy and career maturity. Maturity was conveyed as awareness, exploration, and decision making. Participants included 22 individuals who completed a 12-week intervention. Long-term residents were the only youth eligible for participation. Ages ranged from 12 to 17 and consisted of both males and females. It was hypothesized that the intervention would improve career self-efficacy and career maturity. The Career Decision Self-Efficacy Scale (CDSE) was administered in order to collect pretest and posttest data. The counseling integrated into this study’s treatment program included cognitive behavior therapy (CBT), due to the theoretical foundation of behavior being grounded in an individual’s perception. Results indicated that there was no significant pretest difference between the control and treatment groups. In comparing the groups’ scores on the two dependent variables, “the result was significant for the two tests indicating that one or both of the dependent variables were significantly different” (Allen & Loretta, 2014, p. 35). This study helped exploit the limitations in research regarding at-risk youth and career guidance intervention programs.

Not only is research lacking for interventions designed for incarcerated youth, but there is also a neglect of recognizing specialized needs (SEN) within that population. Gutman and Schoon (2017) investigated adolescents with special educational needs and their career aspirations. This particular research compared early career aspirations of students with SEN to students without SEN. They wanted to see if there were greater opportunities for one group over
the other and possibly less barriers to future goal-setting and employment. Gutman and Schoon considered the related factors during analyses (2017) (e.g., previous academic ability, self-concept, motivation, parental expectations). They also made sure to address a measure on uncertainty. The adolescents included in the sample (n = 139) attended mainstream schools, excluding SEN exclusive schools with students diagnosed with much more severe needs (e.g., severe physical, emotional, and intellectual disabilities). This study serves as an example of how specific needs change the foundation of the intervention which is an additional aspect that should not be overlooked within the justice system.

Conkel-Ziebel et al. (2018) tested an integrative contextual career development model (ICM) with adolescents from high-poverty areas. “Learning to set viable career choice goals motivates young people to proactively pursue their career dreams and moves them toward establishing greater vocational identity and confidence in their career pursuits” (Lapan, 2004). Whether or not a family is considered to be in poverty, young people face challenges within these concentrated areas. Schools can have more dropout rates with less local jobs available. Lack of experience and networking can lead to unemployment. Researchers in this study sought to better the understanding and development of career decision-making of youth in these areas. Measures included collecting data on career exploration, person-environment fit, social readiness, self-regulation, and emotional support. Goal-setting skills were considered the main focus. It was hypothesized that the ICM skills would positively predict the ICM outcomes (i.e., academic achievement, self-efficacy, vocational interests, etc.) (Conkel-Ziebel et al., 2018). Participants (n = 220) consisted of 129 males and 91 females from one public school in a high-poverty area in the Midwest. The mean age was 16.33. “School profiles indicated that 87% of the students were from low-income families as indicated by their enrollment in the National School
Lunch Program” (Conkel-Ziebel et al., 2018). Results did show that the vocational skills were interrelated along with the outcomes, however, the two groupings were not multicollinear. Their findings exposed a stronger need to examine the development of a juvenile’s ability to recognize where and how to get help (i.e., acquiring emotional and instrumental support). This might start with fostering parental guidance and awareness on how to do so.

Parental Support

Ginevra et al. (2013) investigated parental support in adolescents’ career development and examined both the parents’ and children’s perspectives. They grounded their research in the social cognitive career theory (SCCT) of Lent, Brown, and Hackett (2000). It focused on the specific role that the parents play in terms of their support and the influence it may have on adolescents’ career self-efficacy and decision-making skills. The research included 94 youth, 30 of which were males and 64 females, residing in what they described as an industrial economy (i.e., large and small companies throughout the area). The ages of the participants ranged from 16-19 years old. All individuals were attending high schools that held within school activities centered around career preparation. They were administered three questionnaires. The Ideas and Attitudes on School/Career Future (IASCF, 2003) evaluated different levels of decision-making. The Career Decision-Making Self-Efficacy Scale-Short Form (CDMSE-SF, 1996) measured the individual’s beliefs on his or her ability to succeed at and complete tasks. The Social Provision Scale (SPA, 1984) was implemented as well in efforts to measure youth perceptions of parental support. The parents were administered a separate questionnaire entitled, My Children’s Future (Nota et al., 2012), to measure their perceptions of the support they deliver to their children. Data analysis included the computation of means, standard deviations, and intercorrelations. T-tests were computed to measure for any participant differences across different groups. “Moderate and
positive correlations were observed among mothers’ perceptions of support and adolescents’ perceptions of parental support, and moderate correlations with career self-efficacy and career choice were also found” (Ginevra et al., 2013, p. 8). They also found a strong correlation between fathers’ perceptions of the support they feel they positively provide with weaker adolescent’s perceptions of parental support. “Although the relationship among fathers’ perceptions of support and career self-efficacy was not significant (p = .06), we decided to include fathers’ perception of support in the further analysis because it was in the hypothesized direction” (Ginevra et al., 2013, p. 9). These findings highlight the significance of parental involvement in adolescent career planning. The level of parental support plays a role in an adolescent’s future, but so does the adolescent’s perception of what that role truly is. Future research might examine the discrepancies between those adolescent perceptions and the parental perceptions further.

Walker et al. (2015) researched a more specific interest of peer partner support for justice-involved parents. The sample was comprised of adults found waiting in a court lobby for their children’s juvenile court hearings. They were approached in the morning 30 minutes before the hearings began. A perceived flaw of this study is that only English-speaking adults were eligible to participate. Researchers conducted baseline surveys just prior to a video recruitment presentation. The survey was redistributed within the first week as a follow up procedure. Individuals who participated were given $5 gift cards upon completing the first survey and $10 gift cards upon completing the follow up survey. Examples of agreeable or disagreeable statements included in the survey are, “The court is out to get my child,” or, “I am scared about how this process will turn out” (Walker et al., 2015, p. 447). This study evaluated self-efficacy on behalf of the parents involved in the juvenile justice system. Scales intended to measure the
parents’ experiences were not found, so the researchers developed a scale for the purpose of this study to, “measure a sense of efficacy in being able to navigate the juvenile court processes” (Walker et al., 2015, p. 447). Results entailed that court mistrust did not differentiate between genders, ethnicities, or prior exposure from initial information collected. They utilized a linear regression model to evaluate participation and levels of mistrust of legal system processes. This model designated independent variables as conditions and mistrust with the dependent variable being the mistrust score. Participants present at the beginning of the study, but failed to participate further, exhibited higher levels of mistrust. No other statistically significant differences were found. There was a nonsignificant decrease in mistrust found to be associated with the video perceptions. Family involvement and commitment is associated with positive mental health results. However, this research features the point that very little is known or studied regarding family involvement with the juvenile justice system.

**Description of Instrument and Evaluation Process**

The Career Decision Self-Efficacy Scale (CDSE), developed by Taylor and Betz (1993), aims to apply Bandura’s theory of self-efficacy to career decision making. The two authors define career decision self-efficacy as “the individual’s belief that he or she can successfully complete tasks necessary in making career decisions” (psychology.iresearchnet.com, 2018). John O. Crites’ theory of career maturity was used in the creation of the scale. His theory defines these tasks as a person’s ownership of five areas of competencies and career choice attitudes. The five scales within the CDMSE (1994 version) are accurate self-appraisal, gathering occupational information, goal selection, making plans for the future, and problem-solving (Whiston, 2017). The original measure consists of 50 items, and the brief form (CDMSE-SF, Betz, Klein, & Taylor, 1996) consists of 25 items. Both contain the same five subgroup areas. “The CDMSE-SF
can be particularly useful in evaluating whether career interventions help individuals become more efficacious in their career decision making” (Whiston, 2017, p. 227).

The goal of this observation is to explore how an individual’s levels of career decision-making self-efficacy (DV) might relate to the developmental stage (IV) that they are in (i.e., age). Subjects were selected from four age brackets, and all of them signed and received an explanation of the informed consent form. Forms were administered to parents for adolescent participants. “Therefore, researchers who study such ‘vulnerable’ populations should obtain at least the ‘assent’ or agreement of the individual (if possible) as well as the informed consent from someone who can decide on the individual’s behalf – for example, the parent or guardian of a child or the legal representative of a cognitively impaired nursing home resident” (Seligman, 2018, p. 27). The CDMSE-SF was administered to two females within each of those groups (n = 8). From adolescence (10-17), the subjects’ ages were 16 and 17. In emerging adulthood (18-25), the subjects’ ages were 20 and 21. From early adulthood (26-39), the subjects’ ages were 26 and 29, and from middle adulthood (40-65), the subjects were age 52 and 61. All of the female participants grew up and reside in suburban towns within the New York and New Jersey area.

**Participants**

Adolescence (ages 10-17), not recognized until the late 19th and 20th century, begins with puberty and involves significant physical, cognitive, and psychological changes. This period of time reflects the individual becoming relatively independent (Seligman, 2018, Table 1.1). The ability for hypothetical-deductive reasoning has positives and negatives in the world of adolescence. susceptible for suicide, can’t see past trauma, they think always end of world, bullying, so preoccupied of real audience not imaginary (ex-not wanting to go out with parents as a teen), peer approval, self-esteem, gain a sense of identity, imagine alternatives to present
realities, question parents and injustices in the world, confusion and rebellion, understand what is
going on. Adolescent egocentrism can create a difficulty differentiating one’s own thoughts and
feelings from those of other people. Younger children’s’ egocentrism is based in the ignorance of
not knowing others have differing perspectives, but adolescents have the advanced ability to
reflect about one’s own thoughts and the thoughts of others. The imaginary audience
phenomenon involves the confusion of their own thoughts with those of a hypothesized audience
for your behavior (e.g., teenagers self-conscious on a date, questioning why they said something
or if their pimple was noticeable, when the other person is completely preoccupied with the same
sorts of thoughts about themselves). The personal fable is the tendency to think that you and
your thoughts and feelings are unique. No one in the history of the human race has felt such
heights of emotion (e.g., parents could never understand a break up in the eyes of an adolescent,
he or she may start to feel that rules do not apply to them). There is also a sense of indestructible
being (e.g., not using sexual protection, not wearing a seat belt, driving while drunk, etc.).
Additionally, Erikson’s stage of identity versus role confusion (ages 12-20), includes that this is a
period of time when the individual is becoming aware of his or her sexual orientation or
preference for sexual partners of either the opposite sex, same sex, or both (Seligman, 2018).
These individuals are working to figure out where it is that they are going, as well as a
consistency with the virtue of fidelity.

Emerging adulthood (ages 18-25) was recognized as the transitional period from
adolescents to adulthood, which was defined in the late 20th and early 21st centuries.
Psychologists began to describe emerging adulthood as a distinct phrase of the life-span in which
college-age youth spend years getting educated and saving money in order to launch their adult
lives (Arnett, 2011). This is a time where the individual can explore their identity, lead an
unstable life filled with job changes, new relationships, and moves. They can be considered self-focused, relatively free of obligations to others, and consequently free to focus on their own psychological needs (Seligman, 2018). The feeling that is present during this stage is that of the “in between,” being an adult in some ways but not others. Most individuals also feel that they have limitless possibilities ahead. This group falls in between identity versus role confusion (ages 12-20) and intimacy versus isolation (ages 20-40), which includes the notion of whether or not the individual is truly ready for a committed relationship.

Early Adulthood includes individuals from ages 26 to 39. Adults are likely to use formal operations in a field of expertise, but they tend to use concrete operations in less familiar areas. For example, a trauma’s effect on the individual and how they process it will vary depending on the domains that that person has knowledge in. A relativist mindset might include assumptions and influences of first impressions and the effect those assumptions can have on how that person views conflicts. These mindsets allow for an understanding of different points of view. An absolutist mindset tends to view conflicts from only one perspective. Older adults who engage in high-levels of aerobic activity show enhanced mental performance and corresponding increases in activity in certain regions. Adult roles are established during this stage (Seligman, 2018, Table 1.1). This group would also be dealing with the intimacy versus isolation stage, in accordance with a sense of love.

Middle age has been described as an emptying of the nest (ages 40-65), and it began to become recognized in the 20th century as parents began to bear fewer children and live long enough to see their children grow up and leave home. Generativity versus stagnation (ages 40-65), includes the desire to produce something that will outlive you. Individuals might wonder if they have given something to future generations, aligning with a sense of caring.
Results

Adolescence

Adolescent participants, VT (age 17) and JW (age 16), had similarities and differences in their responses. They both felt they had *very little confidence* in their abilities to *make career decisions without worrying about whether right or wrong*. Both also reported having *very little confidence* in the ability to *change occupations if unsatisfied with the one entered*. Similarities in *moderate confidence* were found in the ability to *determine steps to take if having academic trouble with an aspect of a chosen major*, to *determine steps to take in order to successfully complete a chosen major*, and the ability to *identify some reasonable major or career alternatives if unable to get a first choice*. Likenesses they shared *much confidence* in were the abilities to *find information in the library about occupations of interest*, prepare a good resume, and *decide what is most valued in an occupation*. With regards to *complete confidence*, they only reported the same responses on the ability to *define the type of lifestyle each of them would like to live*.

With regards to differences, participant VT reported *very little confidence* in the ability to *select one major from a list of potential majors you are considering* and the ability to *change majors if you did not like your first choice*. She felt she had *moderate confidence* in the ability to *determine what your ideal job would be*, find out the employment trends for an occupation over the next ten years, find out the employment trends for an occupation over the next ten years, *choose a major or career that will fit your interests*, and *identify employers, forms, institutions relevant to your career possibilities*. VT expressed that she had *much confidence* in her ability to *successfully manage the job interview process*. She felt she had *complete confidence* in the ability to *make a plan of your goals for the next five years*, accurately assess your abilities,
persistently work at your major or career goal even when you get frustrated, choose a career that will fit your preferred lifestyle, find out about the average yearly earnings of people in an occupation, and the ability to figure out what you are and are not ready to sacrifice to achieve your career goals.

Qualitative information on VT includes her desire to have options in life. She feels she has such a range of talents and interest that she is not yet sure where life will take her. Interestingly, when asked about an occupation that might not satisfy her, she said she would most likely remain in it. She did not view that as either positive or negative, she just felt that she might acknowledge what could have been a different course of action and that she would not allow this to bother.

Subject JW responded that she had very little confidence in the ability to find out the employment trends for an occupation over the next ten years. She reported having moderate confidence in the ability to make a plan of your goals for the next five years, accurately assess your abilities, find out about the average yearly earnings of people in an occupation, figure out what you are and are not ready to sacrifice to achieve your career goals, find information about graduate or professional schools, and the ability to successfully manage the job interview process. Her responses under having much confidence included the ability to persistently work at your major or career goal even when you get frustrated, choose a career that will fit your preferred lifestyle, change majors if you did not like your first choice, choose a major or career that will fit your interests, and the ability to identify employers, forms, institutions relevant to your career possibilities. Abilities JW felt she had complete confidence in were to select one major from a list of potential majors you are considering, select one occupation from a list of
potential occupations you are considering, determine what your ideal job would be, and the ability to talk with a person already employed in the field you are interested in.

Qualitative information on JW includes her sentiment that she does not struggle with anxiety, which was not asked of her, but instead feels that a lack of education is to blame for an inability to have confidence in the survey items she reported lower levels of self-efficacy on. She did express that she believed she had the ability to learn. JW also stated that she feels she would worry a great deal whether or not she would make a wrong career choice.

Emerging Adulthood

Participants CT (age 20) and JL (age 21) had similarities only in higher amounts of confidence. Their responses that were the same for much confidence included the ability to determine what your ideal job would be, find out the employment trends for an occupation over the next ten years, and the ability to identify employers, forms, institutions relevant to your career possibilities. They both had complete confidence in their abilities to decide what you value most in an occupation, talk with a person already employed in the field you are interested in, and successfully manage the job interview process.

Subject CT reported having moderate confidence the ability to find information in the library about occupations you are interested in, select one major from a list of potential majors you are considering, choose a career that will fit your preferred lifestyle, change majors if you did not like your first choice, and the ability to make a career decision and then not worry about whether it was right or wrong. She believed she had much confidence in the ability to determine steps to take if having academic trouble with an aspect of your major, accurately assess your abilities, select one occupation from a list of potential occupations you are considering, determine the steps to take to successfully complete your chosen major, persistently work at your
major or career goal even when you get frustrated prepare a good resume, find out about the average yearly earnings of people in an occupation, change occupations if you are not satisfied with the one you enter, choose a major or career that will fit your interests, define the type of lifestyle you would like to live, and the ability to find information about graduate or professional schools. CT believed with complete confidence in the ability to make a plan of your goals for the next five years, figure out what you are and are not ready to sacrifice to achieve your career goals, and the ability to identify some reasonable major or career alternatives if you are unable to get your first choice.

CT reported feeling overwhelmed with life’s possibilities and disliking commitment in general. She expressed a desire to obtain a sense of purpose in life, and she knows that she must partake in a career she feels passionate towards. She enjoys learning, and disclosed that it sometimes takes her extra time in order to do so, especially if she lacks motivation. CT does not feel that she has any current, long-term interests regarding a career, but she feels she has professional skills.

Subject JL felt that she had very little confidence in the ability to accurately assess your abilities, and she thought she had moderate confidence in her ability to find information about graduate or professional schools, identify some reasonable major or career alternatives if you are unable to get your first choice, and determine steps to take if having academic trouble with an aspect of your major. She exhibited much confidence in the ability to select one major from a list of potential majors you are considering, make a plan of your goals for the next five years, choose a career that will fit your preferred lifestyle, change majors if you did not like your first choice, make a career decision and then not worry about whether it was right or wrong, and the ability to figure out what you are and are not ready to sacrifice to achieve your career goals. JL
expressed that she had complete confidence in the ability to find information in the library about occupations you are interested in, select one occupation from a list of potential occupations you are considering, prepare a good resume, find out about the average yearly earnings of people in an occupation, change occupations if you are not satisfied with the one you enter, choose a major or career that will fit your interests, and the ability to define the type of lifestyle you would like to live.

JL reported very low levels of self-efficacy in the ability to assess her own abilities. When questioned about this, she said that for as long as she can remember, she has always experienced a large amount of self-doubt. She feels she constantly needs words of affirmation from others, and she does not feel that she has much patience.

Early Adulthood

Subjects in this age bracket, CB (age 26) and CA (age 29), resulted with the most amount of similarity in complete confidence. Neither reported having very little confidence in anything, and both felt they had moderate confidence in the ability to change occupations if you are not satisfied with the one you enter and much confidence in make a career decision and then not worry about whether it was right or wrong. With regards to complete confidence, both women reported such for the ability to select one major from a list of potential majors you are considering, determine steps to take if having academic trouble with an aspect of your major, accurately assess your abilities, select one occupation from a list of potential occupations you are considering, determine the steps to take to successfully complete your chosen major, persistently work at your major or career goal even when you get frustrated, determine what your ideal job would be, choose a career that will fit your preferred lifestyle, prepare a good resume, decide what you value most in an occupation, find out about the average yearly earnings
of people in an occupation, figure out what you are and are not ready to sacrifice to achieve your career goals, talk with a person already employed in the field you are interested in, choose a major or career that will fit your interests, identify employers, forms, institutions relevant to your career possibilities, define the type of lifestyle you would like to live, find information about graduate or professional schools, and successfully manage the job interview process.

In terms of their differences, CB felt that she had complete confidence in her ability to make a plan of your goals for the next five years, find out the employment trends for an occupation over the next ten years, change majors if you did not like your first choice, and identify some reasonable major or career alternatives if you are unable to get your first choice.

CB has been diagnosed with Bipolar Disorder has been medicated for over 10 years. She expressed an anxiety about her academic abilities regarding entering graduate school because she had not been in school for several years. She exhibits high confidence in her abilities in general (e.g., fitness goals), and her ability to accomplish her academic goals. CB also included that she learns visually, auditorily, and kinesthetically, and that she often needs more time in the learning environment. She does not doubt her ability to pass the BCBA exam, for example, but she understands that it might require several attempts.

CA reported having moderate confidence in her ability to make a plan of your goals for the next five years, much confidence in the ability to find information in the library about occupations you are interested in, find out the employment trends for an occupation over the next ten years, change majors if you did not like your first choice, and identify some reasonable major or career alternatives if you are unable to get your first choice.

CA has been diagnosed with an anxiety disorder for about eight years, and felt that this had an impact on her responses to the survey. She feels her career as a teacher best fits her
personal interests and needs, but she also feels that her immense amount of anxiety would never allow her to consider a career change in general.

Participants LT (age 52) and MB (age 61) represented the pairing with the largest age difference. Both reported moderate confidence in the ability to accurately assess your abilities, much confidence in the ability to identify some reasonable major or career alternatives if you are unable to get your first choice, and complete confidence in the ability to find information in the library about occupations you are interested in and make a plan of your goals for the next five years.

LT reported moderate confidence in the ability to determine what your ideal job would be, find out the employment trends for an occupation over the next ten years, choose a career that will fit your preferred lifestyle, change majors if you did not like your first choice, and change occupations if you are not satisfied with the one you enter. She felt that she had much confidence in the ability to determine steps to take if having academic trouble with an aspect of your major, select one occupation from a list of potential occupations you are considering, determine the steps to take to successfully complete your chosen major, persistently work at your major or career goal even when you get frustrated, prepare a good resume, decide what you value most in an occupation, make a career decision and then not worry about whether it was right or wrong, figure out what you are and are not ready to sacrifice to achieve your career goals, talk with a person already employed in the field you are interested in, choose a major or career that will fit your interests, identify employers, forms, institutions relevant to your career possibilities, define the type of lifestyle you would like to live, and the ability to find information about graduate or professional schools, successfully manage the job interview process. Her complete confidence levels pertained to the abilities to find out about the average yearly earnings
of people in an occupation, and select one major from a list of potential majors you are considering.

LT reported feeling less confident in her technology abilities, and she said this is a skillset area she feels needs work when it arises in her occupation. When pressed further, she did say she felt she was capable of these skills, if properly trained.

MB responded that she felt she had very little confidence in the ability to find out the employment trends for an occupation over the next ten years, moderate confidence in the ability to select one major from a list of potential majors you are considering and identify employers, forms, institutions relevant to your career possibilities. She had much confidence in the ability to choose a career that will fit your preferred lifestyle and to find out about the average yearly earnings of people in an occupation. MB reported complete confidence in the ability to determine steps to take if having academic trouble with an aspect of your major, select one occupation from a list of potential occupations you are considering, determine the steps to take to successfully complete your chosen major, persistently work at your major or career goal even when you get frustrated, determine what your ideal job would be, prepare a good resume, change majors if you did not like your first choice, decide what you value most in an occupation, make a career decision and then not worry about whether it was right or wrong, change occupations if you are not satisfied with the one you enter, figure out what you are and are not ready to sacrifice to achieve your career goals, talk with a person already employed in the field you are interested in, choose a major or career that will fit your interests, define the type of lifestyle you would like to live, find information about graduate or professional schools, and successfully manage the job interview process.
MB also reported feeling less confident in her technology abilities, along with a capability of learning if properly taught. Interestingly with MB, being the oldest subject surveyed, she expressed that she had a realistic sense of her skills. Another question posed to her, knowing that until this past year she had never had a career, was whether or not she experienced any hesitancy engaging in the work force now, at age 61. She said that it was nerve-wracking to mentally prepare for, but she also felt that she knew herself and her abilities so well at this point in her life that she was able to conceptualize a source of income that was unique to her interests and skills (i.e., staging houses, home organization).

**Discussion**

Variables that could affect variations in career decision-making self-efficacy, along with the survey responses, are each participant’s demographic, upbringing, cultural, ethnic, or religious beliefs or practices. The amount of parental involvement and support, or lack thereof, throughout development would be interesting to collect data on, along with each participant’s family structure and dynamic. Exploring personal experiences individuals perceived as either a triumph versus a failure could be considered significant in the development of one’s self-efficacy in general. Other aspect to take into consideration might be any possible learning disabilities, mental health issues, and varying education levels.

Karen Horney believed that a child was basically helpless under the influence of parental power. Two basic needs of the child, according to her theory, are safety and satisfaction. She deemed the child entirely dependent on the parents for these needs. Satisfaction needs include food, water, and sleep, while the need for safety refer to the necessity for security and freedom of fear. “At least minimal satisfaction of such physiological needs is necessary for the child’s survival” (Hergenhahn, Ch. 5, p. 136). This would be interesting to apply to information
gathered on parenting styles. Contributions, on behalf of the parents, to the development of any neurotic needs would illuminate differences between the subjects and perhaps provide an enhanced view of their self-efficacy development.

This information can be used to guide parents and teachers in helping children grow into emotionally healthy individuals. If parents and teachers can collectively, and interactively, address the importance, but not sole focus, of early childhood experiences, then perhaps difficulties that arise in development can be better predicted, treated, and even prevented. In accordance with this theory and its possible influence on self-efficacy development, a future counselor’s professional development will require acknowledging and encouraging parents to treat children with affection and warmth. This will satisfy the child’s need for safety. Urging them to refrain from demonstrating indifference, rejection, and even hostility can assist in avoiding the child’s neurotic development. From Bandura’s (1997) publication, Passages Beyond the Gate, “If self-efficacy is lacking, people tend to behave ineffectually, even though they know what to do” (p. 425).
Appendix A

Informed Consent Form (HERB) - Minors

Informed Consent Form

The Department of Psychology at The College of Saint Elizabeth supports the practice of protection of human participants in research. The following will provide you with information that will help you in deciding whether or not you wish to allow your child to participate. If you agree to participate, please be aware that you are free to withdraw at any point throughout the duration of the experiment without any penalty.

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Your participation is solicited, yet strictly voluntary. All information will be kept confidential and your name will not be associated with any research findings.

Signature of Participant

SAMANTHA TISI, Investigator

Print Name
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- uneducated, no anxiety, not knowing
- worried, wrong choice
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Appendix B

Informed Consent Form (HERB) - Minors

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[Signature of Participant]

[Signature of Investigator]

Print Name
Emerging Adulthood (18-25)
- Choose life passions/options
  - Overwhelmed
  - Not wanting to choose
- Have professional skills, no specific direction of interest
  - Must feel passionate/feel a sense of purpose
  - Long-term motivation
  - Extended timeline

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[Signatures]

Signature of Participant

SAMANTHA TISI, Investigator

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OBSERVATION OF SELF-EFFICACY DEVELOPMENT

Middle Adulthood (40-65)

I feel confident that I am capable to do anything I really want to do while also being realistic about my physical limitations and technology knowledge (which I could learn).

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Abstract

Trauma, abuse, and neglect can have devastating and life-altering effects on the developing brain (Teicher et al., 2017). There are hundreds of thousands of cases of child maltreatment reported each year in the United States (Child Trends, 2020). The continued call for action against child maltreatment remains strong and increased knowledge of the effects from abuse and neglect may aid in the prevention, as well as, provide assistance to those who have already experienced trauma. The current review of literature seeks to highlight the most current and applicable research on the physiological effects children experience as a result of abuse and neglect. Clinical considerations that are applicable and digestible for counseling professionals unfamiliar with complex neurological and physiological processes will be reviewed in detail.

Keywords: trauma, development, neurology, physiologically informed treatment
The Physiology of Abuse:

An Overview of the Physiological Effects of Childhood Abuse and Neglect

The plight of child abuse and neglect continues to affect the children of the world. In the United States alone, the number of child maltreatment cases reported per year is measured by hundreds of thousands (Child Trends, 2020). In 2018, it was reported that one in every seven children experience abuse or neglect (CDC, 2020). Unfortunately, some children will experience the worst outcome of child abuse or neglect, which is the loss of their life. The Center for Disease Control (CDC; 2020) reported that over one-thousand children died due to abuse or neglect. While the loss of these lives is without question the worst outcome of these actions, the psychological and neurophysiological effects of abuse and neglect, experienced by the children who survive, are intense and damaging.

Research has shown the psychological effects of children who have experienced maltreatment can be extreme and life-altering (Teicher et al., 2017). Teicher and colleagues (2017) noted the psychopathology that has been linked to maltreatment. Additionally, they note that maltreatment is related to difficulty sleeping. These findings highlight a relationship that is psychological and neurologically based. It has been reported that maltreatment, poor sleep quality, and physical responses from the brain have been recorded (i.e. decreasing of hippocampal size; Teicher et al., 2017). Rideout and colleagues (2019) found that maltreatment affects children’s behavior, as well as, on a biological level, their DNA. There is a large body of research that points to the neurophysiological effects of childhood abuse and neglect (Everaerd et al., 2016; Weniger et al., 2008).

The current review of literature will provide an in depth look at the physiological effects children experience as a result of abuse and neglect. All research considered will evaluate the biological, and neurological consequences of abuse, neglect, and trauma, as well as, the resulting
behavioral components related to all of these aforementioned repercussions. Clinical considerations will be covered and directed for individuals in the counseling profession. These considerations will be applicable and digestible for counseling professionals unfamiliar with complex neurological and physiological processes. Additionally, methods for advocacy and social justice considerations will be discussed. The current review will conclude with a carefully considered suggested course of action and future direction.

**Defining Child Abuse, Neglect, and Trauma**

Before looking at the neurophysiological effects of childhood abuse, neglect, and trauma (Everaerd et al., 2016; Weniger et al., 2008), it is important to define the different forms of abuse, neglect, and some of the resulting traumatic responses from experiencing abuse and neglect, as well as, other traumatic experiences. The most common forms of abuse and neglect will be highlighted and various forms and responses to traumatic events will be discussed.

**Abuse and Neglect**

Within the broad term of childhood maltreatment, there are several forms of abuse and neglect (Teicher & Samson, 2016). Commonly considered and discussed physical abuse, sexual abuse, emotional abuse, and neglect. Neglect is typically discussed as a general term with several subtypes of neglect (ie. safety; emotional; nutritional; Teicher & Samson, 2016). It is important to understand what these forms refer to and the various ways they have been defined and discussed in the literature. Past scholars have taken the approach to consider culture when defining abuse and neglect (Lansford et al., 2015). The current review will similarly take a culturally considerate approach and review how different cultures define these types of maltreatment. Lansford and colleagues (2015) discuss the tenets of the legality aspects of maltreatment via the Conventions on the Rights of Children (CRC). The CRC creates a layout for countries to follow regarding what is deemed as abuse or not (Lansford et al., 2015). This
document is not agreed upon universally however, (and notably), the United States has not signed the CRC in an attempt to maintain parental rights to use corporal punishment (Lansford et al., 2015). Lansford and colleagues (2015) assert that this creates a challenging task due to the difficulty in distinguishing between corporal punishment and physical abuse.

With these considerations, it is important to focus in on different cultures within the United States and their use of corporal punishment and views of abuse. Holden and colleagues (2017) focused on different ethnic-American groups and their use of corporal punishment and “metaparenting.” They found a significant difference highlighting that European-American mothers report using corporal punishment more often than both the African-American and Mexican-American groups (Holden et al., 2017). This is contradictory to Klevens and colleagues (2019) findings that spanking was most common among the Latino participants. Interesting to note, from their findings in their qualitative data, these researchers found more similarities than differences among Black, Latino, and White parents’ perceptions of using corporal punishment (Klevens et al., 2019). Continuing to complicate the conversation, in a Canadian study, Fréchette and Romano (2015) reported highest levels of corporal punishment from their Black and East Asian participants. With such conflicting results, looking at specific beliefs held by cultural groups may serve as an additional way to gauge cultural differences in use of corporal punishment. Lin (2018) looked at common cultural values and beliefs such as machismo (Hispanic/Latino) and filial piety (Asian) and how they affect experiences with physical punishment. Machismo was linked to more experiences with physical punishment while familismo and filial piety were not (Lin, 2018). The research points out the conflicting and clearly varying use of physical punishment in North America (Holden et al., 2017; Klevens et al., 2019; Fréchette & Romano, 2015; Lin, 2018). However, due to the poor definitions of corporal punishment (depending on state), and the inefficiency of this form of punishment (Gershoff &
Grogan-Kaylor, 2016), the current review will consider corporal punishment in a similar manner as physical abuse. Continued and consistent corporal punishment, physical abuse, sexual abuse, emotional abuse, and neglect are all forms of Adverse Childhood Experiences (ACEs) that can lead to psychological damage, such as trauma, that can lead to neurological and physical damage (Cloitre et al., 2019).

**Childhood Trauma**

While children are in a manner of speaking “young adults,” trauma presents differently just as many psychological disorders in children when compared to adults (APA, 2013). Therefore, the current review will consider all responses to traumatic ACEs and their psychological and neuro-physical effects. Similar to adults, in children, nothing is clear cut and there is no one answer for every individual. Children who experience traumatic events can experience a range of outcomes (Forkey et al., 2016). These outcomes range in symptomology and can present as different diagnoses or syndromes (Stolbach et al., 2013; van Der Kolk et al., 2019; Hagan et al., 2018). Children’s rapid development rate and stages may have an impact on how trauma affects each child in a different way (Grasso et al., 2016). Beyond Post-Traumatic Stress Disorder (PTSD), research has suggested the need for developmentally considerate diagnoses (Stolbach et al., 2013; van Der Kolk et al., 2019). Recent research has pointed at the need to include a novel diagnosis referred to as, Developmental Trauma Disorder in conversation when discussing ACEs and traumatic events (van Der Kolk et al., 2019).

Developmental Trauma Disorder is a syndrome of fifteen symptoms that are categorized into the biopsychosocial areas of (1) “emotion and somatic;” (2) “cognition and behaviour;” and (3) “self and relationships” (van Der Kolk et al., 2019, p. 3). Van der Kolk and colleagues (2019) compare the syndrome to an adult Complex Post-Traumatic Stress Disorder (CPTSD; DSM-IV;
APA, 1994). It is interesting to note that DTD appears to have a higher amount of comorbidities than PTSD (van Der Kolk et al., 2019). These additional comorbidities include panic and separation anxiety, amongst others (van Der Kolk et al., 2019). Compared to these children, there are certain groups of children who are more prone to experiencing a subtype of PTSD that includes dissociation (APA, 2013; Hagan et al., 2018). Hagan and colleagues’ (2018) findings suggest that several specific groups of children experience dissociative post-traumatic stress (PTSD-DISS) more often, including: females; and children who have experienced sexual abuse. The likelihood of PTSD-DISS increased with each traumatic event experienced (Hagan et al., 2018). Additionally, children with parents who have a tendency to avoid experiences related to trauma appear to be more likely to experience PTSD-DISS (Hagan et al., 2018). These findings (i.e. van Der Kolk et al., 2019; Hagan et al., 2018) support the devastating effects trauma can have on the developing child’s mental health.

**Abuse, Neglect, Traumas, and the Child Brain**

Presently, it has been seen that different forms of trauma, varying ACEs, and all forms of abuse and neglect have been seen to affect children. It is now imperative to see how abuse, neglect, and traumas can affect the developing brain. By building a knowledge of the neurology behind observable behaviors, counseling professionals will be able to implement a move effective and knowledge-based treatment plan to accurately work with children who have been victims of the aforementioned forms of abuse, neglect, or other forms of trauma.

**The Developing Brain**

Children are in a constant state of development and their brains are responsible for making connections at substantial rates. Similar to the effects of drug use or alcohol consumption, abuse, neglect, and trauma can damper, stunt, and change the development of the
growing brain (Perry, 2009, p. 2). Perry (2009) and the countless others who study his work in neurosequential development highlight the impact ACEs can have on the brain at different stages of development. Perry’s (2009) work notes that a traumatic experience at one age (i.e. 8 months) will have a drastically different effect at a different age (i.e. 8 years). This is due to the development of the different brain areas at different stages of development. The brain develops from the lower regions found in the brainstem to the upper regions found in the cortex (Perry, 2009). The brainstem is the localized area dedicated to basic unconscious life preserving functions such as breathing regulation and the circadian cycle (Perry, 2009). The cortex is responsible for the most complicated functions such as higher level processing (Perry, 2009).

The commonly discussed sensitive period is when specific observable behaviors appear such as beginning to crawl or speak, correspond to a specific sensitive period when micro-neurodevelopment is occurring in specific brain areas (Perry, 2009). During micro-neurodevelopment and key processes like synaptogenesis (or the formation of synapses between neurons) the brain areas that are in midst of development are highly susceptible to the environment and can be drastically affected (Perry, 2009). With this knowledge, it may be apparent that negative social interactions such as abuse, neglect, and trauma can affect specific brain areas depending on the stage of development (Perry, 2009).

**The Physiological Damage and Behavioral Symptoms**

The basis of behavioral symptoms is rooted in physiological and neurological alterations and damage. Children who have experienced abuse have shown physical, structural, brain differences (Lim et al., 2018). Lim and colleagues (2018) highlight the grey matter abnormalities recorded in children who have been victims of maltreatment. In addition to the unmyelinated grey matter, the myelin heavy white matter is also affected by childhood abuse (Lim et al.,...
2019). Specifically, several white matter areas have recorded, significant, decreases in neuronal density. Lim and colleagues (2019) noted marked differences in the inferior longitudinal fasciculus (ILF), a pathway of white matter neurons that connects the occipital lobe to the temporal lobe. Additionally, an observed decrease in the white matter area, the inferior fronto–occipital fasciculus (IFoF), was observed (Lim et al., 2019). This area is a direct connection between the occipital lobe, the temporal lobe, and the orbitofrontal cortices (Lim et al., 2019, p. 2). These areas are thought to be associated with processing visual cues and visual cognition (Lim et al., 2019). Deficits in these areas are related to learning disabilities, as well as, visual hallucinations and socio-emotional impairments (Herbet et al., 2018).

Gold and colleagues’ (2016) findings also suggest decreased cortical thickness. Their findings highlighted that children who have experienced abuse have reduced cortical thickness in the ventromedial prefrontal cortex (vmPFC) and lateral orbitofrontal cortex (OFC). Additionally, there is a reduced cortical thickness in the parahippocampal gyrus (PHG) in this population (Gold et al., 2016). Decreases in cortical volume, not thickness, in the hippocampus and PFC have been correlated to internalizing psychopathology later in childhood after experiencing maltreatment (Gorka et al., 2014). Gold and colleagues (2016, p. 1159) noted in their study that reduced cortical thickness was associated with higher levels of externalizing psychopathology, not internalizing symptoms. Within their extensive review of literature, Blanco and colleagues (2015) note that while some research has suggested hippocampal differences and memory problems associated with this memory center of the brain, other studies have conflicting findings. They note the need for further research to clarify these types of differences (Blanco et al., 2015). Their work is a collection of findings highlighting how each area of the brain is affected by sexual abuse experienced in childhood (Blanco et al., 2015). These researchers
highlight the vastly varying effects of maltreatment and the correlated psychopathology expressed behaviorally (Gorka et al., 2014; Gold et al., 2016; Blanco et al., 2015).

In addition to brain structure, there are additional physiological components at play in abuse, neglect, and trauma. Monoamine Oxidase A (MAOA) is an enzyme that is pertinent in breaking down multiple neurotransmitters including, dopamine and serotonin (Beach et al., 2010). MAOA has been linked to major depression and antisocial personality disorder (Beach et al., 2010). In their study, Beach and colleagues (2010) found a correlation between child maltreatment and MAOA. Their findings significantly linked abnormalities in MAOA function to antisocial personality disorder symptoms in both men and women who experienced child maltreatment (Beach et al., 2010).

Clinical Considerations for Counselors

It has been seen that abuse, neglect, and trauma can have various yet globally damaging effects on victimized children (Cloitre et al., 2019; Forkey et al., 2016). Additionally, the internal biologically based effects have been highlighted in physiological, large brain structures (Gorka et al., 2014; Blanco et al., 2015), specific pathways (Lim et al., 2019), and highlighted in neurologically based components, via genetic enzymes and neurons (Beach et al., 2010). It is apparent after years of research that the brain is greatly affected by early traumatic experiences in a variety of ways that have the potential to surface to observable behavior and conscious thought in all areas of life (Cozolino, 2017). It is worthwhile for psychological counselors who work with children, who were victims of abuse, to understand the physiological and neurological components in order to work on a treatment plan that is well-rounded and considerate of all factors. Many of the common disorders and deficits observed in children could be better understood by counselors if they were aware of the biological underpinnings. To highlight a few
more beyond those aforementioned; deficits in emotional regulation, memory, and reality testing are related to decreased hippocampal gray matter resulting from maltreatment, poverty, preterm birth (Chugani, et al., 2001; Brambilla, et al., 2004); deficits in regulating affect and altered fear activation are related to abnormalities in amygdala volume resulting from neglect (Chugani, et al., 2001; Hanson et al., 2015). Knowing these mind-body connections could aid in the healing process and inform counselors to assure best practice.

Physiologically Informed Treatment

Axline (1969, p. 9) noted that play is the natural form of communication children engage in. She effectively compares “play” for children in therapy to “talk” for adults in therapy. While Axline (1969) established a child centered play therapy that is non-directive, others opt for a different route when working with children who have experienced trauma, abuse, or neglect. Gaskill and Perry (2017) suggest a play therapy model that is informed by Perry’s (2009) neurosequential work and is structured with four major components. Maintaining play at its core, “neurosequentially” informed play therapy has four roots: (1) Relevance, (2) Repetition, (3) Relation, and (4) Rhythm (Gaskill & Perry, 2017). The first root, relevance, speaks to selecting games and activities to engage the child in therapy in specific ways that are specific and hand-selected for their difficulties or deficits (Gaskill & Perry, 2017). Gaskill and Perry (2017, pp. 45-50) note several suggestions and methods that are relevant to different foci, such as somatosensory and cognitive. Repetition refers to a consistent and meaningful “dose” of the specified play treatment (Gaskill & Perry, 2017, p. 50). Relation highlights the need for the play treatment to be meaningful and carried out by a compassionate and warm counselor (Gaskill & Perry, 2017). Similar to Axline’s (1969) work, Gaskill and Perry (2017) note that the play therapy does not need to be directed by the counselor, simply moderated and actively engaged.
Lastly, rhythm refers to the pattern that comes with the first three roots. Rhythm is achieved through successfully carrying out the first three roots and it provides a positive example for observed learning and brain neurons such as mirror neurons to adapt and regulate (Gaskill & Perry, 2017, p. 52). These four components and an understanding of how to effectively decide on relevant, repetitive play interventions that are meaningful and warm, and ultimately create a rhythm that provides an example that is both behavioral and biological can help counselors make a difference in the lives of children who have experienced abuse, neglect, or trauma.

Advocacy for Treatment

Trauma informed care has shown to be effective for children when implemented at child advocacy centers (Kenny et al., 2017). Advocating for the use of trauma informed care that is considerate of neurological and physiological factors would greatly benefit counselors in their mission to aid children who have experienced maltreatment. Educating counselors on best practices like those of Gaskill and Perry (2017) could positively affect therapeutic efficacy. Counselors of all forms and educations should receive education on basic neurological and physiological functioning that guide observable behaviors. A basic understanding of these underlying processes could allow for a full picture to provide the most personalized and considerate.
References


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Integration of Science and Practice: Borderline Personality Disorder

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Integrating Science and Practice: Borderline Personality Disorder

Borderline personality disorder (BPD) is a very prevalent personality disorder, affecting up to 6% of the population (American Psychiatric Association, 2013; Rizvi, Steffel, & Carson-Wong, 2013; Carson-Wong, Hughes, & Rizvi, 2018). In clinical settings it is one of the most observed personality disorders (Al-Alem & Omar, 2008; Barlow, Durand, & Hofmann, 2018) including about 10% in an outpatient setting and 20% in an inpatient setting (Adams, Bernat, & Luscher, 2002; APA, 2013; Rizvi et al., 2013; Carson-Wong et al., 2018), it is often believed that a psychologist cannot avoid working with an individual with BPD while practicing (Rizvi et al., 2013). Early ideas of borderline personality disorder were that people with this disorder actually had a mild form of schizophrenia and it was used as a label for patients who were considered hopeless and treatment resistant (Al-Alem & Omar, 2008). It was not until the late 1970s to early 1980s when a new definition for this disorder was created and was included in the DSM-III (Adams et al., 2002; Al-Alem & Omar, 2008) although this diagnosis has continued to evolve through the current DSM-5 when the axis diagnoses were changed to clusters.

Stereotyping people with borderline personality disorder tends to be very inaccurate and stigmatizing to people with this diagnosis. People with this disorder are seen as reckless and impulsive with no feelings towards others, just wanting attention. It is assumed that they cannot maintain strong healthy romantic relationships, and when in relationships- romantic or platonic- they are insecure, demanding, and sexually promiscuous. Stigmatization often occurs when disorders are misunderstood and can be perceived as other disorders, and with BPD many symptoms overlap with other disorders such as bipolar and major depressive disorder. Although for some the stereotyped beliefs may be accurate, it is not for all, and educating the general
population about the facts about this disorder can reduce stigmatization for people who are diagnosed with borderline personality disorder.

**Symptomatology**

BPD is often simply described as intense emotions and dysfunctional interpersonal relationships and behaviors (Fall & Craig, 1998; Carson-Wong et al., 2018), although in order to meet the criteria for the diagnosis at least five of nine necessary criteria must be met, as outlined in the DSM-5 (APA, 2013). Borderline personality disorder can often be misdiagnosed as another personality disorder, such as paranoid personality disorder, histrionic personality disorder, or antisocial personality disorder (Al-Alem & Omar, 2008). Many of the personality disorders contain overlap within their symptoms such as attention seeking, manipulative behavior, and rapid-shifting emotions; however trained psychologists will notice these patients react differently to each of the overlapping symptoms. It has been suggested that the criteria for BPD is organized into subsystems of dysregulation (Swales, Heard, & Williams, 2000): affective dysregulation, behavioral dysregulation, interpersonal dysregulation, self-dysregulation, and cognitive dysregulation.

The first of nine diagnostic criteria is going to extreme lengths to avoid abandonment, whether it is real or imagined by the person (APA, 2013), and this falls into the interpersonal dysregulation subsystem (Swales et al., 2000). These people would not fare well to sudden changes in plans or time-limited separation. This would result in the person feeling as if they are not worthy of attention. People with this disorder would show difficulties in relationships, both romantic and platonic. They have a belief that people are going to abandon them and they are “bad”. They cannot stand being alone and feel a constant need to have people around them expressing a need for intimacy and attachment (Lazarus, Scott, Beeney, Wright, Stepp, & Pilkonis, 2018).
Another symptom within the interpersonal dysregulation subsystem (Swales et al., 2000), is displayed is a pattern of unstable and intense interpersonal relationships (APA, 2013). They may idealize people and claim to love someone immediately upon meeting them. This can be seen in a therapeutic relationship, by a patient telling the therapist they are the only ones that can fix them, creating an idealized image of the therapist. They also tend to get very angry when they feel people are not there enough for them, thus also feeling abandoned. This also can correlate to why people with BPD also show unstable self-images and have a poor sense of self (APA, 2013), within the self-dysregulation subsystem (Swales et al., 2000). When patients do not experience meaningful relationships, they tend to display poorer self-images and begin to question their ideals, values, and choices. They begin to wonder if their decisions are making them less worthy of having a stable person who is not going to abandon them in their lives. People with BPD tend to view themselves as unacceptable in society, that they are not worthy of people wanting to be around them (Al-Alem & Omar, 2008).

Lazarus and colleagues (2018) tested whether the BPD symptoms would have an effect on affective responses (i.e., hostility, sadness, guilt, fear, and positive affect) to perceptions of rejection or acceptance from a romantic partner compared with non-romantic partners. It is interesting to look at a difference in romantic and non-romantic relationships. Their study showed that people with BPD were more likely to perceive rejection and experience more negative affect than their control group, which was people without a BPD. There also was a greater increase in negative affect when the perceived rejection came from romantic partners. These findings are consistent with the first and second diagnostic criteria for BPD and exemplify when patients perceive caregivers and important people in their lives as no longer caring for them and thus abandoning them.
Borderline patients also display impulsivity which can be self-damaging (APA, 2013) and behavioral dysregulation (Swales et al., 2000). These are actions such as substance use, promiscuity, excessive spending, and eating disorder behaviors, like binge eating. Studies have shown that people with BPD are at a six times greater chance of having a co-occurring substance use disorder than those without the diagnosis (Scalzo, Hulbert, Betts, Cotton, & Chanen, 2018). They are typically using substances to self-medicate and alleviate their chronic feelings of emptiness, which is also in the diagnostic criteria for borderline personality disorder. This diagnostic criterion offers a potential for misdiagnosis, due to the impulsivity patients exhibit they may appear to be experiencing a manic episode, which makes it important to look at the remaining criteria to distinguish if it is impulsivity or mania.

Another symptom of borderline personality disorder is that it is characterized by affective instability from reactivity of mood including; irritability, anxiety, and episodic dysphoria (APA, 2013), which falls into the affective dysregulation subsystem (Swales et al., 2000). This can look like mood swings; small things can trigger intense reactions. For people with BPD once they are upset, they have trouble calming down. They also experience periods of inappropriate and intense anger, and have a hard time controlling that anger (Swales et al., 2000; APA, 2013). Their mood swings tend to happen very quickly, only lasting about an hour at a time, whereas with other mood disorders the intense mood changes take longer to present themselves.

Another behavioral dysregulation (Swales et al., 2000) for this disorder is the tendency to display recurrent suicidal behaviors or self-injurious behaviors (APA, 2013). Parasuicide is another term used for suicidal behaviors, this can include self-harm, self-mutilation, suicide gestures, or suicide attempts (Linehan, 1987). Parasuicide is one of the most associated features with BPD. Thoughts of suicide may last months or years for people with BPD, although they may
not attempt suicide multiple times within that period, they may still be practicing self-harming behaviors (Al-Alem & Omar, 2008). A misconception with BPD is that they always try to kill themselves, however they also perform self-mutilating actions like burning themselves or cutting, although about 75% of people with BPD have attempted suicide at least once in their lives (Carson-Wong, 2018). About 8-10% of people with BPD complete suicide (Lieb, CZanarini, Schmahl, Linehan, & Bohus, 2004; APA, 2013; Carson-Wong et al., 2018), and many more threaten suicide or perform the suicidal gestures without the intent to die, as a means for garnering attention from caregivers. This symptom tends to be the main reason people with this disorder seek treatment.

Another symptom of this disorder is that they may experience periods of depersonalization during times of extreme stress (APA, 2013). This may present itself as appearing out of touch with reality and as if they are outside of their body looking in. They may hear voices, similarly to schizophrenia, however people with BPD recognize that the voices they are hearing are coming from within their minds and they do not respond the same to the voices.

The most common practice for diagnosing borderline personality disorder is through semistructured or structured interviews (Adams et al., 2002; Lieb et al., 2004). A semi structured interview that was designed to measure BPD criteria is called the Diagnostic Interview for Borderlines-Revised ([DIB-R] Adams et al., 2002). The DIB-R measures four elements: affect, cognition, impulsivity, and interpersonal relationships. All four of those elements correspond to the specific criteria for BPD. Due to tests like the DIB-R and other semi structured and structured interviews, other screening methods such as the Multiphasic Personality Inventory-2 (MMPI-2) and the Wisconsin Personality Inventory (WISPI) are completed to determine if further analysis is needed (Adams et al., 2002).

**Etiology and Prognosis**
Although the exact cause of BPD is not known, there are many factors that have been identified as factors that influence the development of this disorder in people (Al-Alem & Omar, 2008). The onset of BPD occurs primarily in early adulthood, 24 to 34 years old (Al-Alem & Omar, 2008; Newman & Newman, 2015; APA, 2013) becoming the most severe around 25 years old (Al-Alem & Omar, 2008). About 75% of this population is female (Lieb et al., 2004; APA, 2013), due to the high rate in women many researchers question if this is due to a genetic reason or overgeneralization due to stereotypical masculine and feminine characteristics (Adams et al., 2002). BPD appears to have a chronic course however with treatment many patients no longer meet the criteria, many factors interact to influence the course of this disorder for each person. For example, the prognosis for someone with this disorder who had substance abuse problems, a history of sexual or physical abuse, and comorbid disorders is poorer than someone who is intelligent, and described as more likeable (Adams et al., 2002), however when participating in the proper treatment up to 75% of people with borderline personality disorder can enter remission after hospitalization (Lieb et al., 2004). Suicidal behaviors are extremely common among this population, and about 10% of patients with borderline personality disorder die by suicide (Al-Alem & Omar, 2008). Patients also tend to show comorbidities such as major depressive disorder, other mood disorders, eating disorders, PTSD, as well as substance abuse disorders (Scalzo, Hulbert, Betts, Cotton, & Chanen, 2018) which can influence their prognosis. One single factor is not responsible for the development of borderline personality disorder, rather it is influenced by biological, psychological, and social factors (Al-Alem & Omar, 2008).

There appears to be a biological component involved in a person having a predisposition to this disorder or becoming diagnosed with BPD. According to the DSM-5 it is about five times more likely to develop in a person who has an immediate relative who also is affected by this
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disorder (Adams et al., 2002; APA, 2013). Personality disorders associated with aggression and impulsivity are linked to dysfunctional levels of serotonin in the brain (Al-Alem & Omar, 2008), BPD included. Adams and colleagues (2002) noted that many family history studies have noticed a positive correlation between relatives having impulse disorders (i.e., substance abuse, alcoholism, and antisocial behaviors) or major depressive disorder with borderline personality disorder.

There are also psychological factors contributing to a person becoming diagnosed with BPD. Many patients with BPD have experienced physical or sexual abuse at very early ages, and although child abuse is not specific to this disorder it can trigger a biological predisposition to this disorder (Al-Alem & Omar, 2008). Between 50-70% of patients with borderline personality disorder have reported experiencing childhood sexual abuse (Adams et al., 2002). In research conducted by Paris (1994), they found that the more severe sexual abuse was the higher it was correlated with BPD. Childhood trauma is not a cause of borderline personality disorder, it is linked to other disorders such as depression, substance abuse disorders, and post-traumatic stress disorder as well, however childhood trauma is a very known psychological risk factor that can trigger predispositions for disorders within different people (Adams et al., 2002; Al-Alem & Omar, 2008).

Parental separation, parental loss, as well as poor parental bonding can also be psychological and social factors that can trigger BPD in people with predispositions (Adams et al., 2002; Al-Alem & Omar, 2008). Parental loss or separation can be from death, incarceration, or divorce, 37-64% of people with BPD reported experiencing early parental loss or separation (Adams et al., 2002). Losing a parent at a young age or experiencing prolonged separation from them can prevent the child from developing strong relationships and instill a fear of abandonment.
Children of divorce also tend to develop a self-image of being a reason for their parents no longer being together, which can trigger them to have poorer self-images and desire intense relationships where the person would never leave them, as is a common trend with people diagnosed with borderline personality disorder. A poor family environment can also trigger borderline personality disorder in people, studies have shown that many people with BPD grew up in dysfunctional families and experienced neglect, conflict, and unpredictable chaotic situations (Adams et al., 2002). Neglect from a parent can also create trust and abandonment issues, as is similar with losing a parent. When parents do not give children a supportive environment, they do not allow their children to develop adaptive emotional regulation skills (Adler, 1985) which is related to symptomology of borderline personality disorder. Children learn through observational learning, and when they are raised in a dangerous household- witnessing violence, promiscuity, drug or alcohol abuse, or self-injurious behaviors from a parent- they grow up thinking that behavior is normal and adaptive. Modeling the behaviors they witness at home at a young age, these children would be more likely to participate in substance abuse, promiscuity, and self-injurious behaviors to reduce stressful situations in their life (Adams et al., 2002).

**Treatment**

Compared to other personality disorders, people diagnosed with BPD are more likely to seek treatment (Barlow, Durand, & Hofmann, 2018; Carson-Wong et al., 2018). They tend to appear as distressed and want help to alleviate the distress. There are two main types of treatment used for borderline personality disorder; psychotherapy and symptom-targeted pharmacology (Oldham, 2004; Al-Alem & Omar, 2008). Within psychotherapy there are also two avenues therapists can also practice, including psychodynamic psychotherapy and dialectical behavior
therapy (DBT). The main goal of therapy being reduction of the behaviors associated with BPD allowing people to better function in society and experience adaptive lives.

Psychopharmacology is the use of medication to target certain symptoms of the disorder. Different types of drugs are used to treat different symptoms of the disorder, and do not specifically treat BPD however they can alleviate some of the symptoms (Al-Alem & Omar, 2008). There are four symptoms in particular that medication can target; affective instability, impulsive behaviors, psychotic symptoms, and anxiety (Adams et al., 2002). Mood stabilizers are often used to target instability in moods, such as inappropriate and intense anger (Barlow et al., 2018). Antidepressants, antipsychotics, and anti-anxiety drugs have also been used to treat impulsivity, cognitive and perceptual impairments, and depression. Medication must be closely monitored by a psychiatrist however, due to the high risk for drug abuse and suicidal behaviors in this population (Linehan, 1987; Adams et al., 2002).

Dialectical behavior therapy was created by Marsha Linehan to specifically target instability and impulsivity within outpatient settings (Linehan, 1987; Rizvi et al., 2013; Al-Alem & Omar, 2008) and is one of the most common treatments for BPD (Al-Alem & Omar, 2008; Barnicot, Gonzalez, McCabe, & Priebe, 2016). Linehan (1987) originally designed dialectical behavior therapy to focus on parasuicidal and suicidal behaviors (Swales et al., 2000) specifically in borderline patients (Linehan, 1987).

DBT uses group skills training and individual therapy- helping patients learn to control emotions (Linehan, 1987)- focusing on acceptance and change (Al-Alem & Omar, 2008; Rizvi et al., 2013). DBT is a form of cognitive behavior therapy (Al-Alem & Omar, 2008; Rizvi et al., 2013) that involves five common tasks of treatment; to teach effective skills for emotional and behavioral regulation, to enhance the client’s motivation to use those new regulation skills, to make
sure the clients can generalize the situations in which they would use these skills, and to help create an environment that reinforces skill use (Swales et al., 2000; Barnicot et al., 2016). It focuses on mindfulness, interpersonal effectiveness, emotional regulation, and distress tolerance (Al-Alem & Omar, 2008) to help patients find skills to shape their environment and stay motivated to continue using the skills to build and maintain positive interpersonal relationships (Linehan, 1987; Barnicot et al., 2016). Therapists are also typically available on an as needed basis to conduct phone coaching (Rizvi et al., 2013) when the client needs help using skills outside of therapy and are in distress.

DBT is organized into five stages of treatment (Linehan 1987; Rizvi et al., 2013), pretreatment followed by four other stages. Pretreatment is used to set goals between client and therapist (Rizvi et al., 2013), it is important to ensure both parties are on the same page when it comes to treatment goals, thus building a strong therapeutic alliance as well as building commitment (Swales et al., 2000). The goal of stage one is to regain behavioral control (Rizvi et al., 2013). It is important to establish a connection as well as ensure the client’s safety early in the process of therapy (Swales et al., 2000) Therapists will work with clients to reduce self-harming and self-sabotaging behaviors. Stage two is designed for exposure and to begin the emotional processing stage (Swales et al., 2000) while focusing on the client’s feelings of emptiness and solitude (Rizvi et al., 2013). Once the patient gains more control over their behaviors, then they are able to deal with their feelings of emptiness, they are able to focus on battling the invalidation they feel from being alone at times and gain the ability to be alone rather than need company all of the time. However, during this stage, it is not uncommon for resistance to present itself within the client, due to their fears of abandonment and lower self-image. In stage three the therapist and client work towards improving their self-image (Rizvi et al., 2013), and building the client’s self-
trust and self-respect up (Swales et al., 2000). It is very important for people with BPD to build stronger self-images to begin feeling worthy of love and acceptance from others. Stage four is the final stage of treatment and involves building self-awareness and help clients feel complete within themselves (Rizvi et al., 2013), while implementing the new skills to combat the issues of daily life (Swales et al., 2000). Although stage four is considered the last step of treatment it is designed to be able to go back and forth between stages due to resistance and the resurfacing of pathologies.

Within these four stages of treatment therapists are implementing many different therapeutic techniques to help the patients gain their own skills to control behaviors (Rizvi et al., 2013). Within DBT clients may be told to keep a diary of their emotions and problems that occur daily to go over in therapy to find coping skills to handle those problems and emotions. They should also be told to honestly keep track of self-injurious behaviors for the therapist to be aware of issues that should be focused on in the subsequent sessions (Rizvi et al., 2013). Role-playing during sessions also show to be effective to help clients rehearse situations and practice new behaviors to make them more comfortable implementing them outside of the therapy sessions. Group sessions are also used to teach mindfulness, interpersonal skills, coping mechanisms, and emotional regulation (Rizvi et al., 2013; Barnicot et al., 2016). Within DBT a main focus is on becoming an active problem solver within the patient's own life. Each session begins with the client and therapist setting an agenda of what they would like to focus on during their time together (Swales et al., 2000).

Barnicot and colleagues (2016) ran a study to evaluate the influence of the use of skills learned in DBT is outside of therapy. Measuring how many times within a week, participants used the skills learned through DBT and they concluded that using the skills learned correlated to lower rates of self-harming behaviors and higher emotional regulation (Barnicot et al., 2016). The skills
focused on in DBT are mindfulness, interpersonal skills, emotion regulation and distress tolerance (Linehan, 1987; Barnicott et al., 2016).

Although treatment cannot “cure” borderline personality disorder, remission is possible if the person is given the right treatment and skills to combat some of their symptoms. Allowing clients to build coping strategies to deal with their cognitions and fears of abandonment, isolation, impulsivity, and low self-worth, they will be more likely to live productive lives with the possibility of building and maintaining healthy relationships with others.
Reference


