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Intuition
Volume 9

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Journal of Undergraduate Psychology

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<td></td>
</tr>
</tbody>
</table>

Published by BYU ScholarsArchive, 2012
Twenty-one and Single!?:
Marriage Desperation Among Single BYU Students

by Brian Ensign, Giles Christman, Jenna Muirhead and Lindsay Bigelow

Getting married at an early age is a social norm for members of the Latter-day Saint (LDS) faith. To our knowledge there are no published studies of marriage desperation in that culture. The goal of our study was to develop an instrument for reliably and validly measuring marriage desperation, which we operationally defined as the frequency of contemplating marriage as well as other actions likely to result in getting married. The Marriage Desperation Scale (MDS) consists of 10 items rated on a 4-point Likert scale. The MDS was administered to a convenience sample of 166 single LDS participants via an online-survey site. The MDS had moderate internal consistency (α = 0.67). Two items had validity coefficients of 0.76 and 0.68 and two others 0.52. A factor analysis revealed three factors, but it was difficult to discriminate between them. We offer suggestions for improving the MDS for future use in research including more domain specific questions and a more experienced panel of experts. The MDS is neither a reliable nor a valid way of measuring marriage desperation.
Twenty-one and Single!?: Marriage Desperation Among Single BYU Students

In the Latter-day Saint (LDS) faith and especially at Brigham Young University (BYU) there is social pressure to marry early and consequently anxiety about remaining single (a condition that we identify here as marriage desperation). According to Uecker and Stokes (2008) conservative Mormons and Protestants are the most likely to marry before the age of 23. The mean age of first marriage in the United States has been increasing since the 1970s and currently is 28 for men and 26 for women (Lee & Payne, 2010). These young marriages may result from the strong encouragement of parents and other family members, friends and other persons of influence for individuals to be married by a certain age (Blakemore, Lawton, & Vartanian, 2005; Heinrichs et al., 2006).

According to Bebbington et al. (2010) the frequency of one's thoughts provides a strong predictor of one's subsequent actions. Marriage desperation may be overzealousness about getting married as quickly as possible or constant efforts that are intended to result in increased chance of marriage. Attitudes leaning towards getting married at a young age may be part of the larger LDS belief that it is one's duty to have children and without being married it is taboo to do so. Having sex outside the bounds of marriage is strictly preached against and considered a very grave sin. Marriage desperation may be a factor in people marrying sooner than they would if they did not feel anxiety about being unmarried (Blakemore et al., 2005). Any number of other factors may result in early marriage as well, including financial circumstances improving through marriage, unwanted pregnancies resulting in marriage, etc.

For this study, we operationally defined marriage desperation as the frequency of contemplating marriage as well as frequency of actions that increase one's likelihood of getting married. After our initial pilot study, content-validity ratios (CVR) indicated that questions of these two categories more accurately represented marriage desperation. Contemplating marriage was defined as thinking about becoming married or about the impact of remaining unmarried. Actions that increase one's likelihood of getting married were defined as (a) conflict-avoidant verbal communication or (b) being one-on-one with potential partners in the interest of becoming romantically involved.

On the campus of Brigham Young University (BYU) it is not uncommon to receive daily reminders of the importance of marriage. These include being told that marriage should be the student's highest priority.
and receiving frequent invitations to attend marriage-preparation classes. Amidst these reminders of the importance of marriage one’s frequency of contemplating marriage may increase. For those who are unmarried, the reminders can lead to self-accusations such as, “I should be married already.”

The purpose of our study was to create a measure of marital desperation and to determine its factor structure, internal consistency, and validity, and thereby its potential use in future studies of individuals who are overzealous to become married. We hypothesized that the Marriage Desperation Scale (MDS) will be both reliable and valid.

Method

Participants

There were 178 participants, all of whom were never-married and LDS individuals. Ten of them did not complete the entire survey. Of the remaining 168 participants, 97 were females and 71 were males. Participants were arranged into four age groups: 56 participants were between the ages of 18 and 19; 62 were between 20 and 21; 30 were between 22 and 23; and 20 were 24 and older. The only demographic questions collected included: marital status, age, gender and religion.

Item Construction

To create the MDS, we first constructed 30 items for a pilot study. We administered them to 46 students in an undergraduate psychological research-methods course. Items with a CVR greater or equal to 0.12 were included in the final 10-item survey. Half of the items addressed one domain of our construct—namely, frequency of contemplation—and the remainder of the second domain of other actions. Participants responded to the items on a 4-point Likert scale: 1 (strongly disagree) to 4 (strongly agree). Five of the items were negatively worded and reverse scored to control for agreement bias.

Survey Administration

We administered our survey via an online-survey site (http://www.qualtrics.com). We recruited using a convenience sample of e-mail contacts and Facebook (http://www.facebook.com) friends. These two methods of distributing and recruiting for the survey were the most efficient way to reach a large number of people in a small amount of time. Although this method of sampling was convenient, the environment in which the
surveys were taken was not controlled for as a result. This lack of control is a potential confounding factor.

Statistical Analysis
We measured the internal consistency of our survey using Cronbach's Alpha and used a Pearson bivariate correlation to measure reliability. We used eigenvalues ≥ 1 (Kaiser's Rule) during factor analysis to reduce the data. The final item of the survey was included as a measure of face validity (see Appendix A). The CVR was used to measure content validity. SPSS 18 was used to analyze the data.

Results

Factor Structure
A factor analysis revealed three factors with eigenvalues greater than 1.0 (2.63, 1.41, and 1.24) that accounted for 52.74% of the variance (see Appendix E). The factor analysis also indicated that 26.25% of the variance was accounted for by one factor. Several items loaded onto multiple factors: Items 1, 2, 3, 4, 7, 8, and 10 onto Component 1, Items 2, 3, 4, 5, and 9 onto Component 2, and Items 4, 6, and 8 onto Component 3 (see Appendix F).

Reliability
Twenty-five of the 45 Pearson bivariate correlations were statistically significant (p < 0.05), with 22 p < 0.01. A Cronbach's alpha of $\alpha = 0.67$ (see Appendix D) revealed that the internal consistency of the survey was moderate.

Validity
As mentioned previously, items with a CVR ≥ .12 composed the survey. Two items had superior validity (0.76, 0.68), two had high validity (0.52), three moderate validity (0.44, 0.36, 0.36), and one with adequate validity (0.28). The other two components had low validity (0.12) (see Appendix B). The measure of face validity was low (27.98%). In order to measure face validity, participants answered the open-ended question, "What do you think this survey was measuring?" Following that, we objectively analyzed their responses to see if correctly recognized the construct as measuring marriage desperation. Only 47 participants correctly recognized the construct as marriage desperation. The remaining participants viewed the survey as about opinions on marriage.
Discussion

The MDS was neither a reliable nor a valid measure of marriage desperation. Revisions to this test, such as administering our pilot study to a panel of professionals and properly evaluating the data to obtain an authentic display of information, are necessary in order for this measure to be accurate and of use to both the LDS community and the general population. The outcome indicated that the survey items measured more than one construct.

An examination of our principal component analysis and our scree plot showed that there were three principal components that described our data. We reason that they did not load onto our two originally projected domains—(1) thoughts about marriage and (2) actions that increase the likelihood of marriage—because the questions measure three different factors: the desire to attain the social norm of being married, the ability to make good decisions despite social norm expectancy, and jealousy due to non-attainment of social norms.

One strength of our results was that 25 out of the 45 correlations were statistically significant ($p < 0.05$), with 22 of these correlations significant at $p < 0.01$. To be applied outside of the LDS faith, the MDS would need to be revised. In doing so, a reliable and valid measure of marriage desperation may be constructed.

The scale would be stronger psychometrically if the items were tested on a group of experts who would be asked to rate the items rather than students who provided ratings merely for a grade. Although experts on the specific topic of marriage desperation may not exist, experts on the subject of marriage may suffice. Greater caution while analyzing the data would also be advised. As data was analyzed, many of the questions that received superior or high CVR were overlooked because we were interpreting our data too quickly due to time constraints and deadlines. Ultimately after revisions are made, the survey may be useful in distinguishing between those who want to marry for more than desperation and out of mere desperation. In this way it may help to reduce divorce and the societal toll that accompanies it if participants of the survey take their results seriously. Participants who have results indicating high marriage desperation will be cautioned that marriage should be taken seriously and not rushed into if entered into for the wrong reasons may result in decreased overall satisfaction of life and increased rates of divorce.
References


## Appendix A

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your marital status?</td>
<td>Single, In a relationship, Married, Divorced</td>
</tr>
<tr>
<td>What is your age?</td>
<td>18–19, 20–21, 22–23, 24 and older</td>
</tr>
<tr>
<td>What is your gender</td>
<td>Male, Female</td>
</tr>
<tr>
<td>What is your religion?</td>
<td>LDS, Other</td>
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<tr>
<td>I try hard to be the person that others want to marry</td>
<td>Strongly Disagree, Disagree, Agree, Strongly Agree</td>
</tr>
<tr>
<td>I do not think about marriage daily.</td>
<td>Strongly Disagree, Disagree, Agree, Strongly Agree</td>
</tr>
<tr>
<td>Meeting my future spouse is not my main motivation behind dating.</td>
<td>Strongly Disagree, Disagree, Agree, Strongly Agree</td>
</tr>
<tr>
<td>Getting married is not a higher priority than finishing school.</td>
<td>Strongly Disagree, Disagree, Agree, Strongly Agree</td>
</tr>
<tr>
<td>I would not date someone unless I could see myself getting married to them.</td>
<td>Strongly Disagree, Disagree, Agree, Strongly Agree</td>
</tr>
<tr>
<td>I feel like everyone but me is getting married.</td>
<td>Strongly Disagree, Disagree, Agree, Strongly Agree</td>
</tr>
<tr>
<td>I will not suppress opinions in order to please a potential spouse.</td>
<td>Strongly Disagree, Disagree, Agree, Strongly Agree</td>
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<tr>
<td>I do not feel jealous when I hear acquaintances or friends are getting married.</td>
<td>Strongly Disagree, Disagree, Agree, Strongly Agree</td>
</tr>
<tr>
<td>If I was dating someone seriously, and decided I could not marry them, I would break up with them immediately.</td>
<td>Strongly Disagree, Disagree, Agree, Strongly Agree</td>
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<tr>
<td>I feel that my life is worthless without a spouse.</td>
<td>Strongly Disagree, Disagree, Agree, Strongly Agree</td>
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<td>What do you think this survey was measuring?</td>
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### Appendix B

**Content Validity Ratio**

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<td>I will not suppress opinions in order to please a potential spouse.</td>
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<tr>
<td>If I was dating someone seriously, and decided I could not marry them, I would break up with them immediately.</td>
<td>.44</td>
</tr>
<tr>
<td>I do not think about marriage daily.</td>
<td>.36</td>
</tr>
<tr>
<td>Getting married is not a higher priority than finishing school.</td>
<td>.36</td>
</tr>
<tr>
<td>I try hard to be the person that others want to marry.</td>
<td>.28</td>
</tr>
<tr>
<td>I do not feel jealous when I hear acquaintances or friends are getting married.</td>
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<tr>
<td>I would not date someone unless I could see myself getting married to them.</td>
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Percentage of Variance Explained

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Extraction Method: Principal Component Analysis

Cronbach's Alpha

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## Appendix E

### Component Matrix

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<td>I feel like everyone but me is getting married.</td>
<td></td>
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<td>I will not suppress opinions in order to please a potential spouse.</td>
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<td>I do not feel jealous when I hear acquaintances or friends are getting married.</td>
<td>.31</td>
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<td>If I was dating someone seriously, and decided I could not marry them, I would break up with them immediately.</td>
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<td>I feel that my life is worthless without a spouse.</td>
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# Appendix F

## Pearson Correlation Coefficients

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<td>.09</td>
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</table>

* Significant at 0.05 level (2-tailed).
† Significant at 0.01 level (2-tailed).
Appendix G
Scree Plot

Scree plot indicating components of the Marriage Desperation Scale.
The pervasiveness of divorce attracts the attention of researchers in many fields. The purpose of this literature review is to summarize and synthesize major themes regarding the adjustment outcomes (the process and outcomes of adaptation to new circumstances) of divorce from current psychological literature. These themes are divided into two distinct age groups for contrast and comparison: young children and adolescents. Review and analysis of the literature revealed unique internalized and externalized outcomes for each age group. Young children showed an ability to comprehend but not cope with problems and an inability to deal with affect, which most often leads to internalized adjustment outcomes. Adolescents tended to show more serious adjustment outcomes—such as depression, anger, anxiety, and behavioral problems. Boys showed more externalized adjustment outcomes, while girls showed more internalized. Individuals at all ages experience unique adjustment outcomes due to age and level of psychological development.
Adjustment Outcomes of Divorce for Young Children and Adolescents

Divorce has become so common in today's world that almost every individual feels its inescapable presence. In fact, 856,000 divorces and annulments occurred in the United States in 2007 (Center for Disease Control, 2009). Divorce effects both those experiencing it directly (as members of the immediate family) or indirectly (as a more distant relative or friend). Scientists in many fields are seeking to understand the source and magnitude of those effects—positive or negative. Every year, scientific journals publish copious research studies on the effects of divorce.

A good portion of published research focuses on the adjustment outcomes of divorce. An adjustment outcome, as discussed in current literature, is defined as the outcome or end result of the adjustment or adaptation process following a major, life-changing transition—such as divorce, adoption, or death of a parent (Størksen, Reysamb, Holmen, & Tambs, 2006; Tan, Marfo, & Dedrick, 2010). Adjustment outcomes are often segregated into categories, such as externalized, internalized, and social. Some of the most common adjustment outcomes of divorce are depression, anxiety, psychological distress, school and social problems, and a decreased level of life satisfaction (Amato, 2001; Størksen et al., 2006). Most current studies focus on specific age groups: young children, adolescents, or those divorcing.

The purpose of this review is to summarize and synthesize major themes from current literature regarding the adjustment outcomes of divorce and to propose future directions for research and application. Primary focus will be on two components of the family unit: young children and adolescents. To more fully explore similarities and differences between age groups, focus will also be devoted to internalized and externalized adjustment outcomes only.

Adjustment Outcomes In Young Children

Research on the adjustment outcomes of divorce for young children (age 0–12) is sparse in today’s psychological literature and mostly discusses children's experience in contrast to adolescents’ experiences. Much of the difficulty for children in post-divorce adjustment comes from the change in relationship status with parents (Salturis, 2002). Children internalize the consistent parent–child interactions as working models of one’s self and of the world. When one parent is removed from the household, the emotional attachment and relationship are disrupted...
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(Bowlby, 1969, 1973; Lewis, Feiring, & Rosenthal, 2000). A relationship disruption between a child and a parent, such as one parent permanently leaving a household, is one potential genesis for negative adjustment outcomes (Lewis et al., 2000).

Divorce is often an emotionally draining time for separating parents and their children. A child will likely encounter a decrease in parent’s emotional availability during and after a divorce. This emotional deficiency may lead children to question their working models of self and the world. If children believe they must face the transition alone, they are likely to over control (internalize) or under control (externalize) affect (Faber & Wittenborn, 2010).

**Internalized Adjustment Outcomes**

Young children who experience divorce are more likely to over control affect than children from non-divorced families. As children begin to internalize their feelings, they are more susceptible to developing psychological issues (Faber & Wittenborn, 2010). This finding is valuable to a parent seeking to guide a child through the life change; a parent who anticipates internalization of feelings will be more prepared to help.

For many years, scientists believed that young children did not understand the meaning, permanence, or consequences of divorce. However, researchers recently found through children's verbal expressions and drawings that children understand much of the process, and that many children try to cope with the life change. While children's expressions were often rudimentary, they gave coherent explanations of divorce and the divorce-related relationship changes, which often included expressions of negative affect (Eblling, Pruett, & Pruett, 2009). These findings show that even young children, though elementary in their understanding, are affected by divorce-induced relationship changes not only socially, but emotionally.

Young children are also often unable to cope with divorce-related changes. When children answered questions about what they felt, thought, and understood about divorce, they most often shared feelings of anxiety, abandonment, anger, and depression. Such feelings were common for children who had lost consistent interactions with either the mother or the father (Tippelt & Konig, 2007). The findings of this study further unfold an interesting dichotomy: a separation between recognizing and coping with the change. Even though young children recognized that a change was taking place, they failed to cope with it. Thus, young children are unable to escape their situation and are ill-equipped for sizeable emotional struggles.
However, age and maturity level (level of cognitive development) correlate with ability to understand and cope with a major life change (Mazur, Wolchik, Virdin, Sandler, & West, 1999; Sandler, Kim-Bac, & MacKinnon, 2000). While young children often display an inability to properly cope with affect, older children often have a greater cognitive capacity to employ effective coping measures. For example, the endorsement of negative appraisals of self and situation amplify levels of depression and anxiety, whereas the endorsement of positively biased appraisals buffers the adverse effects (Mazur et al., 1999; Sandler et al., 2000). Because of their level of cognitive development, older children are more able to modify their cognitions to purposefully guard against emotional distress. These conclusions underscore the uniqueness of each child’s experience and needs: depending on age and level of cognitive development, each requires specific intervention.

**Externalized Adjustment Outcomes**

Young children experience not only internalized adjustment outcomes, but also externalized outcomes. While externalized outcomes for young children are less likely than internalized, young children who experience divorce are still more likely to develop externalized behavior problems (e.g., aggression and rebellion) than peers in non-divorced families (Malone, Lansford, Castellino, Berlin, & Dodge, 2004; Mazur et al., 1999). Furthermore, the conspicuous nature of externalized outcomes could possibly draw a parent’s attention from serious internalized issues.

Researchers have found gender-related correlations in externalized outcomes for children. Interestingly, girls’ externalized behavior problems are not affected by the timing—meaning age and circumstance—of divorce, while boys showed an increase in externalized behavior problems depending on timing (Malone et al., 2004). Understanding the timing of divorce and the related adjustment outcomes for young girls and boys could help parents arrange appropriate treatment to minimize the severity of negative adjustment outcomes. However, most literature fails to identify the connection between timing of divorce and debut of negative adjustment outcomes.

Some evidence suggests that those who experience divorce as young children are more likely than adolescents to experience more long-term difficulties (Malone et al., 2004), though opinions are mixed (Lewis et al., 2000; Malone et al., 2004). Although children may not comprehend divorce to the same degree as their older siblings, young children do experience
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Adolescent Adjustment

Adolescents experience adjustment outcomes from their younger counterparts. Typically, the effects adolescents experience have a more significant impact on their psychological development (Storksen et al., 2006) and, in many cases, longer lasting effects (Malone et al., 2004). Approximately eight years after divorce, adolescents reported more symptoms of anxiety and depression, a lower feeling of well-being, and more school-related problems than peers from non-divorced families (Storksen et al., 2006). These detrimental effects can retard normal development, which can lead to maladjustment. Adolescents living in single-parent, post-divorce homes are at increased risk of psychiatric disease, suicide or suicide attempt, injury, and addiction (Weitoft, Hjem, Haglund, & Rosen, 2003). In comparison to outcomes for young children, the adjustment outcomes for adolescents are dramatically more severe. Parental awareness is key to guiding adolescents down a path of healthy adjustment.

Adolescent girls were more likely to internalize affect, while boys were more likely to externalize (Malone et al., 2004; Storksen et al., 2006). Teenage boys in single-parent families showed higher risk than girls for psychiatric and drug-related disease (Weitoft et al., 2003). The gender-specific nature of these outcomes will assist parents in predicting and preparing for their children’s behavior. The negative adjustment outcomes of divorce—be they internalized or externalized—could be more injurious for adolescents than for young children.

In contrast, some researchers purport that adolescent whose parents divorce do not experience negative behavioral and developmental outcomes (Ruschena, Prior, Sanson, & Smart, 2005), and some even claim that the outcomes are positive (Sever, Guttmann, & Lazar, 2007). Nevertheless, regardless of divorce outcomes, researchers do not deny that adolescents experience great levels of stress on self and family relationships (Ruschena et al., 2005). What all of these studies lack, however, is an explanation of why each of two adolescents experiencing the same life change could have different adjustment outcomes—one negative and one positive. If the sum of similar sets of variables produces starkly different results, there must be alternative explanations or additional variables.
Internalized Adjustment Outcomes

Internalized adjustment outcomes for adolescents can be focused mostly on girls, as girls tend to suffer more from internalized outcomes than boys. Adolescents—girls more than boys—report higher levels of distress (e.g., depression and anxiety) than younger children in the adjustment process following a major family transition like divorce (Malone et al., 2004; Ruschena et al., 2005; Storksen et al., 2006). Girls are also more likely to suffer from those effects longer than boys (Malone et al., 2004; Storksen et al., 2006). Such findings indicate that girls may allow the difficulty of divorce to affect them more deeply and permanently. The consistency of these gender-related findings could be the push for better-planned interventions for girls that focus on resolving internalized emotional issues.

In addition to adolescents’ personal bout with life changes, both girls and boys seem to be aware of how divorce affects parental mental health. Distressed parents and the divorce-related change itself can have a “double exposure” effect on teenagers (Storksen et al., 2006). Parents battling with the stresses of divorce often exhibit a decline in parenting quality, with more inconsistent discipline and affection (Ruschena et al., 2005). As with young children, a relationship disruption like inconsistent discipline and affection could lead adolescents to question their working models of the world and self. The double exposure effect, coupled with a decrease in care from parents, likely contributes to the increased severity in negative adjustment outcomes.

Furthermore, internalized adjustment outcomes in boys and girls tend to last longer than externalized (Malone et al., 2004). Adolescents will likely suffer from depression, anxiety, or anger long after their parents’ divorce.

Externalized Adjustment Outcomes

Adjustment outcomes for adolescents are not limited to internalized outcomes only. In a landmark longitudinal study, researchers found that adolescents whose parents divorced displayed more externalized adjustment problems both before and after their parents’ divorce than adolescents whose parents did not divorce (Cherlin, Chase-Lansdale, & McRae, 1998). This research was followed by more research supporting the claim that adolescents whose parents divorce display pre- and post-divorce externalized adjustment outcomes like aggression, rebellion, and drug abuse (Weitoft et al., 2003; Overbeek et al., 2006). Collectively, these conclusions confirm that externalized adjustment outcomes of divorce are real and significant.
Externalized adjustment outcomes, while experienced by both boys and girls, tend to be manifested more in boys than in girls (Amato, 2001). As discussed above, evidence of gender-related adjustment outcomes can help predict behavior for adolescent girls experiencing a family transition. In like manner, manifestations of male-specific outcomes can help predict behavior and increase intervention efficacy. When taken as a whole, findings on adolescent adjustment outcomes delineate patterns of behavior that can help parents be aware of and prepared for their children’s potential adjustment struggles.

Application and Conclusion

A methodological weakness in the current literature is a failure to identify the genesis of negative outcomes: whether the adjustment outcomes children experience are due to the divorce itself, to the circumstances at home before the divorce, or to some combination thereof. While some researchers recognized this weakness (Malone et al., 2004), others did not. Researchers should focus on increasing intervention efficacy by identifying the correlative triggers of negative adjustment outcomes in young children and adolescents.

Much of the literature distinguishes the gender-specific differences in adjustment outcomes. While that distinction is helpful in a general sense, the majority of research methods did not determine a relationship between timing of divorce (age of child at divorce) and the adjustment outcomes experienced. Were researchers able to correlate specific adjustment outcomes with a given timing of divorce, children could receive the correct intervention at the most efficacious time. More specifically, a greater clarity of gender-outcome relationships could further increase the effectiveness of interventions. Because of the tenacious nature of negative adjustment outcomes, parents and psychologists must provide children with interventions that could greatly reduce the severity of post-divorce maladjustment.

Themes in the literature depict the uniqueness of the divorce experience for young children and adolescents. Young children showed the dichotomous ability to comprehend but not cope with divorce-related changes. Adolescents showed important and significant gender differences, with girls reporting more internalized outcomes and boys reporting more externalized. Additionally, divorce does not affect children of all ages in the same way. Adjustment outcomes appear to be related to age and level of psychological development.
While the literature contained conflicting claims about the significance and severity of divorce-related adjustment outcomes, one theme ran constant: divorce introduces children to copious stressors (Ruschena et al., 2005). The trends described in this review are valuable for those who are in a position to help children and adolescents comprehend and cope with a substantial life change like divorce.

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The Benefits and Implications of Birth Order Position

by Elizabeth K. Passey

This literature review examines the implications and benefits of birth order position on the child. Depending upon position, somewhat predictable differences are likely in expectations, responsibilities, opportunities, nurturing and the like. Consequently, birth order affects the child's peer relationships and the child's self-esteem. Children without siblings have difficulty relating with their peers throughout their lives and have relatively higher self-esteem. First-born children strive towards perfection and report higher self-esteem. This tendency may impact peer relationships negatively, except when in a position of power. Middle-born children have relatively good relationships with their peers and lower self-esteem. Last born children tend to have good relationships with their peers when they are not in a position of power and report higher levels of self-esteem.
The Benefits and Implications of Birth Order Position

A child is born into a family. Whether that family consists of one parent or two, siblings or no siblings, or any other of the endless familial possibilities, that child occupies a particular birth order position. Birth order is the station that a child possesses among a family and is established when he or she is born. The basic birth order positions may point to individual personality characteristics later in life (Adler, 1964). There are four separate, generally accepted stations: only child, first-born child, middle-born child, and youngest child. These positions may shift over the course of life; for example, some children were first an only child and then a first-born child. Other children were a last-born child and then a middle-born child. Yet, whether or not a shift in birth order position occurs, a child is influenced by these positions: a child’s birth order position affects the psychological characteristics of the child (Rodgers & Thompson, 1986).

A child’s birth order position may affect that child’s relationships with others, as well as his or her self-esteem. A child’s birth order position may influence interaction with other children at school or how the child forms relationships with family members. Therefore, birth order may be an important factor in understanding individual behavior and experience. This literature review will examine the implications and benefits of a child’s birth order position as evidenced in the contemporary research literature and will focus on how birth order position affects the child’s relationships with his or her peers and family members as well as the child’s self-esteem.

Relationships

Research indicates that a child’s birth order position affects that child’s relationships with parents and peers. When a child feels subordinate they will act differently than if they perceived themselves as superior. In most cases, when relating to parents and other adults, a child is the subordinate. When relating to peers, including siblings, a child potentially fills many different roles. The way children comprehend the world around themselves is important in determining the child’s relationship with those in that world.

Relationships with Parents

Children of the same family are not born into the same social or historical environment. A first child and a second child are born into entirely different situations of parental experience and availability of peers or siblings (Adler,
BENEFITS AND IMPLICATIONS OF BIRTH ORDER

Research indicates that the reaction of parents to the birth of a child influences the environment into which that child is born. For example, mothers raising temperamental infants may feel unrewarded by their parenting, while mothers raising good-natured, highly responsive infants are more likely to obtain satisfaction with their child-rearing skills (Honjo et al., 1998). In some cases, mothers are raising multiple children at the same time: a mother raising a first-born may be raising a middle-born and last-born as well. In this case, the stress a mother feels raising her children may correlate with her perceived effectiveness in child-rearing (Honjo et al., 1998; Suitor & Pillemer, 2007). In any case, a child’s temperament may influence the relationship between parent and child.

First-born children. Children in the only child and first-born child birth order positions have similar experiences with their parents (Mellor, 1989). This is because every first-born child who receives a sibling into his or her family was first an only child. In a study rating mothers’ stress in child-rearing by a self-report questionnaire, parental stress in child-rearing was recorded, as well as the relationship of the stress to the temperament of the child, which was measured with an infantile temperament rating (Honjo et al., 1998). It was found that child-rearing stress is greater among first-time mothers. When the first (or only) child is born, a woman quickly experiences both the fulfillment and anxiety of raising a child. A first-born or an only child is likely to be raised by parents experiencing high levels of stress and the child’s temperament may be influenced by this environment.

Thus, the anxiety-promoting stress a first time mother might feel may temporarily reduce her ability to express positive emotion for her child (Harel, Eshel, Ganor, & Sher, 2002). However, first-born children report unique relationships with both parents later in life: this is often attributed to the greater significance given to the first birth and the larger amount of one-on-one time parents invest in first-born children (Suitor & Pillemer, 2007; Tashakkori, Thompson, & Yousefi, 1990). First-born children are generally identified by parents as mature, conscientious, and responsible (Eckstein, 2000). Because of these identities, parents tend to grant first-born children greater autonomy. This independence plays a role in first-born children becoming more mature and responsible (Suitor & Pillemer, 2007). Also, parents invest more time, money, and effort in the first-born child, and, apparently, most do so because that child has been in the household the longest. This investment by a first-born child’s parents contributes to parental preference and higher expectations for
the first-born child to return the support when parents need assistance in later years (Suitor & Pillemer, 2007). This, however, does not only occur in the parents' later years. In a study conducted by Suitor and Pillemer (2007), it was found that mothers prefer assistance from first-born children and are more likely to confide in or turn to first born children for crisis support.

**Middle-born children.** A middle-born child's relationship with his or her parents is influenced by the parent's ability to express their positive emotions for the child (Harel et al., 2002). A middle-born child experiences less one-on-one interaction time with parents because other children are present. They are generally not as close to the parents as the first-born or last-born child because individual interactions with the parents are not facilitated by the middle-born's environment (Romeo, 1994). This may lead to less close relationships with their parents when compared to their first-born and youngest-born siblings. Middle-born children experience fewer feelings of family cohesion and report they are less likely to name parents as those whom they would turn to in times of crisis (Salmon & Daly, 1998). Comparably, in Suitor and Pillemer's study (2007), mothers were least likely to name their middle-born children as those whom they would turn to for crisis support.

**Last-born children.** Generally, last-born children report good relationships with their parents (Kiracofe & Kiracofe, 1990). A division in parental attention by the older siblings may contribute to less parental involvement in the life of a youngest-born child (Harel et al., 2002). However, later on in life the last-born child tends to be spoiled more often and mothers report greater feelings of affection for the youngest-born children (Dunn & Plomin, 1991), perhaps due to the greater amount of parental one-on-one time with the youngest-born later in life. In many cases, last-born children develop sensitive social skills. They are able to create less conflict-driven relationships with their parents than did their older siblings (Suitor & Pillemer, 2007). This allows parents to feel emotionally closer to their last-born children due to lower levels of stress and higher levels of affection (Dunn & Plomin, 1991). Their potentially more complex social skills may contribute to lasting parental emotional attachment to the last-born child.

**Relationships with Peers**

A child's birth order position influences the manner in which the child interacts with his or her peers, both related and unrelated. A child's
relationship with his or her peers is characterized by his or her views of other children being favored by adults. When others are perceived as favored, a child’s relationship with his or her peers may become more competitive.

**Only children.** An only child holds one of the most independent birth order positions and generally regards his or herself as having worth (Mellor, 1989). This is due to the only child remaining the unchallenged center of parental attention (Romeo, 1994). Oftentimes, children without siblings have greater interest in adult rather than peer relationships (White, Campbell, Steward, Davies, & Pilkington, 1997) and are not as comfortable with other children. Therefore, only children are unfamiliar with relating to other children, have difficulty appropriately opposing other children, and lack the knowledge of how to share with other children (Romeo, 1994). The peers of an only child are regarded as curiosities with whom the only child has neither learned to share nor surpass (Shulman & Mosak, 1977). Only children often seek adult acknowledgment and approval, neglecting peer relationships in the process.

**First-born children.** Only children and first-born children are similar in their development: a first-born child is in the only-born birth order position for a period of time before being transferred to the first-born birth order station (White et al., 1997; Mellor, 1989). First-born children have been found to be less trustful and to reciprocate less among their peers in a study involving a game with their siblings (Courtiol, Raymond, & Faurie, 2009). This may point to a first-born child struggling to relate to peers as an equal. A first-born child may be adept at being a leader but research suggests that such a child is not likely to be a natural follower among groups of children and may feel uncomfortable when other children act as leaders of the peer group (Romeo, 1994). A first-born child has the most favorable birth order position as they enjoy singular parental attention for some time before becoming a sibling to subsequent children. This time alone with their parents may contribute to many first-born children striving for perfection and exhibiting a strong need to please the adults around them (White et al., 1997). They may stress the importance of following rules to their younger siblings and impose rules upon them (Shulman & Mosak, 1977). Like only born children, often first-borns neglect to find good relationships with their peers, especially when not in a position of dominance.

For a significant period of time, the later born children will be younger, smaller, and less-developed than the first-born child. Therefore, the first-born child will spend much time developing the superior self-esteem of
someone who is bigger, stronger, and smarter than their peers (i.e., siblings). Many first-born children carry this superior self-esteem throughout their lives. Once an only child, a first-born child is eventually usurped from a position of undivided parental attention by a younger child. This is not always a positive experience for the first-born child given his or her status as the sole receiver of attention is threatened by the newborn and subsequent children. The first-born child may react as resentful and anxious when gaining a new sibling and losing undivided parental attention. Oftentimes, this results in the greatest differences between the first-born and second-born children (Courtiol et al., 2009). These differences may contribute to the competitive relationship had by many first and second-born children.

Middle-born children. A middle-born child is typically thought to be more relaxed and sociable than an only-born or first-born child. Yet the middle-born child is constantly in competition with the "cuter" younger siblings or the "smarter" older ones and many times, the middle child suffers from low self-esteem reflected in their peer relationships (Romeo, 1994). Middle-born children generally compare themselves to those around them and worry they will be lost in the mix, and, oftentimes, they are (Suitor & Pillemer, 2007). They do not exhibit characteristics that the youngest-born child develops through parental coddling. They do not have the self-esteem the first-born child develops through feeling superior, or the self-worth of the only-born child through their treatment as a peer by the adults surrounding them. The middle-born child may feel habitually victimized by their place among siblings. They may, however, feel "squeezed" in the middle because they are constantly behind an older child and ahead of a younger child. Middle-born children tend to be more innovative as they are searching for an area where they can succeed (Shulman & Mosak, 1977). Middle-born children report feeling persecuted by their siblings and, therefore, stress the importance of fairness. Learning how to stress fairness appropriately among siblings results in a middle-born child's efficacy in relationships with his or her peers (White et al., 1997). Because a middle-born child may struggle to find a place in the family, he or she may become adept at forming reciprocating relationships.

Last-born children. Youngest-born children tend to be the most sociable of their siblings. Youngest-born children learn to demand the attention they desire and many are driven to out-perform their siblings. They are used to following in the footsteps of their siblings and have a pre-developed niche in their home life, determined by their birth (Shulman
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Mosak, 1977). They are not comfortable leading groups of people in unfamiliar situations because their position in their family is predetermined. The relationship a youngest-born child has with their peers is generally dominated by craving the attention and the comfortable relationships established at home (Romeo, 1994). In many cases, a youngest-born child uses their charm as the “baby” to sway others into recognizing their significance (White et al., 1997). Because of this, youngest-born children may first become skilled at influencing their siblings and later at influencing their peers.

However, youngest-born children do not believe they have the good relationships with their parents that their older siblings have. In the United States, many youngest-born children report not identifying with or becoming emotionally close to their parents (Suitor & Pillemer, 2007). In some instances, older siblings act as authority figures for their younger siblings; this affects the way the youngest-born child is raised. This may be due to the youngest-born child having older siblings with whom they can identify with more closely (Romeo, 1994). This may play a role in a youngest-born child feeling emotionally closer to his or her siblings, which could lead to better relationships with other peers.

Self-Esteem

Although a child’s self-esteem may be determined by many factors, parental favoritism has been shown to be of particular significance. Children are hyper-aware when parents favor one child over another (Kiracofe & Kiracofe, 1990). Whether or not parents actually exhibit favoritism does not matter in the case of a child’s self-report of how their parents view them. Regardless, the child’s self-esteem is affected.

Favoritism

The time a child spends with his or her parents may influence feelings of parental favoritism in children. Among various studies, children in different birth order positions found themselves as the favorite child. In one, youngest children perceived themselves as the favorite (Harris & Howard, 1985). Another study reported that first-born children felt favored among their siblings. This may be correlated with the first-born child’s tendency toward perfectionism (Ashby, LoCicero, & Kenny, 2003) and desire to please the adults around them. As they strive to please their parents they may be complimented more often and, thereby, come to feel favored. Often, first-born children have a need for achievement (White et al., 1997). Additionally, many children attribute parental favoritism to
their gender relative to their parents' gender. In a study by Kiracofe and Kiracofe (1990) examining parental favoritism, female first-born children perceived their fathers as exhibiting favoritism towards them, whereas male first-born children perceived this same tendency of favoritism from their mothers. However, more than two-thirds of the subjects in this study perceived themselves as the favorite of at least one of their parents (p.78), regardless of their particular birth order position.

Parental Influence

Children without siblings have different interactions with their parents than children in other birth order positions (Honjo et al., 1998). The only-born child is accustomed to being the center of attention. Many only children regard themselves as autonomous, motivated, and industrious; often, only children have a stronger personal identity (Romeo, 1994; Mellor, 1989). They develop self-confidence from significant adult attention (Romeo, 1994). In studied cases, only children had significantly higher positive outcomes when faced with crises than children in other birth order positions (Mellor, 1989). These positive outcomes may be due to the confidence and good self-esteem held by only children.

First-born children. First-born children's lives start out in a manner similar to an only child. As previously stated, they feel the need to please adults (Ashby, LoCicero, & Kenny, 2003). Many first-born children report a higher level of parental involvement in their lives (Harel et al., 2002). They are the focus of the parental attention, and therefore generally develop good self-esteem, inner security, and confidence (Romeo, 1994). The excess attention the first-born receives, or thinks they receive, may contribute to the development of good self-esteem.

Middle-born children. Generally middle-born children report relatively lower self-esteem than their older siblings. They feel less important to the family (Romeo, 1994). Though many middle-born children exhibit feelings of inferiority among their family members, middle-born children generally strive toward gaining status. This is done by gaining a title, oftentimes as the peacemaker to help others achieve justice (Kiracofe & Kiracofe, 1990). Oftentimes, middle-born children proactively seek position in the family and lower self-esteem often results if they perceive their siblings as being superior or unsurpassable.

Last-born children. Some last-born children develop feelings of inferiority. This may be due to family member's lack of confidence in the
youngest-born's abilities and assumptions that they are weak (Romeo, 1994). Last-born children are spoiled more often than other siblings, yet sometimes feel that no one puts much weight to what they say because they are the youngest (Harel et al., 2002). However, youngest-born children tend to have good self-esteem (Neale, 1986) and many are regarded as the most sociable, least demanding, and least jealous.

Conclusion

Through examining the implications and benefits of a child's birth order position a few general conclusions can be drawn about what the literature regards as specific to the separate positions. Children without siblings report higher self-esteem, yet have difficulty relating with their peers throughout their lives. First-born children report high self-esteem and strive towards perfection, which may impact peer relationships negatively. However, first-born children tend to thrive in a position of power. Middle-born children typically report lower self-esteem and yet have relatively good relationships with their peers. Likewise, last-born children tend to have good relationships with their peers when they are not in a position of power, though report higher levels of self-esteem.

Birth order position can affect an individual's relationships and self-esteem; the research does not provide concrete evidences for the position always affecting an individual's relationships and self-esteem. Circumstances remain wherein individuals breach their birth order position. Therefore, research regarding the separate positions may aid in the conception of how much birth order position affects an individual. Additionally, studying birth order position among larger families will enhance the body of research on birth order.

References


Patient Suicide and Its Impact on the Therapist

by Kelly Prue

Patient suicide is shown to have a substantial impact on therapists' personal and professional lives. Although various populations are affected differently, psychologists, psychiatrists, and mental health social workers may experience intense emotions, such as depression, trauma, anger, and guilt after patient suicide. This literature review will explore the effects of patient suicide on both the personal and professional life of therapists, as well as identify methods of "postvention" that have been shown to be most helpful for the therapist. After experiencing patient suicide, therapists often gain a greater awareness of future patients' well-being and may change the way they practice. Therapists-in-training are shown to be particularly affected and are more likely to change their profession due to patient suicide than their more experienced colleagues. Strong support groups have been shown to be particularly important to therapists in the weeks and months following patient suicide. Studies indicate that not all populations react or cope in the same way, indicating that research should be directed at developing postventions that cater to individual therapist's specific needs.
Patient Suicide and Its Impact on the Therapist

Suicide is an increasingly prevalent cause of death and has a significant impact on all who encounter it. According to the Centers for Disease Control and Prevention (2009, 2012), suicide was the 11th leading cause of death in the United States for the year 2006 and the 10th leading cause in 2009. Often, a person who commits suicide leaves behind family and friends on whom the impact can be permanent and far-reaching. The patient's absence is often felt daily by those close to him or her, as well as people in the settings that the patient may have frequented (e.g., work, community groups, school, etc.). One of these settings may have been regular sessions with a therapist.

Mental health professionals, including psychologists, psychiatrists, and mental health social workers are often in contact with those who suffer from a plethora of challenges, such as depression, obsessive compulsive disorder, schizophrenia, and eating disorders. Patients may also exhibit suicidal tendencies, a problem that usually receives top priority for treatment from the therapist. Unfortunately, therapists are not always successful in preventing suicide — or even predicting it — and are typically greatly affected personally by the event. In an early postulation of these emotional effects, Litman (1965) states that therapists often react to their patient’s suicide in much the same way as do actual relatives of patients.

Current research explores the effects of patient suicide on therapists personal and professional lives, as well as attempts to identify what methods of “postvention” are shown to be most helpful for therapists. Unfortunately, the impact of patient suicide on therapists is a relatively new area of research and only a couple of studies actually examine any particular group. As a result, this review covers a broad spectrum of mental health professionals. The findings of the studies were fairly consistent, but there are certain small discrepancies that suggest factors such as culture and amount of experience may affect individual reactions to patient suicide. The emotional and professional repercussions for the therapist who experiences patient suicide can be severe. Mental health professionals will greatly benefit from continued research on both the effects of patient suicide and the various coping methods that may be most effective in dealing with such events.

Personal Impacts

Patient suicide has been shown to be a traumatic event in a therapist’s life, evoking many emotional responses. Even from the earliest studies,
Impact of Patient Suicide

Therapists who have recently had a patient commit suicide report experiencing depression, guilt, anger, and inadequacy (Litman, 1965; Kahne, 1968; Koldny, Binder, Bronstein, & Friend, 1979). Early studies focused on interviewing small groups of therapists who gave their personal reactions. These studies mostly consisted of small populations, were strictly qualitative in nature, and could not be generalized to the larger population of therapists. Later studies deal with more specific categories of therapists and used different rating systems to gauge severity of reaction. Chemtob, Hamada, Bauer, and Kinney (1988a) found that 57% of psychiatrists who had experienced a patient suicide exhibited distress comparable to the level of distress of individuals who had just lost a parent. Chemtob, Hamada, Bauer, Torigoe, and Kinney (1988b) found that 40% of psychologists exhibited similar distress. Memories of the event are characterized by many studies as “flashbulb memories,” and although emotions related to the event are painful and overwhelming at first, studies show that these feelings lessen over time (Brown, 1987; Chemtob, et al., 1988a, 1988b; Sanders et al., 2005; Wurst et al., 2010). More recently Sanders, Jacobson, and Ting (2005) found similar responses in social workers who reported sadness, depression, trauma, and shock. Appreciating the magnitude of the emotional response to patient suicide may help us better understand why it is so important to continue research both into the emotional impacts as well as how they might be handled.

The experience of anger was another common finding across the literature (Berman, 1995; Chemtob et al., 1988a, 1988b; Litman, 1965; Menninger, 1991; Sanders et al., 2005; Tanney, 1995; Wurst et al., 2010), but it did not affect all populations equally. Objects of the therapists’ anger were varied and included anger toward the patient, their institution, those around them, and themselves (Sanders et al., 2005). While anger was a common and strong reaction to patient suicide in most of the American and European studies, a study focusing on Thai psychiatrists conducted by Thomyangkoon and Leenaars (2008) reported that most participants gave the lowest rating for experiencing feelings of anger. Thomyangkoon and Leenaars (2008) attributed this finding to the fact that it is not culturally acceptable to show anger among Thais. This study introduces new ideas about the influence of culture, and more studies need to be done in order to determine what the reactions of other therapists are worldwide and in what ways culture can be a factor in therapist responses to patient suicide.
Professional Impacts

Research indicates that therapists who have experienced a patient suicide often changed the way they practiced therapy afterwards, with many coming to consider the experience a valuable learning opportunity (Brown, 1987; Menninger, 1991). After the suicide, therapists became more aware of warning signs of suicide exhibited by their current and future patients, were more able to assess their patient's risk for suicide, and realized that the ability of a therapist to predict or prevent suicide is limited (Hendin, Lipschitz, Maltzberger, Haas, & Wynecoope, 2000; Thomyangkoon & Leenaars, 2008). After experiencing a patient suicide, however, some therapists decide to no longer take-on patients who are at risk of suicide (Hendin et al., 2000), while others express a renewed determination to help their patients even if suicide is a risk possibility (Alexander, Klein, Gray, Dewar, & Eagles, 2000).

While patient suicide is a traumatic experience for any therapist, it is especially difficult for trainees, as the effects may be stronger initially and longer lasting (Wurst et al., 2010). Studies show that some novice therapists express a desire to leave the profession entirely after a patient suicide (Dewar, Eagles, Klein, Gray, & Alexander, 2000; Sanders et al., 2005). This reaction is rare among older, more experienced and established therapists possibly because of their experience which may enable them to better cope with the suicide. Dewar et al. (2000) looked specifically at psychiatric trainees and found that 9% of their respondents reported giving consideration to a career change. However, this number could be low because those who had already left their profession as a result of patient suicide were not included in the study.

Not all the professional impacts were negative, however. Brown (1987) found that the 62% of psychiatric graduates who had experienced a patient suicide expressed the suicide as having a “major effect” on their professional development. When asked whether the effect was “for the worse” or “for the better,” none of them answered “for the worse.” What they did express was that it helped them to better understand their limitations as a therapist and lack of absolute control over their patient’s situation.

Postvention

Many studies have shown that patient suicide is a fairly common event, but there is frequently no procedure for therapists to follow after experiencing the death of one of their patients (Alexander et al., 2000). Postvention is a type of intervention used to help the remaining friends and
relatives of the patient work through their grief and any other problems that may arise as a result of the suicide. More recently, it has become clear that therapists, too, need postvention in the aftermath of patient suicides (Kaye & Soreff, 1991). Psychiatrists and psychologists who experienced a patient suicide reported many methods of coping including conversations with colleagues, critical incident reviews, and methods specific to the culture of the therapist (Thomyangkoon & Leenaars, 2008; Hendin et al., 2000; Alexander et al., 2000).

A strong support system helps the therapist to work through the event. Many therapists found talking informally with a colleague about their patient's suicide was helpful (Alexander et al., 2000; Dewar et al., 2000; Hendin et al., 2000; Kaye & Soreff, 1991; Menninger, 1991; Thomyangkoon & Leenaars, 2008). Thomyangkoon and Leenaars (2008) claimed 90% of their participants reported that talking to a colleague was the most helpful coping strategy they employed. Hendin et al. (2000) found that therapists felt especially comforted by colleagues who were willing to share their own experiences with patient suicide. In addition to talking with colleagues, many therapists found it helpful to talk to their friends and family about the suicide (Hendin et al., 2000; Kolodny et al., 1979).

In some cases, support may be provided through the workplace of the therapist in the form of either a psychological autopsy or some form of a critical incident review which can give therapists the opportunity to review the case of their patient. Litman (1965) and Kaye and Soreff (1991) strongly encouraged psychological autopsies, examinations of the patients actions and state of mind before suicide, as a way of providing an environment in which the therapist could move forward emotionally. Chemtob, Bauer, Hamada, Pelowski, and Muraoka (1989) noted that therapists-in-training were at an advantage because they were more likely to have support systems already built into their training, as opposed to therapists in private practice who were less likely to work in an environment that provided these support groups. However, Alexander et al. (2000) and Hendin (2000) found that these incident reviews or autopsies were unhelpful to the therapists, if not detrimental to their growth and ability to move forward. Thomyangkoon and Leenaars (2008) noted that whether these incident reviews were found to be helpful was greatly determined by the way they were conducted. Kaye and Soreff (1991) explained that there should be two clear purposes for the autopsy: (1) it should be an opportunity for the therapist and others to be honest and open about their feelings about the incident and (2) it should allow for policy reform and facilitate learning in order to provide better
patient care in the future. Alexander et al. (2000) suggested that incident reviews and psychological autopsies would be most helpful if conducted with the intent of treating the case as a learning tool and opportunity for growth rather than an opportunity to blame others and focus on flaws in the treatment. In short, incident reviews can be very beneficial to the therapist when conducted with attitudes conducive to building up the therapist and moving forward.

Research also indicates that some therapists coped in less common ways; they reported coping by seeing their own therapist, attending the funeral of their patient, and talking to the relatives of their patient (Alexander et al., 2000; Hendin et al., 2000; Wurst et al., 2010). Thomyangkoon and Leenaars (2008) found many Thai psychiatrists coped with patient suicide by “doing merit,” a religious practice that is believed to help the dead to heaven. However, therapists are as diverse as their patients, and continued research needs to be done to narrow down the list of coping strategies that are most effective and specific to different populations.

As research continues to focus on psychological and emotional impacts and coping strategies, the findings should be used to develop better training programs for novice therapists and trainees. As therapists are better prepared to handle patient suicide, their ability to move forward and learn from the event will increase. They will be more likely to deal with the suicide in a healthy and productive way that leaves the road open to continued work with other clients in a competent manner, taking the lessons learned and incorporating them into their work. Prepared therapists will not only know how to minimize the negative impacts of patient suicide, but their ability to do so will allow them to be a better therapist and offer better care to their patients.

**Conclusion**

Patient suicide has been shown to have a substantial impact on both a therapist’s personal and professional life. In the wake of a patient suicide, therapists may go through intense emotions, including depression, trauma, anger, and guilt. After experiencing patient suicide, therapists are more likely to change the way they treat their patients and are more aware of suicidal indicators as well as the consequences of not taking patients seriously or dealing with them carefully. Following patient suicide, therapists often become more conservative in the methods they use to treat their patients and utilize more resources in order to ensure the safety of their patients (Alexander et al., 2000).
Perhaps one of the most significant impacts of patient suicide is the way in which therapists learn to see their role in the lives of their patients. Many studies have discussed the fine balance that is needed for therapists to be effective, namely that therapists need to acknowledge the limits in their ability to keep patients from killing themselves while maintaining the belief that they can make a difference in the lives of their patients and that the suicide is not inevitable for even the most troubled patient. A therapist's belief that he or she is worthless, incompetent, or cannot be helpful to others can impair the therapist's ability to assist patients.

At present the literature on coping with patient suicide is sparse regarding various categories of therapists. So far, most of research has focused on psychiatrists, who likely see higher rates of suicide among their patients due to their position in a medical setting which treats, among other things, those who self-harm and engage in suicidal behaviors (Chemtob et al., 1989). However, studies show that suicide rates are also high among patients of psychologists and mental health social workers (Chemtob et al., 1988b; Jacobson, Ting, Sanders, & Harrington, 2004). As more research is done, studies should move from a general focus of all therapists to a narrower one that focuses on a particular subset of therapy providers so that postvention programs can perhaps be designed to fit the specific needs of differing groups of therapists. Likewise, there have been surprisingly few studies done outside of the United States, and the study done by Thomyangkoon and Leenaars (2008) suggests that culture may have a significant influence on the psychological and emotional impacts and responses of therapists. These cultural factors are important and should be taken into consideration during the development of postvention and training programs for therapists.

Chemtob et al. (1989) call patient suicide an “occupational hazard” for psychologists and psychiatrists, and the literature shows that this is true for other types of therapists and mental health providers as well. By learning what programs and practices can help therapists cope, we can turn what is a devastating experience into something that can offer new perspectives to the therapists that may in turn help them to improve their ability to help future patients. By developing and offering better training programs, we can prepare therapists for what may be a life-changing experience and teach not only what can be expected after patient suicide, but also ways of coping and recovering. By doing this, progress in the quality of mental healthcare can continue to be made while helping to protect those whom it may inadvertently harm.

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Caging the Ill
The Mental Health Crisis in U.S. Prisons and Jails

by Christina Smart

The U.S. criminal justice system contains many people with mental illness. In fact, the lack of mental health institutions has, in part, converted prisons and jails into detention facilities for the mentally ill. Yet prisons and jails are ill-equipped to handle these individuals. Additionally, prisons and jails foster an unstable environment for the mentally ill that can ultimately result in harm to themselves and others. A viable alternative for mentally ill offenders is the use of mental health courts. These courts provide professional treatment, supervision, training, and disciplinary proceedings that reduce recidivism, promote rehabilitation, and incur fewer financial costs. The psychiatric specialization of mental health courts enables mentally ill offenders to navigate the criminal justice system in a more efficient and effective manner that yields better outcomes than regular courts. Preliminary studies of mental health courts support the notion of their widespread incorporation into the U.S. criminal justice system.
Caging the Ill: The Mental Health Crisis in U.S. Prisons and Jails

In 2003, Human Rights Watch reported that “prisons have become warehouses for a large proportion of the country’s men and women with mental illness” (Abramsky & Fellner, p. 18). In 1998, the U.S. Bureau of Justice Statistics estimated that 283,800 inmates in U.S. prisons and jails had been diagnosed with a serious mental illness, such as schizophrenia, bipolar disorder, or major depressive disorder (Ditton, 1999). The high prevalence of mental illness in U.S. prisons and jails raises the question of how effectively the U.S. criminal justice system manages mentally ill offenders.

Within the past century, the United States has incarcerated increasing numbers of mentally ill individuals. At least some of this increase is associated with the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963. The purpose of this act was to treat mental illness by focusing federal funding on community-based mental health programs instead of on state institutions. After the act was passed, the mental hospital population in the United States declined from 500,000 in the 1950s to 38,000 in the 1990s (Dumont & Dumont, 2008). Subsequent statistical analyses indicate that this decrease in mental health admissions correlated with an increase in jail/prison admissions (Palermo, Smith, & Liska, 1991). When individuals with serious mental illnesses are denied admittance to or ejected from state mental hospitals, they often enter the criminal justice system because jails and prisons are often the only institutions for mentally ill individuals who exhibit disruptive or illicit behavior (Palermo et al., 1991).

Although mentally ill offenders may be guilty of crimes punishable by incarceration, U.S. prisons and jails are ill-equipped to handle mentally ill individuals. Inmate brutality, unsuitable disciplinary policies, undertrained correctional officers, and inadequate access to mental-health services create an unstable environment for mentally ill inmates that can ultimately result in harm to themselves and others. A viable alternative for mentally ill offenders is the use of mental health courts. These courts provide professional treatment, supervision, training, and disciplinary proceedings that reduce recidivism, promote rehabilitation, and reduce costs.

Mentally Ill Individuals in the U.S. Criminal Justice System

In the U.S. criminal justice system, 14.5% of men and 31% of women suffer from a serious mental illness (Steadman, Osher, Clark Robbins, Case,
& Samuels, 2009). Between 1989 and 1999, 69% of U.S. jails reported an increase in the number of inmates with serious mental illnesses (Ditton, 1999). Mentally ill individuals are increasingly placed in prisons and jails incapable of meeting their needs.

**Prison Environment**

The prison environment can be dangerous for mentally ill inmates. In prisons and jails, overcrowding, undertrained staff, violence, and inadequate facilities can weaken the safety and psychological stability of inmates (Abramsky & Fellner, 2003). The stressful prison environment can instigate rapid emotional deterioration and impair rational judgment, especially for inmates who are already psychologically unstable. Fewer than half of U.S. local jail systems offer mental-health services (Solomon, Osborne, LoBuglio, Mellow, & Mukaua, 2008). Of U.S. jail inmates who reported mental health problems in 2006, only 18% received treatment after admission, and most of those were only prescribed medication. Of the inmates who did receive treatment, only 15% received their prescribed medication, and only 7% received professional therapy (James & Glaze, 2006).

Placing mentally ill offenders in a stressful environment without access to mental-health resources can exacerbate their mental illnesses, thus contributing to destabilization. Forensic psychiatrist Dr. Cheryl D. Wills argues that the brutal prison environment ultimately “puts mentally ill inmates at substantial risk of seriously harming themselves, seriously harming others, and of being seriously harmed and/or killed” (Abramsky & Fellner, 2003, p. 54).

**Physical & Sexual Harm**

Interaction between mentally ill inmates and other inmates can be mutually harmful (Palermo et al., 1991). Studies reveal that mentally ill inmates are nearly twice as likely as other inmates to be physically victimized and nearly three times as likely to be sexually victimized than non-mentally ill inmates (Blitz, Wolff, & Shi, 2008; Blitz, Wolff, & Shi, 2007). However, mentally ill inmates can also be victimizers. Some mentally ill inmates are disruptive and aggressive (Abramsky & Fellner, 2003). In 1998, the U.S. Bureau of Justice Statistics (BJS) reported that mentally ill inmates have greater tendencies toward violence than other inmates have. The BJS report revealed that since admission, 21% of mentally ill federal inmates reported involvement in a fight compared to 9% of other federal inmates (Ditton, 1999). The presence of mentally ill inmates may increase prison crimes and elevate the risk of physical and sexual abuse among inmates.
In the prison environment, mentally ill inmates are also at greater risk of suicide than other inmates. According to Goss, Peterson, Smith, Kalb, and Brodey (2002), 15% of the general jail population had attempted suicide during incarceration. In contrast, 77% of the mentally ill jail population had attempted suicide during incarceration. These comparative statistics emphasize the severe impact of the prison environment on mentally ill individuals. In the hostile prison environment, mentally ill offenders can rapidly deteriorate, often to the point of self-mutilation and suicide (Abramsky & Fellner, 2003). Violence, isolation, poor supervision, and a lack of mental health services may facilitate suicide among inmates who are already weakened psychologically and emotionally.

**Disciplinary Action**

Mentally ill inmates are often held to the same behavioral standards as other inmates. As a result, they often have more disciplinary problems. In 1998, 41% of mentally ill federal inmates had been formally charged with a violation of prison rules. In comparison, 33% of non-mentally ill inmates had been charged with a rule violation (Ditton, 1999). Mental illness symptoms may be manifested as acting out and rule breaking, which result in punishment (Kupers, 1999).

An inmate at Tamms Correctional Center in Illinois with a diagnosis of chronic schizophrenia attempted several times to harm himself and his surroundings. After attempting suicide twice by swallowing a piece of his mirror, this inmate was found guilty of damaging state property. When he attempted to hang himself with a rope made from a bed sheet, correctional officers ticketed him and ordered him to pay restitution for the torn sheet (Abramsky & Fellner, 2003). Punishment of mentally ill inmates attempts to deter unwanted behaviors while possibly ignoring the inmate’s mental illness. Disciplinary action may intensify the psychological and emotional strain of mentally ill inmates and counter therapeutic and behavioral progress. In the strict environment of most prisons and jails, infractions usually incur punishment but rarely lead to therapy and counseling, which could aid mentally ill inmates in coping with their illness and prison life (Abramsky & Fellner, 2003). Instead, mentally ill inmates are reprimanded for behavior that may be related to their psychopathology.

Punishing mentally ill inmates does not always solve the internal problem. Many prisons and jails do not offer treatment and therapy to help change mentally ill behavior. As a result, many mentally ill inmates end up spending more time in prison or receiving multiple prison sentences.
Correctional Officer Training

Correctional officers receive little formal training in dealing with mentally ill inmates, which compounds the mental health crisis in prisons and jails. The U.S. Department of Justice (2001) revealed that 30 departments of corrections provide preservice training for new correctional officers on how to handle mentally ill inmates, but this training is limited and insufficient. Only 7 of the 30 departments provided officers with more than four hours of preservice training in mental health. Kropp, Cox, Roesch, and Eaves (1989) revealed that 86% of correctional officers felt they had inadequate training in handling mentally ill inmates.

Correctional officers' lack of mental-health training threatens mentally ill inmates' well being. Many individuals with mental illness need to be monitored carefully and have specialized treatment needs. Inadequate mental-health training can prevent correctional officers from fully understanding the nature of mental illness and from responding appropriately. As long as the inmate is clean, quiet, and obedient, correctional officers are unlikely to refer an inmate to mental health services even if they are needed (Abramsky & Fellner, 2003). As a result, many inmates with serious mental illness are left untreated.

For example, in November 1996, Massachusetts inmate John Salvi committed suicide. Following the suicide, an evaluation team determined that although substantial evidence pointed toward a serious thought disorder, the correctional officers in charge of Salvi did not believe his strange behaviors warranted mental health services. Later, the correctional officers admitted to insufficient training in identifying mental illness and making necessary referrals to mental health services (Abramsky & Fellner, 2003). Mentally ill individuals need treatment, supervision, and disciplinary proceedings provided by psychological and medical professionals, not minimally trained correctional officers.

Recidivism

Deviant behavior stemming from mental illness results in many mentally ill individuals being funneled into jails and prisons because there are no alternate institutions of detention. However, many mentally ill offenders do not cope well with incarceration. Incarceration can exacerbate mental illness, making mentally ill offenders more unstable upon release from
prison or jail than they were upon entry (Nurse, Woodcock, & Ormsby, 2008). Decreased mental stability may cause mentally ill offenders to commit another crime shortly following their release from prison, which leads to reconviction (Baillargeon, Binswanger, Penn, Williams, & Murray, 2009). Mentally ill offenders should be held accountable for their crimes, but restitution for those crimes should be served in an environment that focuses on rehabilitation, not punishment. Proper treatment of an inmate’s mental illness lessens crime more than incarceration does.

For all the effort and funds associated with the incarceration of mentally ill inmates, their recidivism rate is still higher than that of other offenders. In 1998, 49% of mentally ill federal inmates reported three or more previous convictions. In contrast, 28% of all of federal inmates reported three or more previous convictions (Ditton, 1999). Incarceration is generally an ineffective method of crime deterrence for mentally ill individuals.

Mental Health Courts

A more effective method of dealing with mentally ill offenders is the use of mental-health courts. In the U.S. criminal justice system, mental health courts emerged in the late 1990s as a means to reduce the incarceration rate of mentally ill individuals (Linhorst et al., 2010). As of 2009, there were over 150 mental-health courts operating in 35 states (Sarteschi, 2009). Mental-health courts differ from traditional courts on several dimensions. In 2007, The Bureau of Justice Assistance defined the essential elements of a mental-health court, including voluntary participation; a criminal court with a separate docket for mentally ill individuals that emphasizes problem-solving in the court process; mental-health treatment designed and implemented by court staff and mental-health professionals; community supervision and hearings to gauge the progress of the participant; and inducements and sanctions for compliance and noncompliance, respectively (Thompson, Osher, & Tomasini-Joshi, 2007; Linhorst et al., 2010).

In mental-health courts, participants can be put on probation with the stipulation that they receive treatment. The court enlists a variety of services, including mental-health treatment, vocational training, and crisis intervention services (Thompson et al., 2007; Sarteschi, 2009). The fundamental premise of mental-health courts is that by diverting mentally ill offenders from the criminal justice system and providing them with court-mandated treatment, mentally ill offenders will be less likely to commit more crimes.
Preliminary Studies

Preliminary studies of mental health courts have revealed reduced recidivism rates for mental-health court participants. In 2007, McNiel and Binder studied the differences between mentally ill offenders who were incarcerated in the San Francisco Jail and those who were diverted to a mental-health court. Statistical analyses revealed that mentally ill offenders who participated in a mental-health court were 39% less likely to have a new charge on their record 18 months following their initial charge. Another study concluded that offenders who completed a mental health court program were 3.7 times less likely to re-offend than offenders who did not complete a program (Herinckx, Swart, Ama, Dolezal, & King, 2005).

In Palmer County, Alaska, the recidivism rate for mentally ill offenders who participated in a mental-health court was 17% compared to 40% for incarcerated mentally ill offenders (Sarteschi, 2009). Van Vleet, Hickert, Becker, and Kunz (2008) found mental-health court participants had a rate of new booking charges at 66.9% per year prior to mental health court participation. During participation in mental health court programs, the new booking charge rate decreased to 19.8%. In a meta-analysis of 23 studies involving over 11,000 mental-health court participants, aggregate effects had a mean effect size of -0.52 on recidivism. Additionally, mental health courts positively affected a participant's quality of life (Sarteschi, 2009).

Apart from reports of positive outcomes, mental-health courts are also financially beneficial to society. In 2006, the direct expenditure on criminal justice was nearly 215 billion dollars (Perry, 2008). The United States has 2.29 million prisoners, the highest prison population in the world (Walmsley, 2008; Ziedenberg & Schiraldi, 1999). The high costs of maintaining such a massive prison population are compounded by increased incarceration rates. Between 1980 and 1999, the number of jail and prison inmates more than quadrupled (Ziedenberg & Schiraldi, 1999). Incarceration of mentally ill offenders costs about $51,000 per year. In contrast, the cost to help mentally ill individuals obtain intensive community treatment, shelter, food, a job, and other services is between $10,000 and $20,000 per year (Lamberg, 2004). Mental-health courts reduce criminal justice costs by lowering recidivism rates, offering alternatives to incarceration, and stabilizing mentally ill offenders so they can procure jobs and become financially self-reliant.

Conclusion
Mental-health courts are a viable alternative to the traditional criminal justice system for mentally ill offenders. The lack of mental-health detainment facilities in the United States requires prisons and jails to care for mentally ill individuals. Within the prison environment, mentally ill inmates may be subject to inmate brutality, unsuitable disciplinary policies, insufficient supervision, and inadequate access to mental health services. The combination of these factors may create an unstable environment for mentally ill inmates that triggers symptoms of their psychopathology and result in harm to themselves and others. In contrast, mental-health courts provide resources that can stabilize mentally ill offenders, ultimately resulting in reduced recidivism rates, smaller prison populations, and lower costs.

Mental-health courts benefit society and court participants by adopting a problem-solving approach. Instead of punishing deviant behavior like traditional courts, mental-health courts attempt to eliminate deviant behavior by stabilizing mentally ill offenders and enable mentally ill offenders to become self-reliant members of society. A widespread incorporation of mental-health courts in the United States could reduce crime and criminal justice expenditures. But most importantly, mental health courts can aid mentally ill individuals who are in need of treatment and assistance. For those struggling with the pain, insecurity, and instability of mental illness, mental-health courts could be an important part of their treatment.

References


Characteristics of Exercise that Influence Emotional Health
Type, Intensity, and Duration

by Karen Sullivan

The importance of exercise in molding a healthy mind, body, and emotional perception has been well established in scientific research. A review of the recent literature examining type, intensity, and duration of exercise illustrates how to achieve the best emotional results. Because exercise is not naturally built into the modern lifestyle, people need to make concerted effort to exercise in order to better deal with stress and experience positive emotions. Studies indicate that both animals and humans are better able to cope with stressors when able to voluntary exercise. However, not all exercise is alike. Aerobic exercise appears to be more beneficial than anaerobic exercise in improving emotion. Research suggests that those with originally low levels of positive emotions most significantly achieved an increase in positive emotions when they exercised at a low intensity. Manageable intensity and low duration work together to provide the best emotional results. Studies indicated that about 30 minutes of aerobic exercise at an intensity below the lactate-threshold is sufficient to produce achieve emotional benefits.
The Best Work Out for Improving Emotional Health

Anecdotal evidence and the scientific community agree that exercise has beneficial effects on cognition, longevity of life, and emotion (Backhouse, 2007). Physical education courses are part of the core curriculum in many public schools, physical therapists advise senior citizens to maintain activity, and angry children are often sent to run laps to blow off steam. All of this illustrates the public's belief that exercise is influential in creating a healthy mind, life, and emotional outlook.

The common belief in the importance of exercise has been supported by scientific research. Exercise is important in a variety of ways; from increased memory to increased longevity. A recent structural study of the brain found that aerobic exercise affects the size of the hippocampus (Inskeep, 2011). The hippocampus grew in those who participated in aerobic exercise, and this is implicated in better memory and remembering. Researchers were surprised to find that even seniors experienced an increase in hippocampus size leading to better cognition. The benefits of exercise are not, however, limited to increased cognitive ability. Another study examining the effects of exercise on lifespan found that those who participated in moderate exercise lived between 1.3 and 3.7 years longer than those who did not exercise, and they enjoyed an increased quality of life (Bumgardner, 2005). The importance of exercise is clear and yet, the average person still participates in little physical activity.

The rise of industrialization correlates with a decrease in physical activity and an increase in poor physical health. Farmers, railroad workers, and mountaineers had no need for a treadmill or weight machine to work out because exercise was built into their day. However, now machines have replaced most farmers, and there is no need for explorers to settle new frontiers. Most jobs require specific intellectual knowledge as opposed to physical exertion. As the careers that people choose change from mainly physically taxing to mentally taxing labor, scientists have begun to see the many areas of life that are affected by exercise—or the lack thereof.

Studies conducted over the past 35 years support the consensus that "exercise makes you feel better." (Backhouse, 2007). The importance of exercise in helping people feel better has been strongly indicated, but many still refuse to exercise. This dichotomy is explained by the fact that most people have an unclear knowledge of the most effective type, intensity, and duration for emotional health. Aerobic and anaerobic exercise, for example, do not elicit the same results. Research suggests...
that aerobic exercise yields the best results for improving mood (Penninx et al., 2002).

Lack of understanding of personal physical capabilities leads some to inactivity. Some exercisers push themselves too hard while others do not push themselves enough (Reed, 2009). If a person exercises at a higher intensity than his or her body is capable of, it is possible that negative emotions would arise because of pain or fatigue. Conversely, a positive correlation between emotion and intensity may occur because of an exerciser's perceived physical and psychological exertion (Schneider, 2009). Relaxation can be one form of positive emotion, and the more exhausting the work out the more relaxed an exerciser can feel afterward.

A final excuse that many people use to justify not exercising is lack of time. Many inexperienced exercisers believe that they must exercise for extended periods of time every single day, and believe that emotional highs will last in proportion to the length of the work out. However, this may not be true, and professionals, in fact, often prescribe a rest period between sessions of intense exercise (Woo, 2009).

Increased positive emotions might be one of the most important benefits of exercise because attitude determines many factors in quality of life. While the best exercise may vary to some degree for each individual, there are foundational similarities to guide exercise for every body. Type, intensity, and duration of exercise all interact together to affect what emotional outcome is experienced after each work out; and when all are properly accounted for, the best emotional outcomes can be achieved.

Type

Type of activity—aerobic versus anaerobic—has a direct relationship with emotional outcomes. Aerobic exercise has different benefits from anaerobic exercise. Penninx et al. (2002) compared aerobic and resistance exercises looking for emotional change. They found that older persons with depressive symptomology who participated in aerobic exercise experienced a significant reduction in depressive symptoms, but no significant decrease in the negative emotion—depression—was found with resistance training.

Similar results were found in a study addressing the effects of different types of physical exercise versus leisure activities on the depression scores of obese Brazilian adolescent girls (Stella et al., 2005). During the study, all of the groups experienced a reduction in body mass and anxiety scores regardless of the program. These changes may be explained by
the availability of professional supervision in nutritional eating or other outside factors. Nevertheless, aerobic exercise was the only activity that displayed long-term benefits of decreased depression levels.

Furthermore, one experiment (Buckaloo et al., 2009) found that the type of exercise had no effect on the positive results acquired by inmates in a low-security facility on depression, stress, and anxiety. Researchers found that those who performed aerobic or anaerobic exercise scored significantly lower on the Beck Depression Inventory II and Life Experiences Survey than the inmates who did not participate in any kind of exercise. Participation in some kind of physical activity yielded positive results regardless of the type of exercise chosen. Experimenters found that the more reasons the inmates had for exercising (i.e. improved health, lower depression, lower stress), the more emotional benefits were achieved. However, the fact that inmates were grouped according to previous interest in exercise or a lack thereof may have jeopardized the validity of the experiment. Those who do not choose to exercise on their own may have underlying conditions that would explain a predisposition toward negative effectual symptoms leading to lower scores on emotion testing. Because the inmate study did not account for all variables, this study does not allow us to reach a conclusion about the best type of exercise; however, it does support the conclusion that even some activity is better than no exercise at all.

The importance of exercise on mood has also been demonstrated in animal models. Rats, in confined living-conditions, like inmates in stressful conditions are also prone to depression. A study (Zheng et al., 2006) examining the effects of exercise on coping ability found a significant decrease in eating and open field behavior (otherwise described as play) in rats that did not have access to a form of aerobic exercise, and were subjected to chronic unpredictable stress (CNS) for four weeks. Rats were submitted to a variety of stressors in a random order, and rats that did not have the option of aerobic exercise in such an environment showed impaired spatial performance in a Morris water maze test even two weeks after the end of subjection to CNS (Zheng et al., 2006).

In summary animals and humans in stressful environments have both displayed an enhanced ability to function when voluntary exercise was available. Aerobic exercise has been shown to increase positive emotions among individuals with depressive symptoms, as well as in the obese adolescent girls, inmates, and highly stressed rats. These consistent results indicate that aerobic exercise has a significantly beneficial effect on emotions.
Intensity

Intensity of exercise also affects the emotional reward that an individual receives. Some studies (Reed, 2006; Schneider, 2009) have found that high intensity workouts are the best because a significantly high increase in heart rate results in more brain activity. However, other research (Rose & Parfitt, 2007) supports the position that the intensity does not matter at all or even that the intensity is best when it is low and manageable.

Several independent studies have found similar results regarding the optimal level of intensity. Positive Activated Affect (PAA) is a measurement for emotion based on a scale of levels of both activation (either activated or deactivated) and valence (positive or negative in response to exercise). When positive-activated affect started out low, a low intensity workout for a short duration yielded the most positive emotions (Reed & Buck, 2009; Backhouse et al., 2007). Low levels of PAA are associated with a depressed mood (Reed & Buck, 2009). So, when a person starts out with a negative response to exercise and a low level of activity, a short, low intensity workout is best for emotional benefits.

Exercise is related to an increase in PAA partly because the chemical that triggers positive feelings (dopamine) has receptors that are associated with physical activity levels. The most drastic change in dopamine levels provides the best recognition of a change from negative to positive emotions. When exercise is too strenuous, people don't have a positive psychological response to the activity.

An analysis and explanation of differences in affective responses to prescribed and self-selected exercise intensities in sedentary men and women (Rose & Parfitt, 2007) further supported the evidence that a low intensity workout yields the most positive results for emotions. This is because lactic acid (an intramuscular chemical that develops during exercise that can result in pain) builds up during high intensity exercise. Researchers discovered that affect scale responses were more positive below the lactate threshold than above the threshold. When the exercisers did not produce lactic acid, they did not experience the pain that comes with it, and thus they had a more positive emotional response to the exercise.

Self-selection of exercise intensity provided a more positive emotional change than prescribed exercise intensity. However, if the exerciser was unaware of his or her own capabilities and selected too high or too low an intensity, negative emotions could be experienced (Rose & Parfitt, 2007). This is why it is so important to have an adequate understanding.
of personal physical ability to achieve a positive emotional experience through exercise.

In contrast, an experiment focusing on male students who regularly exercise found a high intensity was preferable for short duration (1.7 km) aerobic exercise (Kerr & Kuk, 2001; Kerr & Kuk 2006). However, for a long run (5 km), this study found no significant difference in emotions pre- to post-running between high and low intensities. Although more bodily stress is experienced with a long distance high intensity work out, the emotional rewards are not significantly different from a long distance low intensity work out. The longer distance seems to have made up for difference in affect between intensity levels.

The key distinction between the results found by Kerr & Kuk (2001; 2006) and the results found by Rose & Parfitt (2007) is level of experience with exercise. Those who are experienced runners need a higher intensity than those with little experience in order to achieve an emotional change. This is a logical conclusion because there is a negative correlation between intensity and positive affect for those who had a below average baseline affect (Reed & Buck, 2009). If we follow the idea that exercise has positive emotional benefits, then those who exercise often may have higher emotional baselines. Therefore, it makes sense that one with high baseline emotions may require a higher intensity work out than an exerciser with low baseline emotions in order to see a significant difference in emotions.

Duration

Many people do not work out because they say there is not enough time. However, it is not necessary to spend excessive amounts of time exercising. In fact, working out for too long can have negative effects. In the previously mentioned studies by Reed (2006; 2009), the most positive emotional changes for inexperienced exercisers came from low intensity and low duration.

Woo and colleagues (2009), reported that a relatively short amount of exercise provided enhanced vigor (the only positive emotion defined in this test, also defined as activity). Exercise provided enhanced vigor after 30 minutes of exercise more significantly than after 45 minutes of exercise. No significant difference was found among vigor scores following rest, 15 minutes, and 45 minutes of exercise. A separate study conducted by Buckaloo et al. (2007) examining the effects of exercise duration among inmates also demonstrated that increased duration of exercise did not predict significantly greater improvement in mood. Inmates who exercised
for more than an hour did not enjoy significantly better emotions than those who exercised for 30 minutes.

Positive effects are most significant about 10 to 15 minutes after exercise with lingering effects for up to 24 hours (Hansen, 2001). Twenty-one college students were surveyed and then physically tested to examine the effects of single bouts of moderate exercise. When positive moods—such as vigor and activity, and negative moods—such as depression and anger, where measured, researchers found no significant improvement in any one specific mood’s state. Rather, a significant improvement in general affect was found.

However, it is still unclear exactly why exercisers “feel better” after a workout. Researchers have attempted to correlate a relationship between plasma endorphin levels and mood improvement with little success (Schneider, 2009). Although a correlation between plasma levels and emotion has not yet been found, a relationship between frontal brain processes and emotion was discovered. Using electroencephalogram (EEG), researchers examined signals in the brain to discriminate emotions. Female undergraduate students were assessed for EEG and self-reported affective responses as measured by the POMS. Results supported a dose-response relationship between exercise duration and affect, meaning that the best results were found at a moderate intensity and duration of exercise.

Optimum duration of exercise as found with the inmates, in Reed and Buck’s (2009) research, Backhouse et al.’s (2007) research, and the EEG testing study (Schneider, 2009) is 30 minutes of aerobic exercise three to five days a week for at least ten to twelve weeks.

**Conclusion**

The positive effect of exercise on emotions as demonstrated by the research above has been well established. The best emotional health can be achieved when an exerciser pays attention to the proper type, intensity, and duration of exercise. Research supports the conclusion that aerobic exercise at a moderate self-selected intensity at or below the lactate threshold for about 30 minutes yields the highest positive effect on overall emotion. However, because the positive effects of exercise are short-lived, in order to maintain the positive emotions gained, exercise should be conducted 3–5 times a week.

Some of the common beliefs about exercise are correct but others are false. While some activity is emotionally better than no activity, not all activity is alike. Adequate exercise is not naturally built into the modern
lifestyle. However, when a little time is set aside for exercise, positive emotions can be achieved. It is not necessary to train for a marathon with every work out in order to feel happy. Rather, the right dose of intensity and duration of aerobic exercise should be manageable to improve emotional health.

A review of the literature examining characteristics of exercise which contribute to mood improvement revealed several important predictors. First, research suggests that aerobic exercise is more beneficial for mood than is anaerobic exercise. Second, exercise intensity appears to be important, with research suggesting that more intense exercise produces greater mood benefits. Finally, 30 minutes of exercise is the optimum duration for emotional benefit. Although it is still largely unclear why exercisers feel better, research shows that exercisers who adequately consider the type, intensity, and duration of exercise reap emotional rewards.

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The Effects of Shyness on Scholastic Experience
A Review of the Literature

by Rebecca Thomas

Shyness can affect adjustment into school, teacher–student relationships, and scholastic achievement. This literature review covers several studies published in the past 10 years on the effects of shyness and introversion on scholastic experience. Research implies that shy students have a more difficult time adjusting to new environments and school settings than their non-shy peers. Most research indicates that teacher–student relationships are weaker when students are shy, and that teachers are more likely to underestimate introverted students' academic abilities. Whereas shy students perform well on group tests, they often perform significantly below average on individually administered tests. Further research should be done on the effects of shyness on scholastic experience in order to increase understanding of shy students' setbacks. This could enable shy students to be compared more fairly to their non-shy peers in academic settings, and help teachers know how to reach shy students more effectively.
The Effects of Shyness on School Experience

Approximately 42% of children are shy (Zimbardo, 1977). Zimbardo (1977) defined shyness as an internal suffering one experiences while participating in normal social interactions. Stereotypically, shy people are usually quiet and nervous in social situations, and are often distrustful and wary of strangers. While shyness has no real effect on intelligence or cognitive abilities, it does have the potential to have a large influence on children and adults in scholastic settings.

School can be a very different experience for shy people because they tend to have a difficult time feeling comfortable interacting with other people (Zimbardo, 1977). While show-and-tell may make the average elementary school student feel excited to be in the spotlight, it could cause a shy student stress for an extended period of time. Similarly, shy college students giving a presentation could know the material they are teaching well, but their shyness could inhibit their ability to share their knowledge and wisdom to its full extent. Because of these types of problems, many research studies have been conducted concerning shyness and introversion and its effects on scholastic experience. Research specifically reports that shyness can affect students of all ages in adjustment to school, teacher-student relationships, and academic achievement and aptitude.

Adjustment to School

Research suggests that shy students have a difficult time adjusting in new environments, and school is no exception (Asendorpf, 2000). In coping with changes in schooling, many shy students place great emphasis on returning to familiarity (Asendorpf, 2000). For example, responses to a survey showed that shy students encountering their first year of college call home more often than most students, keep in closer contact with previous friends, and avoid new social situations presented at the college (Asendorpf, 2000). Shy college students have been shown to have higher levels of boredom than non-shy college students, and this boredom could be a contributing factor to increased levels of homesickness (Maroldo, 1986). Boredom is often associated with excess free time, giving shy students more time to think about home and what they miss about it. Similarly, young children may wish to spend more time at home or with their family during the start of school, just to make sure a percentage of their life remains constant (Coplan, Arbeau, & Armer, 2008). People enjoy comfort, and shy people find comfort in familiarity. Having places and people that comfort shy students can assist their transition into new experiences.
In one study done on adolescents’ adjustment to college, a survey was administered to 350 diverse college freshmen. Each student took tests that measured shyness, friendship quality, loneliness, and depression. The findings were that shy students were more likely to be lonely, have less friendship quality, and in consequence, have either minor or major symptoms of depression (Mounts, Valentin, Anderson, & Boswell, 2006). Symptoms of depression can influence every aspect of a person’s life, including desire and well-being. A self-report survey reported that shy students are much more likely to lose the desire to make goals, socialize, or try hard in school (Sreeshakumar, Nagalakshmi, & D’Souza, 2007). This loss of desire can cause their self-esteem to be impacted negatively (Sreeshakumar et al., 2007). Similarly, another survey reported that shy students are much more likely to become passive in school, and their perceived social weaknesses can eventually spiral into perceived weaknesses in everything (Paulsen, Bru, & Murberg, 2006).

Shy students in a new school often suffer academically because of the overwhelming worries and distractions thrust upon them in a short period of time. In group activities, shy students often prefer to look on as opposed to fully participate, keeping them from comprehending the concepts that the activities were meant to teach (Coplan & Arbeau, 2008). Because of this inhibition, lack of confidence with other people, and perceived inability to communicate effectively, shy students often view themselves as less competent than non-shy individuals (Feng, 2006). It is difficult for people to feel like they fit into a new environment when they feel inferior, and thus, feeling inferior can cause shy individuals to become even more isolated (Mounts et al., 2006).

Studies regarding shy students’ adjustment into school generally employ the same basic method. In some studies reviewed, researchers would take a certain number of students and give them a self-report measure to determine their level of shyness. In a few studies, teachers or parents would also take a similar test about their students’ or children’s shyness. After this, most researchers would instruct teachers or parents to observe the students’ behavior, and fill out a questionnaire regarding how students would react in certain situations (Mounts et al., 2006). While this method is respectable, it has errors. Self-report measures can be accurate; however, they can also vary depending on the time of day, and the self-perception (which is not always accurate) of the test-taker. In addition to these variations, different parents and teachers are likely to fill out the questionnaire differently. For example, a highly extroverted teacher may compare her students to herself,
causing scores in her classroom to imply that there are more shy students than are actually there. Similarly, parents may only see their child when he or she is comfortable at home, and not know their child’s shyness level in other environments.

These studies may be strengthened by both having participants fill out a self-report measure of their perceived shyness and having teachers and parents fill out a shyness measure about the students. Also, all the students should have the same teacher in order to reduce error in ratings on the questionnaire. In addition to this change, researchers ideally would be able to observe students in the classroom environment and at recess in the case of elementary school students. This way, an objective third party with education in research and shyness could be able to record data as well, and then the data from the teacher and the researcher could be compared to see if they are consistent. Adding these methodological approaches would increase both the validity and reliability of the research.

Teacher–Student Relationships

In addition to school adjustment, shyness can also affect students’ relationships with their teachers. Teacher–student relationships vary greatly, depending on the student or the teacher. Some shy students bond with their teachers more easily than their peers, and are more likely to develop relationships with their authority figures than their classmates. However, some shy students may be frightened of their teachers, especially if the teacher is particularly strict or judgmental (Coplan & Arbeau, 2008). Because of the extreme variation between personalities of teachers, research in this respect is inconclusive.

Some studies have found that shyness promotes negative teacher–student relationships. Opt and Loffredo’s study implied that introverted people tended to be high in communication apprehension (2000). Fear of anticipated communication, or communication apprehension, (Opt & Loffredo, 2000) may have contributed to why some shy students felt that their relationships with their teachers were limited (Lund, 2008). In qualitative interviews with shy adolescents, many shy students expressed their frustration on feeling invisible and constantly being ignored by their teachers (Lund, 2008). Participants in this study felt that extroverted students often got more academic attention than introverted students, and that teachers seemed to think students who spoke up more in class discussions were more intelligent. In support to that claim, a study was done where teachers were to rate each of their student’s intelligence levels,
and then all the students took a standardized test (Hughes & Coplan, 2010). The results showed that teachers tended to rate shy students to be lower in intelligence than their standardized test scores indicated. This could be because introverted students are more likely to be passive in classroom settings than extroverted students (Murberg, 2010). Murberg conducted a study that implied that introverted students were less likely to participate in class discussions and start conversations with teachers (2010). Talkative students may stand out to teachers, causing introverted students to be underestimated.

On the other hand, another study found shy students to have stronger relationships with their teachers than non-shy students did. Arbeau, Coplan, and Weeks found that first-grade teachers often give shy children more attention because they feel the need to do so (2010). In addition to this, the study claimed that the same first-grade teachers attempted to make the transition easier for all students, both shy and non-shy. It could be that teachers of younger students are more sympathetic toward shyness than secondary teachers or college professors are. However, that theory has yet to be supported with further research.

Multiple methods were used in measuring student–teacher relationships. For example, the study done by Lund was strictly qualitative (2008). In his study, he interviewed less than 10 adolescent girls that self-identified themselves as being shy, and recorded their responses (Lund, 2008). While his interviews were highly in depth, his conclusions were limited due to a tiny sample size, and the fact that he only interviewed one gender. After interviewing the girls, Lund found points that all or most of the girls had said and named them to be the results of his study. In order to strengthen this research, more interviews should be done with a much larger and more diverse group, with both males and females. Also, in order to create a comparative sample, both shy and non-shy students should be interviewed. In the case of the other studies, they were done in a similar fashion to the adjustment studies (and some of them overlapped with adjustment and academic achievement studies). Observing students in multiple environments and administering shyness measures to students, teachers, and parents would help researchers get a more accurate estimation of students’ shyness levels in future studies.

**Academic Achievement and Aptitude**

So far, many studies have found that shy students tend to have disadvantages at school, particularly in adjustment to school and
teacher–student relationships. However, these disadvantages do not always hinder academic achievement. Crozier & Hostettler (2003) found that the difference in math scores on a standardized test between shy and non-shy students was not statistically significant. However, that same study noted that shy students scored particularly lower in verbal examinations, and had a lower average score for English tests as well (Crozier & Hostettler, 2003).

Shy students also perform better on group-administered tests (written tests given to multiple people at once), such as the ACT, than on individually administered tests (verbal tests administered to only one person at a time), like an IQ test (Hughes & Coplan, 2010). AbdElBasit (1994) found that introverted female students scored higher on the SAT than extroverted female students. However, Aubeau et al. reported that when shy students' group test scores were the same as their peers, teacher ratings of shy students were still significantly lower than their test scores, indicating that, in a verbal or social context, shy students appeared less intelligent (2010). On the other hand, Hughes and Coplan (2010) found that, for individually administered tests, shy students performed, on average, one standard deviation below the mean.

Some argue that shy students perform poorly on individual tests because of their low self-esteem and self-belief; however, others believe low self-esteem is a consequence of having poor cognitive abilities (Pajares & Schunk, 2001). One study found that self-concept of math was not correlated with self-concept of English. Students' perceived abilities of one subject did not affect their perceived abilities of another subject (Crozier, 2001). Results of studies have indicated that low self-concept influences test performances because shy students perform well on group-administered tests that are essentially measuring the same material as individually administered tests (Crozier, 2001). Anticipatory anxiety is also much more prevalent in shy students, especially in areas they are uncomfortable with, which could cause test scores to drop (Vassilopoulos, 2009).

Methods for these research studies included self-report shyness measures. Due to this, there was a possibility of measurement error. However, standardized tests were all administered in the same fashion, indicating that those scores were as close to accurate as possible. Even though these studies imply that shy students perform badly only on verbal tests, further research would be required to draw a firm conclusion.

**Conclusion**

Shyness can affect students of all ages in adjustment to school, teacher–student relationships, and academic achievement and aptitude. Starting
in a new scholastic environment can be particularly challenging for shy students, and can cause them to seek familiarity, and withdraw from new experiences, which often holds them back. Most teachers consider shy students to be less intelligent than they really are, and a few teachers offer shy students special attention. While shy students perform on par with their peers in group and written tests, they often fall behind in individual and verbal examinations. Unfortunately, more research is needed to further support these claims.

With more understanding of the effects of shyness on various aspects of scholastic experience, more can be done to help shy students cope and succeed in traditional academic settings. One cannot fix a problem unless one knows of its existence. Raising awareness of findings of studies relating to shyness and school can help students (shy and non-shy), teachers, and parents of shy students understand how shyness typically affects performance, relationships, and adjustment to school. Expanding these findings can pave the way for further studies on all aspects of shyness and school, and can eventually aid in finding a way to put shy students on exactly the same playing field as non-shy students, and help enable all students to succeed.

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Family Life as Context for Adolescent Moral Development

by Ryan Woodbury

Adolescence (ages 12–19) is foundational for adulthood. Many changes occur during adolescence preparing adolescents for adult life. Some of these changes include physical changes accompanying puberty, cognitive changes, and social changes like spending less time with family and more time with peers. Adolescents' social shift away from family has raised questions on how much influence parents have on their teens. Researchers found parents have an influence on their teens, particularly on teens' moral development. Different parenting styles (Baumrind, 1966), family structures (two-parent vs. single-parent vs. adoptive-parents, etc.), and levels of family cohesiveness play roles in adolescents' moral development. This review examines research on adolescent moral development within the context of family life, specifically, analyzing results and the research implications, then directions for future research are discussed.
Family Life as Context for Adolescent Moral Development

Adolescence is a foundational developmental period that can prepare children for adulthood and society (Hart & Carlo, 2005). Teenagers (12–19 years old) are pressured from all sides, even from within, to become more adult-like. Indeed, nearly 25% of adolescents are legally considered adults (18–19 years old). Some of the influences include individual pressures like biological and cognitive development mostly due to puberty, or social pressures from family, peers, teachers, and society in general. These influences may cause “disorientation or discovery” (Psychology Today, 2011, para. 1; “Teens”, American Psychological Association, 2011, para. 1). As teens explore new developmental abilities (cognitive and physical) and do so within various social structures (family life, peer relations, and culture or society as a whole) that they may not have had or experienced as children, they begin to realize their autonomous choices require some responsibility (Daddis, 2011). As part of adolescents’ perceptions of autonomy and responsibility, parents must give up authority over certain choices. Interestingly, research has shown only personal issues (e.g., hairstyle, curfew, time spent on computer) are fought over between adolescents and parents. There are normally no disagreements between parents and teens about moral issues (Daddis, 2011; Smetana, 2000; Smetana & Asquith, 1994). Because of this continued relationship between adolescents and their families, particularly the teens parents, within the moral domain, the present paper explores research on adolescent moral development within the family, then discusses future research and how it may elucidate richer information for moral develop research.

Moral Development Research History

Morality has generally been defined as having a sense of what is right or wrong (Hart & Carlo, 2005). Research on morality has grown over the past 40 years and has become a central focus in the field of psychology (Walker, 2004). Reasons for this front-and-center view include, first, the possible implications of research. To know what is moral, is to know human goodness; to know how to develop morality is to know how to develop human goodness (Williams, 1995). This point is particularly relevant to adolescence, where teens are developing autonomy and preparing for adulthood. Second, morality is more than just the making of ethical decisions in professional occupations (e.g., doctors, lawyers, etc.), but is at the heart of the human condition and all genuinely human relationships.
This second point is relevant to adolescent development because adolescents make decisions in their social world; they must follow certain laws or face consequences (e.g., schooling, driving, alcohol, etc.). Third, there has been a research shift toward the question of human agency (i.e., the ability to have and make choices) in moral judgment and action (Moretto, Walsh, & Haggard, 2011) and, therefore, the nature and meaning of morality has become a renewed topic of discussion and research. Agency and autonomy become more salient during adolescence. Research on perceived autonomy exposes differences between children and adolescents, illustrating that adolescents exhibit more autonomy and are more concerned with making (or allowed to make) self-determined choices, while children are very dependent on parents and other authorities (Daddis, 2011; Hart & Carlo, 2005; Walker, Henning, & Krettenaur, 2000). There is less dependence on parents and more autonomy. Yet, while teens may become more autonomous, they seek help from other sources to develop an identity that will propel them into adulthood (Erikson, 1966).

Lawrence Kohlberg (1984), expanding on Piaget’s (1965, 1932) formal cognitive development theory, explored moral reasoning and planted theoretical seeds for a crop morality research. Due to the stage-like developmental nature of morality (Kohlberg, 1976, 1984), subsequent researchers started using longitudinal studies to explore contexts of development, as well as the possible causal influences (e.g., parenting styles, educational programs, peer relationships and social norms, community service, etc.) of moral development (Pratt, Hunsberber, Pancer, & Alisat, 2003). Researchers have explored contexts such as family life and parenting (Hardy, Padilla-Walker, & Carlo, 2008), peers (Walker et al., 2000), religion (King & Furrow, 2004), school (Covell & Howie, 2001), culture (Baek, 2002; Nasir & Kirshner, 2003), and more recently evolutionary and biological factors of morality (Casey, Getz, & Calvan, 2008; Killen & Smetana, 2007; Krebs, 2005). Due to the amount of research on adolescent moral development, there is no concise literature review of all the influences on moral development. There are, however, many specialized journals (see, e.g., Journal of Moral Education, Journal of Youth and Adolescence, and Journal of Adolescence), books (Killen & Smetana, 2005), and book chapters (Eisenberg, Morris, McDaniel, & Spinrad, 2009; Eisenberg & Murphy, 1995; Turiel, 2008; Walker & Primer, 2011) on adolescence and moral development. This article, however, will only discuss family life as a context for adolescent moral development. Recently, the most studied context of adolescent moral development is
family life (Hart & Carlo, 2005; see also Walker, 1999; White & Matawie, 2004). The family is a complex relational whole that differs greatly in its organization and constitution across and within cultures. Even with the many differences evidenced in family life, researchers have focused on the universal effects of moralization from parental influence and styles, family cohesion, and family structure.

**Family Life and Moral Development**

Family life greatly affects child socialization, including the development of morality (see Coleman, Hardy, Albert, Raffaelli, & Crockett, 2006; Hart & Carlo, 2005; White & Matawie, 2004). The main moral influence researched within the family has been parenting style. Parental influences that have been identified include: involvement, autonomy support, and structure (Hardy, Padilla-Walker, & Carlo, 2008). These influences have been measured in terms of verbal interaction, communication quality, and ego functioning (Walker et al., 2000; Walker & Hening, 1997). Family cohesion is another important influence on which researchers have focused their efforts (Bakken & Romig, 1994; White, Howie, & Perz, 2000). Finally, family structure (i.e. single- vs. two-parents, homosexual vs. heterosexual parents, number of siblings) has also been studied in regards to its moderating effects on adolescent moral development.

**Parenting**

Parents play an important role in the socialization of children, yet just exactly how influential are the parents is a deeper question. Parental interaction with children differs between families as there is wide variety in how parents interact with their children. Both mothers and fathers have influences on their teens' moral development, regardless of the teens' age or gender (Hardy, Olsen, Woodbury, Funk, & Walker, in review). Discussing parental influence, Diana Baumrind and others (1966; Maccoby & Martin, 1983) suggested that there are four basic parenting styles: Authoritarian, Authoritative, Permissive, and Negligent. Authoritarian parenting is demanding and controlling. Authoritative parenting, on the other hand, provides structure and firmness, as well as autonomy for children. Permissive parents, however, are lax toward family rules and tend to provide a maximal environment for children's autonomy. The Negligent parenting style is low on autonomy support, structure, and involvement. Negligence is a "non-existent" parent and has not studied much due to the non-existent effects. These parenting styles were discovered through observational and survey studies (Baumrind, 1966), yet are now used as
quasi-variables in relation to adolescent moral development. Researchers have tried to obtain representative samples of parenting styles to compare and contrast parenting styles' influence on moral development. Yet, parenting styles cannot be randomly assigned and manipulated to different groups of teens, therefore, no causal relationship can be firmly identified between parenting styles and adolescent moral development.

Though random assignment and variable manipulation may be improbable (and most likely unethical) in experimentation on adolescent moral development, there have been informative studies of the importance of parenting employing correlational designs. For example, Walker et al. (2000) and Walker & Hening (1997) measured parenting influences by inviting parent-child dyads to read and discuss how moral certain hypothetical dilemmas were thought to be (Moral Judgement Interview; MJI; Colby & Kohlberg, 1987). The discussions (verbal interactions) were coded using the Developmental Environments Coding System (DECS; Powers, 1983, 1988). Both measures proved to be reliable (MJI: \( a = .92 \), DECS: \( a = .69 \)).

DECS coded for conversational turns given by each participant, summaries of topics or conversations, and purpose of conversational turns (supportive, informative, operational, etc). The dyads were also asked to discuss a real-life dilemma involving the child and parent. The discussions of real-life or hypothetical dilemmas were randomized to avoid order effects. Again, the verbal interactions were coded using DECS. Compared to other parenting styles, the authoritative style was most influential on moral reasoning. In other words, children whose parents were authoritative, rather than authoritarian, permissive, or negligent, displayed significantly higher moral reasoning (Walker & Taylor, 1991). Walker and Henning (1997) also reported another interesting finding when they compared a child's real-life moral dilemma to a hypothetical dilemma. There seemed to be greater moral development over time with parents and children who discussed the child's real-life dilemma. When a parent and child discussed real-life dilemmas, the parents were coded to use questions for understanding and gave support to the child's reasoning, as well as offered applicable suggestions for greater moral reasoning. Nonetheless, even with significantly greater moral reasoning development via real-life dilemma discussions, many current researchers use hypothetical dilemmas in parent-child research. The reason may be hypothetical dilemmas have been standardized, and therefore are seen to be easier to code and analyze (Matsubo & Walker, 2004).

Parenting measures have normally erred in only using one parent and one child (for exceptions to this practice, see Hardy et al, in review;
Researchers often have trouble recruiting fathers. Researchers have suggested providing larger cash incentives and home interviews to recruitfather participation. Cash incentives, however, may have their own recruitment biases based on socio-economic status. Home interviews are also problematic in some ways because they do not allow researchers to control for some variables in the way that a more controlled setting might. Though home interviews may be less controlled, they provide more direct access to the rich context of family life and the relationships within the home (Dollahite, 2008). Home interviews may also take one step closer to the phenomenon of interest, therefore providing higher validity for the data. Adolescent moral development research may help parents have a better idea of how to raise their children and prepare them for adulthood. Parents must keep in mind that their adolescents are autonomously engaged in creating and internalizing moral standards and therefore are agents of their own morality and moral domain.

**Family Cohesion**

Family cohesion is the emotional bonding that takes place between family members (Olsen et al., 1992). White (2000) and his colleagues (White et al., 2000) surveyed families' cohesion and adaptability, investigating if these constructs affected children's perception of moral authority. Family cohesiveness was measured by the Family Adaptability and Cohesiveness Scale (FACES II; Olsen et al., 1992), in which teens were asked to what extent they agreed with various statements about their family (e.g., "Our family does things together"). It was found that the greater the perceived family cohesion, the more likely it was that teens perceived their parents as moral authorities. Other studies have found that single-parent families are less cohesive and, thus, teens are more likely to not see their parents as a moral authority (Walker & Hening, 1997; Cohen, 1994). White's studies were cross-sectional and, therefore, did not provide clear evidence for any causal sources of family cohesiveness and perceived moral authority. Walker and Hening (1997), however, performed a longitudinal study and found that due to less family cohesiveness single-parent teens exhibited a clear decrease in the amount of moral authority they perceived in their parents.

While parenting styles normally only looks at one parent with one child, investigations of family cohesiveness may reveal a more holistic measure of the family. Different children may have different perspectives of each
Adolescent Moral Development

Parenting and family cohesion are important research topics for determining moral influences on adolescent moral development. Researchers have used self-reports and interview coding systems to measure the context of family. However, self-reports about morality, whether about prosocial or antisocial behavior, may produce socially desirable responses. To get at the heart of morality, a variety of alternative methods are being used, including narratives (Matsuba & Walker, 2005) and having others (i.e., parents, siblings, peers) report on adolescent moral development (not just self-reports; Hardy et al., in review). Not only are these measures' reliability high, using these methods allows for greater breadth of investigation and more holistic results.

Family Structure

In addition to parenting style and family cohesion, family structure has also been found to play an important role influencing adolescent moral development. The structure of the family may be seen as a moderating factor in parenting styles and family cohesion. As mentioned previously, Walker and Henning (1997) found that over time single-parent families, compared to two-parent families, decline in cohesion and that adolescents are less likely to see their parent as a clear moral authority. This result has also been seen in adoptive and divorced heterosexual-parent families (Habersaat, Tessier, Larose, Nadeau, Tarabulsy, Moss, & Pierrehumbert, 2010; Storksen, Roysamb, Holmen, & Tambs, 2006). The incidence of homosexual parents adopting children has increased in recent years and much research has tried to examine homosexual-parent families. In comparison on most outcomes, homosexual-parented adopted adolescents are not significantly different than heterosexual-parented non-adopted peers (Drexler, 2001). This interesting result may have significant legal consequences. Some scholars worry about the detrimental impact to children growing up in a homosexual home, yet most studies have found no significant differences. Due to space limitations, however, these legal, moral, methodological, and philosophical issues cannot be adequately addressed here. (For more information, the reader is encouraged to read Richard Williams' address to the National Association for Research and Therapy of Homosexuality given November 2000).

As mentioned previously, most research done with the family has focused on parenting styles and parent-child relationships. Parent-child relationships are only half of the family dynamic. Sibling relationships make up the other half. Unfortunately, studies of siblings relationships are...
not as prevalent in the literature and so there is little information regarding the precise nature of siblings' effect on adolescent moral development. There have been, however, sibling studies providing a model to study siblings' effects on adolescent moral development (Tucker, Updegraff, McHale, & Crouter, 1999).

Future Research

Many of the familial context studies have shown there was positive adolescent moral development in families that provided an authoritative parenting style, moderate family cohesion, and two-parent households (Bakken & Romig, 1994; Hardy et al, 2008; Walker & Taylor, 1991). Most of these findings, however, came from correlational studies and so do not provide sufficient evidence for drawing clear causal connections. These types of studies can provide, nonetheless, some predictive power and direction for future research. Correlational studies (compared to randomized, controlled experimentation) may be the most quantitative form of experimentation on adolescent moral development within a familial context due to possible infringements on ethical standards via manipulation of variables. For example, it would not be ethical to provide certain families with authoritative sets of family rules by which they must abide by while providing other families with permissive rules. It would also not be ethical to experimentally raise some children in a single-parent household while raising other children in a homosexual-parent household. By the nature of the complex dynamics of families, there are many quasi-variables that can be studied (e.g. parenting styles, family structure, religiosity, socio-economic status, etc.) in order to better understand the effect of family life on adolescents.

The idea of examining entire families has become a more viable option to capture adolescent moral development (Walker, 1999). Looking at an entire family, though more complex (i.e., time consuming, demand on resources, small sample sizes, expectancy and Rosenthal effects, etc.), can provide a greater breadth and depth to understanding family dynamics and the families' effects on adolescents' moral development. Qualitative research, using family narratives or interviews, can provide rich amounts of data. This would create a more comprehensive family model that would help to understand the family dynamic as a whole, instead of just parent-child relationships as isolated exchanges between individuals.

Conclusion

Family life is only one context of adolescent moral development. Family life itself has not truly been studied in holistic fashion, excepting perhaps
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some research on family cohesion and adaptability (Olsen et al., 1992; White et al., 2000; White, 2000). Increasingly, however, researchers are looking into family narratives as measures of adolescent moral development. This provides a breadth to family life as a dynamic, relational, and meaningful context. Future research can also include longitudinal data. Few studies have looked into adolescent moral development longitudinally; most research has been cross-sectional or cross-lagged samples. If researchers want to explore causality between any context (i.e., family life) and adolescent moral development, longitudinal experimental designs must be used. Yet, these experiments may be ethically difficult insofar as they would seem to require treating some families as experimental groups (i.e., receiving a “moral” treatment) whereas treating other families as control groups—not receiving “moral” treatment. This design may be problematic, so other possible quasi-experimental design could be used combining family life and some other context, like religious life, socioeconomic status, culture, or ethnicity. Even though all these other contexts are part of the family life context, they are normally studied separately.

One practical benefit of studying adolescent moral development within a familial context is that it can provide information on relational strategies to be used in family therapy. Not only can this research benefit therapeutic techniques, but it may also provide quality information for families wanting to promote morality within their homes. Family life can be one of the most vital developmental contexts an adolescent has. Even though teens may change constantly, a strong moral influence comes from their families, particularly their parents, and perhaps siblings. Parents may not be the only influence on teens. Peer relationships, religiosity, physiological changes, and school environments can and do effect adolescent moral development. Teens can depend on a cohesive family and authoritative parents to help them develop capacities for sophisticated moral reasoning and behavior. And parents can be a positive influence to their children, even while the children are in the dynamic adolescent years.
References


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Williams, R. N. (Nov. 2000). The effect on children of the sexual orientation of parents: What the research doesn’t say. Invited address to the National Association for Research and Therapy of Homosexuality, Honolulu, HI.
Submission Guidelines

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• Articles submitted for publication cannot have been accepted for publication elsewhere.
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When the blind men had felt the elephant, the raja went to each of them and said to each, ‘Well, blind man, have you seen the elephant? Tell me, what sort of thing is an elephant?’

Thereupon the men who were presented with the head answered, ‘Sire, an elephant is like a pot.’ And the men who had observed the ear replied, ‘An elephant is like a winnowing basket.’ Those who had been presented with a tusk said it was a ploughshare. Those who knew only the trunk said it was a plough...

Then they began to quarrel, shouting, ‘Yes it is!’ ‘No, it is not!’ ‘An elephant is not that!’ ‘Yes, it’s like that!’ and so on, till they came to blows over the matter.