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# Table of Contents

Responding to Bullying by Gender  
*Berrett Blaylock* ................................................................. 9

Real Men Burp Babies and Real Women Deliver Dough: The Advantages of Nontraditional Parental Roles  
*Katherine Christensen* ......................................................... 32

A Bi-Directional Association Between Depression and Romantic Relations in Adolescence  
*Kaelene L. Fenn* ................................................................. 50

Chronic Pain: Understanding Its Effects on the Spouse  
*Summer B. Frandsen* ........................................................... 61

Treating Neuropathic Pain: Mindfulness Meditation Is More Effective Than Pharmacotherapy  
*Jayden Goodwin* ................................................................. 76

Teacher Expectations and the Black-White Scholastic Achievement Gap  
*Jacob Johnston* ................................................................. 83

Chronic Illness and Functionality: How It Affects Adolescents Academically and Socially and How They Can Cope  
*Emilee King* ................................................................. 94
Virtually Free Speech: The Problem of Unbridled Debates on Social Media
Brandon Parker ......................................................... 107

Understanding Reactive Attachment Disorder in Children
Chaz Anthony Rich ..................................................... 119

Isolated Insanity: The Damaging Effects of Solitary Confinement
Stephanie Ringwood ................................................... 125

Animal Hoarding by Humans: A Literature Review
Corina L. Schroeder ..................................................... 135

The Use of Positive Psychological Methods by Religious Leaders and Their Effects on Depression in the LGB Community
Bayleigh Serage ............................................................. 142

Effects of Extracurricular Activities and Physical Activity on Academic Success
Braden Tanner ............................................................. 158

Can Self-Compassion Reduce Depression and Anxiety in Adolescents?
Kelsi Wilson .............................................................. 169
et al.: 12.2
From the Editor:

I am very proud and honored to present this semester’s newest issue of *Intuition*. The journal has undergone and is continually undergoing many changes and improvements, namely operating, editing, and publishing now on *Intuition*’s new website scholarsarchive.byu.edu/intuition. Past publications and current publications are available for download and viewing online for interested persons, and readership now spans the entire world! Currently, the *Intuition* staff and I are also working to broaden submission diversity and acceptance as well as aiming to publish three issues each year and possibly even more.

I would like to sincerely thank each and every one of the editorial staff members who gave their time to work on the journal. We had some students who were able to dedicate their time to work on the journal for their capstone credit, and we had others who simply wanted the experience and donated their free time to help with the journal. Their careful, consistent, and reliable efforts have made this current publication possible.

I would also like to thank the faculty who donated their time and effort to the journal. We realize that the faculty members are very busy with their teaching, research, and personal lives, and we appreciate the time they set apart to give authors of the manuscripts didactic and valuable feedback. These dedicated faculty members have also made this current publication possible.

I especially would like to express my personal thanks to Dr. Harold Miller, who is the advisor for the journal. His support, insight, and care have helped us to improve and progress the journal far beyond what we could have been able to do ourselves.

Lastly, I would like to thank the authors for their consistent effort in the reviewing process and for their dedication until the end of this process.

I hope you enjoy this issue of *Intuition* and look forward to the upcoming changes for the journal!

Chaz Rich

Co-Editor-in-Chief

https://scholarsarchive.byu.edu/intuition/vol12/iss2/16
Responding to Bullying by Gender

Berrett Blaylock
Brigham Young University

Abstract

The present literature review examines how the construction of gender influences bullying among children and adolescents, as well as the possible effects of bullying on children, both as bullies and victims. An in-depth, theoretical analysis of gender stereotype and gender construction is presented, through a review of cognitive development theory, social learning theory, and cultivation theory. Gender construction leads children to adopt different behaviors and to interact with peers in various ways (Emilson et al., 2016; Fagot, 1994; Tobin et al., 2010).

Among children and adolescents, the two most prominent forms of bullying that result from gender construction are physical bullying and relational bullying, both of which can be observed in varying degrees based on the bully’s and the victim’s perceptions of gender stereotypes (Hazler, 1996). One of the most damaging forms of relational bullying among adolescents is sexual harassment. Although often seen as a legal issue, sexual harassment is a form of bullying that results from gender construction and perceptions that often begin at very young ages (Gruber & Fineran, 2016). After examining the responses to bullying given by peers, teachers, and counselors, this review will provide suggestions for addressing, preventing, and intervening in bullying situations within schools. Schools should look to address bullying from a young age by combating prevailing gender stereotypes and offering safe environments for students through support from teachers, families, and student-run groups.
Responding to Bullying by Gender

Bullying is a systematic abuse of power through repeatedly and deliberately harming others with the express purpose of intimidating or gaining control (Smith & Sharp, 1994). Bullying is also a cultural constant seen in almost every aspect of life, from a young child’s experience watching cartoons to an adult’s experience in the workplace. Bullying can be seen in some of the most popular children’s shows, such as the well-known “Hey Arnold!” television show (Bartlett & Harrington, 1996), which aired on the Nickelodeon channel from 1996 to 2004. The show blatantly depicts bullying behavior as acceptable entertainment for children, as the character Helga is a constant tormenter to the protagonist, Arnold, in the form of name-calling and physical harm. Bullying is not limited to physical harm, as explained by Hazler (1996) and Roffey (2000); it also includes emotional harm. The character of Helga is presented to young children and adults as a perpetrator of multiple forms of bullying, including cross-gender, direct physical, direct verbal, and indirect bullying.

Bullying takes on many forms and is not limited to a specific action, time, or gender. Bullying involves an aggressor (i.e., bully) and a victim. Bullies tend toward dominant behavior and victims tend toward less dominant behavior. Yet this relationship is not always dyadic: As Hazler (1996) explains, bullying may occur between individuals or between groups. Eagly and Karau (2002) and Harper and Schoeman (2003) suggest that groups and individuals are most likely to be positively evaluated by those who perceive them when their characteristics conform to typical social roles. Moreover, the appropriateness of these social roles is often explained in terms of gender. Thus, individuals who do not act per accepted gender roles tend to be evaluated negatively in the form of bullying, exhibiting prejudice, or both.

This description by Eagly and Karau (2002), Harper and Schoeman (2003), and Hazler (1996), illustrates that bullying can be both cross-gender and same-gender—boys bully boys and girls, and girls bully boys and girls. It is important to note that although cross-gender bullying does occur across all four gender pairings, Melton et al. (1998) and Whitney and Smith (1993) note that boys tend to report
being bullied by other boys, and girls report being bullied by both girls and boys. However, reported trends may not equate to reality, as gender stereotyping may make it uncomfortable for boys to admit that they have been bullied by girls (Harper & Schoeman, 2003). Gruber and Fineran (2016) suggest that it is generally safe to assume that bullying victims who are male are bullied by other males, while females are bullied by other females.

As explained by Heald (1994), bullying is long-standing violence, physical or psychological. Direct physical bullying is the easiest form of bullying to identify, and since boys tend to use physical aggression—tripping, punching, pushing, etc.—more frequently than girls, teachers and counselors tend to identify boys as bullies more commonly than they identify girls (Fox, Jones, Stiff, & Sayers, 2014). Psychological forms of bullying include direct verbal and indirect (sometimes referred to as relational) bullying. Direct verbal bullying may include actions such as name-calling, teasing, and taunting. Indirect, or relational bullying, is done in a way that the bully or aggressor is not easily identifiable; these behaviors may include gossip, social exclusion, intimidation, or sexual harassment (Dukes, Stein, & Zane, 2009; Felix & McMahon, 2006; Fox et al., 2014; Gruber & Fineran, 2016; Reid, Monsen, & Rivers, 2004). Understanding the role of gender within bullying, as well as the different types of bullying, allows for more anti-bullying measures to be taken. To fully address the issue of bullying, a third aspect, victim response, must be considered. To understand victim response, it is important to know who the victim is, not only by name but also by gender and background.

Gender stereotypes directly influence the socialization of young children into gender roles (Elsesser & Lever, 2011). Males are socialized to be independent and strong, while females are socialized to be understanding, weak, and vulnerable (Gerber, 1991). According to Baumeister and Sommer (1997), “women prefer close relationships whereas men prefer large-group memberships” (p. 39), as the current American culture teaches women to foster close relationships while teaching men that close male friendships indicate homosexuality. In lieu of this, females are more prone to experience interdependent self-construal (i.e., they define themselves in terms of their relationships with others) as opposed to independent self-construal (defining
themselves based on internal attributes, values, and preferences) (Markus & Kitayama, 2010). According to Morales, Yubero, and Larraaga (2016) and Choi, Fuqua, and Newman (2008, 2009), it is easier for men to define themselves by their internal attributes, because the current American culture sees masculinity as an individual’s behavior toward others. Because of this socialization, boys and girls experience bullying differently, both as aggressors and victims. As already mentioned, males most commonly use direct physical forms of bullying (Fox et al., 2016; Harris, Petrie, & Willoughby, 2002; Nansel, Overpeck, Haynie, Ruan, & Scheidt, 2003) but also use direct verbal forms. Females tend to use indirect and relational forms of bullying, such as gossiping, rumor spreading, and excluding (Nansel et al., 2003). These distinct, socialized gender differences play a critical role in the psychology of bullying, both for the bully and the victim.

As a worldwide phenomenon, bullying is a tool used within and between genders to gain and retain dominance (Morales et al., 2016). Given the multitude of known bullying practices, preventative and intervention techniques are necessary to curb the amount of cross-gender violence and same-gender violence that occurs between children. Gender differences should not be overlooked by school teachers and counselors as they respond to bullying because responding to a bullying victim without considering their identified gender may result in an ineffective outcome. By identifying both how gender is constructed and how different genders respond to bullying, school teachers and counselors can change how their prevention and intervention techniques address bullying within schools. This paper will examine the construction of gender and the different learning theories associated with gender. It will then examine the impact of gender on different forms of bullying and finish with a discussion of the importance of considering gender effects when addressing bullying.

Construction of Gender

One of the defining characteristics of an individual is his or her gender. Gender is how infants and children first learn to identify themselves and distinguish between different people (Aydt & Corsaro, 2003). Most societies have only two gender classifications, male and female, which parallel the biological chromosomes of XY and
XX, respectively (Muehlenhard & Peterson, 2011). When a baby is born, society assigns a gender to the child based on the appearance of the genitals, creating an implied gender belief system wherein gender differences are assumed to correlate with biological sex. The differences between males and females are assumed to be innate, with the created gender differences and beliefs taken for granted (Emilson, Folkesson, & Lindberg, 2016). Within gender construction, two theories address the creation of a child’s gender: cognitive development theory and social learning theory. This discussion will focus primarily on cognitive development and social learning theory, including whether gender identity and stereotypes originate from society or from within individuals. Cultivation theory, a subset of social learning theory, will also be discussed. These theories are interconnected, but each addresses a different aspect of the issue.

Cognitive Development Theory

Cognitive development theory studies the offer of intrinsic returns for behavior consistent with gender stereotypes. The assumption is, as presented by Kohlberg (1966): “I am a boy, therefore I want to do boy things, therefore the opportunity to do boy things [and to gain approval for doing them] is rewarding” (as cited in Aydt & Corsaro, 2003, p. 1306). However, to further understand cognitive development theory and Kohlberg’s reasoning for it, the definitions of gender identity and gender stereotypes need to be identified.

The traditional definition of gender identity involves a fundamental and motivating awareness through which an individual accepts and feels belonging to his or her gender (Tobin et al., 2010). Kohlberg was the first to suggest that a child’s gender identity is a biologically based motivating factor in adopting same-sex gender stereotypes and rejecting cross-gender stereotypes (as cited in Tobin et al., 2010). In a similar vein, gender identity is also defined as conformation to gender stereotypes, rather than a feeling of gender acceptance (Kagan, 1964; Martin, 2000; Spence, 1985). Stereotypical gender differences are evident by age 3, as most children separate play based on clothing and gender roles (Tobin et al., 2010). For this discussion, gender identity is the link or relationship a child feels between themselves and a gender (e.g., “I am male”) and gender stereotypes are the characteristics children assign to gender groups (e.g., boys play tag and girls play house). Even within the last 50 years,
gender identity and stereotypes have evolved and been assigned a multitude of definitions. Yet together with self-perception of gendered attributes, the concepts of gender identity and gender stereotypes (as Kohlberg defines them), are key to understanding how children cognitively process and develop gender.

In reviews of literature on gender development and bullying, Aydt and Corsaro (2003) and Tobin et al. (2010) discuss cognitive development theory as presented by Kohlberg. Kohlberg’s cognitive developmental theory states that a child’s gender progresses through three stages. The first stage is basic gender identity at age 2–3. In this stage, the focus is on the child knowing and understanding that they are either a boy or a girl. Maccoby (1999) explains that after 12 months, infants can tell the difference between men and women and, by age 3, can identify their gender and other peoples’ gender. The second stage is gender stability at age 3–4. In this stage, the emphasis is on children understanding that gender does not change and is not a fluid characteristic. The final stage is gender constancy at age 5–7. This stage is different from gender stability, as it involves knowing that gender remains constant even though other external characteristics or qualities, such as height or weight, may change. Gender segregation may appear in children around the gender stability stage but becomes most noticeable around age 5 and through elementary school, as children experience gender stability and gender constancy.

Social Learning Theory

Social learning theory purports that the gender and the sex of an individual are not the same. Sex is a biological designation based on the number and type of chromosomes within cells. Gender is a social construct based on ideas and stereotypes; it is a learned behavior and performance, which can be different from the sex of an individual (Aydt & Corsaro, 2003; Emilson et al., 2016; Mazzarella, 2015). According to Kyratzis (2001), theories that highlight gender differences as biologically based “do not give sufficient emphasis to the role of social practices, activities, and contextual factors” (p. 5). Social learning theory seeks to avoid biological biases and emphasizes the factors listed by Kyratzis when discussing gender differences (Aydt & Corsaro, 2003; Kyratzis, 2001). Social learning theory argues that gender is taught in accordance with societal expectations and assumes: “I want rewards, I am rewarded for doing boy-things, therefore I want
to be a boy” (Aydt & Corsaro, 2003, p. 1306). Just as young children are taught and socialized to behave in school and to play games and to interact with people, they are also taught how to portray and navigate gender.

**Cultivation Theory**

Socialization comes from different factors in a child’s life, such as play between peers, teacher–child relationships, and media influences (Aydt & Corsaro, 2003; Emilson et al., 2016; Fagot, 1994; Hellman, 2010; Larson, 2001; Mazzarella, 2015; Tobin et al., 2010). As part of social learning theory, cultivation theory specifically examines how media influences and alters ideas about reality (Mazzarella, 2015). Cultivation research indicates a consistent connection between television and stereotypical gender views (Larson, 2001; Mazzarella, 2015). In one study of televised children’s programs, males were found most often to be aggressive, direct, and ingenious, while females were more relationship-orientated and needed more help to succeed (Mazzarella, 2015). Larson (2001) and Van Damme (2010) examined televised presentation of gender stereotypes and found that girls are more likely to show passiveness, emotion, and relational aggressiveness. Boys were shown to be more competitive and physically forceful. By studying gender as a social construction rather than just a biological or cognitive developmental structure, a clearer picture of gender construction and development emerges.

To understand gender construction among children, one must look at where much of a child’s time is spent: schools and daycares. Recent research shows that the teacher–child relationship is instinctively influenced by gender stereotypes (Emilson et al., 2016). The teacher–child relationship is especially potent with preschoolers, who rapidly acquire stereotypes to identify gender and guide behavior (Tobin et al., 2010). Hellman (2010) further demonstrated that societal norms and expectations are created and repeated in preschools. For preschool boys, rowdiness, dominance, and aggressiveness were expected by teachers; when girls exhibited the same traits, however, they were met with indifference or incomprehension because the teachers did not expect girls to act that way (Hellman, 2010). Similarly, Fagot (1994) found that boys and girls are rewarded differently for certain behaviors and that these rewards influence styles of gendered interaction. Gendered stereotypes are presented to children as they
continually interact with teachers and caretakers, which lead children to adopt certain behaviors in order to receive rewards for their behavior.

According to Fagot (1994), there is no difference in the amount of assertive behaviors or communicative behaviors performed by infant boys and girls aged 12–14 months. However, as shown in Figure 1, there is a perceived difference by caretakers. A year-long longitudinal study conducted by Fagot (1994) on infant children illustrated how caretakers give differential responses based on gender. One year later, the continued influence of differential responses could be seen as boys acted more aggressively and girls were more prone to social interaction and speaking with caretakers.

Fagot’s research demonstrates how children’s gender identities and roles are influenced and constructed by adults beginning at an early age. As girls learn to respond through social interaction and verbal negotiation, boys learn to respond through aggressive behavior and dominating interactions. These differences lead children to create their own play groups based on gender and to increasingly delineate gender boundaries. Aydt and Corsaro’s (2003) research provides an example of gender boundaries within children, where two preschool girls were observed chasing two male peers. As the boys were chased, the girls pulled up their shirts and asked the boys if they wanted to see their bras. Though preschool girls lack breasts and have no need for bras, in this situation they were already using gender stereotypes and knowledge of gender differences to tease the boys and emphasize the difference between them.

Knowledge of stereotypical gender differences can also be seen in the labels children give each other when engaging in cross-sex play. A girl who plays with boys is labeled a tomboy, while a boy who plays with girls is a sissy. These labels carry powerful social stigmas, and, as demonstrated by Aydt and Corsaro (2003) and Tobin et al. (2010), preschoolers rapidly identify gender stereotypes and become aware of the problem of being labeled. Through examination of cross-sex play at an early age, social learning theory posits that gender is a learned, performed, and socially constructed behavior.

Learned gender differences continue to develop throughout early childhood and into adolescence as children’s knowledge of gender stereotypes expands with age. An increase in brain development
around ages 5-7 allows children to notice additional gender differences (beyond surface changes like clothing or hair length) in personality, perceived scholastic ability, social motives, and behavior as they experience gender constancy (Tobin et al., 2010). Those sex differences solidify into gender beliefs about masculinity and femininity and become embedded in interpersonal relationships, societal institutions, and society at large (Emilson et al., 2016; Tobin et al., 2010). Embedded gender beliefs are manifest in both words and actions toward other people, as individuals place themselves in positions of dominance and submissiveness according to environmental circumstances.

Cognitive developmental theory and social learning theory both present the idea that children learn gender from those who are similar. For many children, that similar individual is someone of the same sex and most often another child (Mazzarella, 2015). However, the difference between these theories lies in an individual knowing whether or not he or she is a specific gender and feeling intrinsic reward (or receiving reward) for being that gender.

**Bullying by Gender**

Gender stereotypes play a large role in the formation of gender construction and identity in children. As children grow, there is a general transition in adolescence during which a child’s direct and overt aggression becomes more indirect and covert due to the social norm that aggression is not an appropriate behavior (Lee, Liu, & Watson, 2016). Included in this general adolescent transition is a change wherein teenagers begin to rely more on peers’ acknowledgment for social acceptance and popularity while simultaneously seeking independence from parents or guardians (Lee et al., 2016). This increased pressure to obtain a place in social hierarchy, acceptance, and superiority over other peers may lead to an increase in bullying, as risk-taking behaviors and delinquency significantly increase with the presence and influence of adolescent peers (Lee et al., 2016). As children seek social prominence and parental independence, the socialization of gender prompts children to look for acceptance and superiority through involvement in athletic, academic, and sexual domains and may lead to increased bullying during adolescence.
Bullying Among Children and Adolescents

In 2004, the American Psychological Association (APA) concluded that bullying and victimization among children and youth occur due to a multitude of factors, including individual, familial, peer, school, and community influences (American Psychological Association, 2004). Research suggests that as these factors converge, bullying appears most frequently during childhood, peaks in early adolescence, and begins to decline during late adolescence (Nansel et al., 2001; Tsaousis, 2016). Despite the cognitive, relational, and behavioral changes that young adolescents experience due to puberty and changing schools, the behaviors of bullying and victimization stabilize after students enter secondary school environments (Sentse, Kretschmer, & Salmivalli, 2015). However, it is not just change that comes from new schools and puberty that fosters bullying. Early adolescence presents many social challenges to youth as they transition from childhood, including concerns over self-esteem and social image as the importance of peer acceptance and physical appearance among their social groups (Lee et al., 2016; Tsaousis, 2016). In other words, secondary schools provide an environment for bullying to happen due to the changes occurring in adolescents’ lives.

As adolescents prioritize popularity and self-image, self-esteem begins to be based on how an individual believes society will interpret their actions. To achieve the desired higher self-esteem, adolescents may disregard what is socially accepted and what is not (such as not bullying; Swearer & Cary, 2003). A disregard for accepted behaviors allows bullying to become more prevalent within secondary schools and also allows for the possibility of greater social rewards among peers (Sentse et al., 2015). Accordingly, bullying can be seen to have a positive association with popularity for the bullies, while victims of bullying have a negative association with popularity and self-esteem (Sentse et al., 2015). Desire for a high self-esteem can thus be seen as a contributor to bullying.

Bullying perpetration (i.e., the act of bullying) and bullying victimization can both be accounted for by the presence of weak social ties. Weak social ties (e.g., little to no school or extracurricular involvement, little to no participation in social activities, or no friends) offer greater possibility of either being a bully in an attempt to increase social standing or of being a victim on the bottom of the social
hierarchy (Tsaousis, 2016). Lee et al. (2016) reported that children who are engaged in bullying behaviors for substantial amounts of time are likely to develop maladaptive relationship patterns, while Olweus (1992) and Tsaousis (2016) suggested that individuals with low self-esteem appeal to bullies, because their behavior indicates a lack of retaliation. One study by Sentse et al. (2015) indicated that boys who are bullied and rejected socially tend to display bullying behavior in return, because they are more likely to be socially maladjusted and already stereotypically gendered to be aggressive. This relationship between maladaptive behavior and the appeal of victims creates a loop wherein victims with low self-esteem are bullied but may bully others in return to raise social standing and avoid their own future victimization (Sentse et al., 2015). Bullying is a behavior intended to increase social ties, but victimization is a behavioral response that cannot increase social position.

Direct physical bullying often decreases with age in accordance with visible social norms, but indirect and relational bullying increase within secondary schools. This increase occurs between the ages of 11 and 15, during which children experience the previously discussed cognitive, relational, and behavioral changes (Tsaousis, 2016). In addition, secondary schools are larger than primary schools, with a greater diversity of students and fewer teachers per student, which leads to a greater incidence of indirect and relational bullying (Popp, Peguero, Day, & Kahle, 2014; Sentse et al., 2015). Students experience a wide variety of bullying, from direct verbal to relational peer victimization. Knowing how children develop and construct their gender will help counselors and teachers as they address bullying in all its forms in schools.

Relational vs. Physical Bullying

The APA (2004) has stated that children are bullied differently based on their gender: Boys are more likely to be bullied physically, and girls are more likely to be bullied relationally. The difference in bullying perpetration is largely due to the socialization and construction of gender that occurs at a young age, with boys generally becoming more physically aggressive and girls becoming more relationally aggressive (Dukes et al., 2009; Popp et al., 2014; Tsaousis, 2016). Gender stereotypes dictate that the norm for girls is to not be physically aggressive. Therefore, as Dukes et al. (2009) and Sentse
et al. (2015) stated, a girl’s sociality gives rise to relational bullying. A sense of interdependent self-construal, seen more among females, is such that girls will define themselves through the values and attributes assigned them by a peer group (Markus & Kitayama, 2010). In conjunction with gender stereotypes, multiple forms of bullying contribute to the rise of a variety of bullying methods across genders.

Bullying perpetrators are thus generally split along gendered lines, although these lines are fluid. Boys can and do use forms of relational bullying, most notably in the form of sexual harassment, and girls can use forms of physical bullying (Fox et al., 2014; Gruber & Fineran, 2016). Physical bullying involves hitting, pushing, and kicking a victim to raise one’s social status while simultaneously lowering the victim’s (Dukes et al., 2009; Sentse et al., 2015; Tsaousis, 2016). Results obtained by Dukes et al. (2009) showed that physical and relational bullying have nearly the same consequences for adolescents. Victims of both forms of bullying experience a sense of hopelessness, lowered academic performance and self-efficacy, lowered self-esteem, and withdrawal from social ties and activities (Dukes et al., 2009; Popp et al., 2014). Foels and Tomcho (2005) suggested that women are higher in relational interdependence and that interdependence is a greater factor in female self-esteem. So, although bullying negatively impacts both men and women, relational bullying may cause more psychological distress to women due to the importance they place on social groups. Fox et al. (2014) and Reid et al. (2004) suggested that this greater psychological distress may be because, within relational bullying, the threat or harm itself appears to come from all peers and not from a singular individual or the environment (e.g., school, sports team) and is not a singular instance. Combating direct physical bullying is of great importance because of the immediate threat it presents; however, combating relational bullying is just as important because of its linkage to sexual harassment and other violent behavior.

**Sexual harassment.** Sexual-harassment victimization is similar to bullying victimization, as it produces a negative effect on an individual’s self-esteem and identity (Dukes et al., 2009; Gruber & Fineran, 2016; Popp et al., 2014). Researchers disagree as to what the differences are between bullying and sexual harassment, since not all cases of sexual harassment occur repeatedly and deliberately with the purpose of intimidating or gaining control (Gruber & Fineran, 2016).
Currently, sexual harassment is viewed as a legal issue, while bullying remains a social problem (Gruber & Fineran, 2016). Thus, while sexual harassment is not classified as a form of bullying, it presents many of the same victimization effects and should be addressed within schools.

As children reach adolescence and move into secondary schools, sexual harassment becomes more prevalent. It is not that other forms of bullying disappear, but adolescents seek more powerful ways to establish social dominance, and sexual harassment is very powerful. Driven by gendered stereotypes, sexual harassment can be used to demean both girls and boys (Felix & McMahon, 2006; Gruber & Fineran, 2016; Swearer, Turner, Givens, & Pollack, 2008). At a time when adolescents’ bodies are changing and sexually maturing, sexual harassment carries more of a stigmatizing effect in victims. Consequently, both females and males report being victims of sexual harassment (Felix & McMahon, 2006; Gruber & Fineran, 2016). Seen this way, sexual harassment can be viewed as a type of relational bullying, the kind most often perpetrated by males (Gruber & Fineran, 2016; Swearer et al., 2008). Felix and McMahon (2006) argue that the most frequent perpetrators of sexual harassment in secondary schools are boys with a high social status, who make lewd gestures and comments about women while using homophobic slurs against other boys. As young adolescents solidify and reinforce gender identity and stereotypical beliefs, sexual harassment and gendered relational bullying function to construct new and unstable gender stereotypes and relationships, which impact self-identity and future patterns of interactions within society (Gruber & Fineran, 2016). Sexual harassment is a form of bullying in that bullying can be classified as deliberate and intentional as well as physical or psychological (Heald, 1994; Smith & Sharp, 1994). Although girls are most commonly perpetrators of relational bullying, boys are the most common perpetrators of sexual harassment. Within schools, students experience multiple forms of victimization, from direct physical bullying to relational bullying or sexual harassment. Comprehensive programs that account for these multiple forms of bullying, as well as for sexualized and gender-related victimization, should be used by counselors and teachers to protect and enable students.
Addressing Bullying

Schools are beginning to recognize the negative effects of bullying and victimization on students’ overall health and are working to solve the problem by implementing programs to prevent bullying or to intervene when bullying occurs (Felix & McMahon, 2006; Radliff, Wang, & Swearer, 2016). In 2004, the APA reported the development of many bullying prevention programs and strategies and indicated that bullying perpetration may be significantly reduced within schools through school-wide programs that aim to change behavioral norms. However, there are obstacles that remain in the paths of teachers, counselors, and administrators, including gender perspectives and the difficulty of identifying bullying forms.

Gender Perspectives

As has been previously theorized, gender is a social construct. It is a learned behavior that is taught within the first year of an infant’s life (Fagot, 1994). Teachers and caretakers instinctively respond with gendered stereotypes that imprint on boys and girls with or without intent, resulting in the inevitability of gender as a social construct (Emilson et al., 2016). To combat the resulting development of gender traits and stereotypes (e.g., aggression in boys), Morales et al. (2016) suggested that schools support non-traditional gender views. By doing so, educators can work to remove the social masculine traits which are commonly found in young bullying perpetrators. Accordingly, starting in elementary school and preschool, teachers should strive to develop a climate in classrooms that does not force gender (Swearer et al., 2008). Rather than students responding to teachers’ assumptions, students should be free to develop their own genders, which counselors and teachers then respond to and work into school programs. Swearer et al. (2008) stated that a student’s participation in bullying begins with the attitude and view they hold toward it. If a child learns that aggressive behavior successfully contributes to their wants or desires, or similarly, if a child learns at a young age to expect victimization, these experiences will reinforce participation or non-participation in bullying.

By educating preschool and elementary school teachers about their role in the process of gender construction, teachers can communicate the seriousness of bullying and the consequences of bullying.
Bullying prevention programs can help adolescents by educating teachers to not judge students based solely on sex characteristics or gender stereotypes. The APA (2004) and Morales et al. (2016) recommended viewing bullying and victimization through the lens of a gender perspective. To fully address bullying, social and gender stereotypes should be considered at all levels, including research, school intervention programs, and parental and teachers’ influence.

**Identification of Bullying**

Identifying the type of bullying that is occurring is crucial in helping victims of peer victimization. Without a knowledge of who a perpetrator is or even if bullying is occurring, victimized students cannot be helped, so it is important to recognize when and if bullying is taking place and in which way (Swearer et al., 2008). Fox et al. (2014) and Lee et al. (2016) reported that the specific context of a bullying incident will change a teacher’s attitude toward it. Bullying is different from general aggression, as bullying assumes a specific relationship between dominant and weak individuals, is proactive, and aims to hurt others in a variety of ways (Gini & Pozzoli, 2006). Lee et al. (2016) explained that, as defined by the Child Behavior Checklist (CBCL), aggression includes more general violent tendencies, while bullying includes intentional or relational components between specific bully–victim pairings. The APA’s resolution on bullying in 2004 detailed this difference, resolving that bullying is a form of peer victimization and is different from other forms of aggression among children. Not all highly aggressive people are bullies, and not all bullies have highly aggressive tendencies. In other words, if an individual teacher does not know or does not consider perpetrators to be bullying, they may not help victims. There is a difference between aggressive behavior and bullying, and teachers need to understand the difference to intervene and prevent bullying.

Physical bullying (i.e., kicking, pushing, and tripping) is the easiest to identify and prevent, but Radliff et al. (2016) and Swearer et al. (2008) explained that relational victimization has greater negative consequences for victims, including internalized feelings of hopelessness and a change to an external locus of control. However, there is a shortage of anti-bullying programs that address relational bullying, and anti-bullying policies that attempt to prevent direct
physical bullying often force bullies to turn to more discreet relational bullying (Dukes et al., 2009). While physical bullying and victims of physical bullying are easily identifiable, teachers can learn to also recognize the effects of relational bullying. Victims of relational bullying can be identified as students who withdraw from friendships and social activity and possess lowered self-esteem, increased negative attitude about school, lower academic performance and self-efficacy, and disruptive behavior (Dukes et al., 2009; Popp et al., 2014). It is important for teachers and counselors to be able to recognize relational bullying as it is occurring so that victimization is not continued.

It is also important that teachers are aware of what relational bullying entails. Relational bullying is characterized by teasing, gossiping, social exclusion, intimidation, or sexual harassment (Dukes et al., 2009; Felix & McMahon, 2006; Fox et al., 2014; Gruber & Fineran, 2016; Reid et al., 2004). According to Felix and McMahon (2006), many secondary schools have acknowledged the negative impact that bullying has on students, but most of the anti-bullying programs that have been put in place do not address sexual harassment as a form of bullying. Opinions are difficult to change on this issue, as many educators tend to view sexual harassment among adolescents as simply flirting or failed romantic signaling between teenagers (Gruber & Fineran, 2016). Sexual harassment is illegal according to Title IX, and addressing sexual harassment in adolescence is not an attempt to criminalize flirting or romantic signaling. Educators should be sure to make the distinction between illegality and romantic attempts, as they should do with bullying and general aggressive behavior. The available literature on bullying makes it apparent that when teachers are knowledgeable and educated on the symptoms and effects of bullying, boys and girls will not suffer psychological effects or a change in externalized behavior (Dukes et al., 2009; Felix & McMahon, 2006; Gruber & Fineran, 2016). Given successful intervention and prevention, schools should become safe havens where students can feel comfortable and safe.

Conclusion

Bullying is prevalent in American society in books, television, schools, and society at large. It can be seen on college campuses in fraternities and sororities and the tradition of hazing, in sports locker
rooms, and in work settings (e.g., sexual harassment, exclusion, gossiping). Bullying occurs when there is a power imbalance between dominant and submissive individuals or groups. It is the abuse of an individual by another person with the intent of using the power gained through the abuse to advance among peers and along a social hierarchy (Swearer & Cary, 2003). Victims of bullying develop problems with interpersonal relationships and psychological functions, especially when bullied at a young age (Morales et al., 2016). Although anti-bullying programs are promoted by the APA and schools are implementing prevention and intervention techniques, an understanding of the origins of bullying and its methods must be gained before such programs and techniques become successful (APA, 2004; Felix & McMahon, 2006).

Almost from birth, children are socialized into two genders and gender conformity, with boys generally labeled as physical and aggressive, while girls are labeled as social and gentle (Fagot, 1994; Hellman, 2010). These respective gender differences are taught and enforced through play interaction and through student–teacher dyads and lead to differing ways of interacting with peers (Emilson et al., 2016; Tobin et al., 2010). As children age, peer interaction becomes centered on social hierarchies and social dominance, which gives rise to behaviors that limit some individuals and promote others. A focus on social hierarchies promotes perceived popularity among adolescents as a valued aspect of a reputation, and being known as popular is a highly valued characteristic (Sentse et al., 2015). This perceived popularity is central in adolescents’ self-view of their peer rejection or peer acceptance. Peer acceptance generally leads to a sense of popularity, and children who are popular are known to use aggressive behavior to advance personal interests at the expense of those who are rejected by peers (Sentse et al., 2015). In other words, popular children are more prone to bullying to remain popular and further personal interests. However, not all bullying is acceptable in the eyes of students. Gender stereotypes that were imprinted on children at a young age may lead students to reject most forms of cross-gender bullying, due to the need for gender conformity (Fox et al., 2014). When cross-gender bullying does not occur, different methods of bullying become apparent between genders. To stay within gender stereotypes, boys typically rely on physical bullying, while
girls use more relational bullying (Dukes et al., 2009; Sentse et al., 2015). Different methods of bullying require different responses from teachers and counselors, as physical and relational bullying cause different effects.

The literature on bullying consistently agrees that schools are the best medium through which to intervene and prevent adolescent bullying behavior (Felix & McMahon, 2006; Radliff et al., 2016). Schools that focus on familial involvement, student discipline, and academic achievement should have the most success in combating bullying, as the promotion of a strong support system among all aspects of students’ lives (e.g., family, peers, teams) would create a sense of group resistance (Dukes et al., 2009; Popp et al., 2014). Bullying tends to increase in schools when adolescents reject their peers and focus on a winner-take-all attitude where there are winners and losers (Sentse et al., 2015). However, research suggests that schools which focus on empathy and self-efficacy are most helpful in preventing bullying (Dukes et al., 2009). Schools that implement ideas such as these should note that policies without a program to enforce them do not see success (Dukes et al., 2009; Popp et al., 2014). Student involvement appears to be most helpful in targeting bullying; students are more likely to witness bullying and have primary knowledge of the situation, as large student bodies create more diverse peer groups for students and limit teachers’ interactions with individual students (Sentse et al., 2015). Approaches that use student involvement allow physical bullying to be halted immediately and offer a support system for victims suffering from relational bullying. Victims of relational bullying can be identified through symptoms such as withdrawal from friendships, increased negative attitudes, and lower academic performance, to which student-group resistance can offer support at school as well as at home (Dukes et al., 2009; Popp et al., 2014). Anti-bullying programs should offer involvement and have time to gather students, rather than teachers, as groups to educate and intervene.

Anti-bullying programs should aim to target both bullies and victims in intervention techniques. Generally, most bullies have a cause for their aggressive behavior, but it should be remembered that not all bullies are highly aggressive. When anti-bullying programs target the psychological process of bullying, victims can be helped to navigate their negative experiences (e.g., feelings of
hopelessness, lowered self-esteem), and bullies can be helped to resolve their aggressive behaviors (Radliff et al., 2016). Moreover, if bullying is stopped early enough, then there is a recovery effect and less permanence of negative externalized behaviors (Lee et al., 2016). Victimization and bullying should not be thought of as things that occur at school but as things which are part of a school. In other words, victimization and bullying should not be looked at as just events that happen within a school building but as part of the students’ environment.

An environment where victimization is tolerated indirectly creates the idea within victims that teachers and educators endorse bullying (Gruber & Fineran, 2016). Having a school environment that offers support from teachers and students in any instance of bullying is essential to preventing and ending bullying behavior. To deal with and counteract bullies, teachers should look to create positive experiences for every student, encourage growth and maturation through positive involvement in social settings, and highlight and praise examples of positive, socially accepted behavior.
References


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Figure 1. Response of Caretakers to Infant Behavior (Fagot, 1994). This figure illustrates the type of responses by caretakers to infants aged 12–14 months.
Real Men Burp Babies and Real Women Deliver Dough: The Advantages of Nontraditional Parental Roles

Katherine Christensen
Brigham Young University

Abstract

Stay-at-home fathers and working mothers continue to defy gender expectations despite traditional societal beliefs pertaining to gender roles. These nontraditional couples model a contemporary and egalitarian lifestyle for their children in a world that is increasingly advocating for more gender equality within and outside of the home. Children within these households exhibit positive cognitive traits, enhanced behavioral developments, and enriched familial relationships (Brown, Mangelsdorf, & Neff, 2012; Deutsch, Servis, & Payne, 2001; Dunn, Rochlen, & O’Brien, 2013; Fischer & Anderson, 2012; Flaskerud, 2012; Lucas-Thompson, Goldberg, & Prause, 2010; Rushing & Powell, 2015; Williams & Radin, 1999; Wills & Brauer, 2012). Despite the positive implications of nontraditional dynamics, these families continue to be misunderstood and are often isolated due to social stigma associated with gender stereotypes (Dunn et al., 2013; Rushing & Powell, 2015; Sinno & Killen, 2009; Zimmerman, 2000). In order to better support these families, society ought to acknowledge the decisions that all families make in regards to work and domestic roles and educate children about all future and career opportunities, regardless of gender. With increased understanding and acknowledgment of the developmental benefits that come to children within these dynamics, nontraditional families can pave the way for a less-gendered, more egalitarian world.

Keywords: Stay-at-home fathers, egalitarianism, nontraditional families, gender roles
Real Men Burp Babies and Real Women Deliver Dough:  
The Advantages of Nontraditional Parental Roles

In an interview pertaining to the dynamics of her family, my mother, a working mother, proudly recollected the unique relationship my sisters and I have with our father, a stay-at-home dad:

My children aren’t going to remember whether the kitchen floor was clean or if dinner was on time. What they will remember is that they had a loving home and an amazing father who adored them. He devoted all of his time to their activities and needs. Yeah, maybe I wasn’t there all the time, but as a result of our non-traditional choices, my girls have formed a really close, loving relationship with their father. (C. Christensen, personal communication, October 9, 2016)

Growing up in a nontraditional family, I was curious to discover any benefits inherent in adopting this unique family dynamic as well as to better understand any implications that may arise for my siblings and myself. Indeed, stay-at-home fathers are becoming the new standard in society (Fischer & Anderson, 2012; Kramer, Kelly, & McCulloch, 2015). With more fathers staying at home and more mothers providing for the family’s financial needs, traditional gender expectations are being reevaluated and even altogether rejected (Kramer et al., 2015). Although couples may choose from a variety of work arrangements to best serve their specific circumstances, an evaluation of the effects of these contemporary roles, especially on child development, is needed in order to understood and better support nontraditional families within present-day culture. Perhaps an increased understanding of the developmental benefits that come from adopting nontraditional parental roles for children may serve to better garner societal support for these families.

Traditionally, women have shouldered the responsibilities of caring for children and performing household chores. Women’s roles have been represented by various female stereotypes including the domestic housewife, the primary caretaker, and the perfect hostess. However, recent studies have cited the increasing prevalence of domestic fathers, as more women begin to enter the workforce (Fischer & Anderson, 2012; Kramer et al., 2015; Rushing & Powell, 2015). According to the U.S. Bureau of Labor Statistics (2014), women
constituted over half of the total labor force in 2013. In addition, the percentage of women graduating with college degrees has more than tripled when compared to 1970 (U.S. Bureau of Labor Statistics, 2014). As more women enter the workforce, there is a greater need for fathers to assume the primary caretaker role.

According to the U.S. Census Bureau (2009), the number of stay-at-home fathers has more than tripled in just a little more than a decade (as cited in Dunn, Rochlen, & O’Brien, 2013). Not only are the numbers of stay-at-home fathers increasing, but the reasons behind their choice to become the primary caregiver are dramatically changing (Kramer et al., 2015). In a study evaluating the various characteristics of stay-at-home father households, Kramer et al. (2015) revealed that present-day stay-at-home fathers are increasingly choosing the caregiving role as opposed to performing domestic duties out of necessity or inability to work. Despite this increase, few studies have examined the direct effect that increased paternal participation can have on children. Furthermore, many of these studies are outdated, and an updated examination of these societal developments is needed.

In contrast, an abundant number of studies have been devoted to examining the effects that maternal employment has on children (Flaskerud, 2012; Lucas-Thompson, Goldberg, & Prause, 2010; Ruhm, 2008; Wills & Brauer, 2012). Results from these studies have been mixed. While some studies have argued that maternal employment harms children’s well-being and leads to poorer developmental outcomes, other literature has found the effects of maternal employment to be inconsequential and even positive to the overall well-being of the child (Flaskerud, 2012; Ruhm, 2008; Wills & Brauer, 2012). For example, in a study comparing differing household arrangements among groups of married couples with children, Hill et al. (2006) found support for professional women to continue working within their careers instead of opting out after having a child. Additionally, in a review on the health of working mothers and their children, Flaskerud (2012) found that children of working mothers had less behavioral problems and a stronger desire for academic achievement than their peers from traditional households. Nevertheless, it is important to understand the effects of both the mother’s employment coupled with the father’s role as the caretaker to obtain a holistic and more complete perspective regarding children’s well-being.
Another dynamic examined in various studies pertaining to nontraditional families has been the effect that these reverse gender roles have on the couple’s relationship (Dunn et al., 2013; Rushing & Powell, 2015; Zimmerman, 2000). Nontraditional couples enjoy enhanced marital equality, marital satisfaction, and parenting cohesion (Rushing & Powell, 2015; Zimmerman, 2000). In a study conducted by Rushing and Powell (2015), nontraditional couples were found to be more supportive of one another’s roles within the home. As a result, these couples exhibited a high level of satisfaction and happiness within their marriage, translating into a happier and healthier home (Rushing & Powell, 2015). Nevertheless, although nontraditional families are on the rise, these families are still misunderstood and are often negatively perceived within society (Dunn et al., 2013; Fischer & Anderson, 2012; Rushing & Powell, 2015; Zimmerman, 2000). Prevailing gender stereotypes can create unmerited stress and strain within familial relationships; thus, it is important to understand the roles that nontraditional families have within society.

Nontraditional families ought to be better understood so that stay-at-home fathers and working mothers can feel supported instead of isolated, particularly within social contexts. Especially important within this dynamic are the effects that reverse gender roles have on children. Although there has been a wealth of literature pertaining to the benefits of the traditional family for future outcomes for children, parents who exhibit nontraditional gender roles also have a positive impact on children’s development. This could be because they model a less-gendered perspective within a changing society in which nontraditional families are increasingly accepted. Children within these families exhibit positive cognitive traits, enhanced behavioral developments, and enriched familial relationships, preparing them for an egalitarian future in which gender lines are increasingly blurred. The present literature review attempts to explore the inherent benefits of adopting a nontraditional family dynamic for children by addressing (a) the positive cognitive traits, (b) the enhanced behavioral developments, and (c) the enriched familial relationships that are observed within children of these families.
Positive Cognitive Traits in Children of Nontraditional Families

Recognizing the ways in which children reason about and understand gender roles in present-day society has important implications for both families who exhibit nontraditional roles and those who exhibit traditional roles. Because parents are important contributors to their children’s own understanding of gender roles within society, family dynamics prove to be highly influential in the early formation of gender stereotypes (Sinno & Killen, 2009). Important cognitive differences have been found between children coming from traditional circumstances and those coming from nontraditional dynamics (Deutsch, Servis, & Payne, 2001; Dunn et al., 2013; Williams & Radin, 1999). Indeed, children from nontraditional families hold a less gendered view of society, have higher self-esteem, and exhibit career or future aspirations that are not limited by gender confinements.

Less Gendered View of Society

Children from nontraditional families are less likely to endorse or adhere to gender stereotypes regarding roles within and outside of the home, demonstrating an important cognitive distinction between both groups of children (Sinno & Killen, 2009). In a study conducted by Fagot and Leinbach (1974), the concept of gender developed within the first two years of a child’s life, with gender roles forming soon thereafter (as cited in Williams & Radin, 1999). Since gender and its respective roles are crucial building blocks to understanding one’s role within society, the formation of these beliefs has important implications for children. In conjunction with these findings, Sinno and Killen (2009) demonstrated that children’s family dynamics affect their beliefs about gender roles within society. When justifying parental domestic competence, children from nontraditional households consistently relied less on gender stereotypes and more on reasons pertaining to personal effort as compared to children from traditional families (see Table 1). Thus, those growing up with nontraditional roles within the home have diminished stereotypical beliefs about gender expectations.

Moreover, Williams, Radin, and Allegro (1992) demonstrated that children who grew up with an increased level of paternal involvement were more likely to endorse nontraditional family and work roles
(as cited in Deutsch et al., 2001). Deutsch et al. (2001) further supported this finding, indicating that children who were exposed to an egalitarian lifestyle grew up to endorse equal opportunities for both men and women inside and outside of the home. As children from nontraditional households grow up within these unique family dynamics, they will be prepared to face the atypical trends and ever-changing beliefs of a society that demonstrates increased flexibility in regards to gender expectations.

**Higher Self-Esteem**

Another compelling cognitive distinction of nontraditional children is the high level of self-esteem they often exhibit, due in part to the development of healthy relationships with both their mother and their father. In a study conducted by Deutsch et al. (2001), children whose fathers were actively involved in their emotional well-being and who showed concern for their welfare had higher levels of self-esteem than their peers from traditional backgrounds. Deutsch et al. (2001) found that levels of paternal emotional involvement ($r = .58$, $p \leq .01$), discipline ($r = .62$, $p \leq .01$), and attention ($r = .30$, $p \leq .10$) were all significantly correlated with children’s self-esteem levels. Furthermore, the working mothers within these households were not less involved; rather, both parents contributed equally to their children’s well-being, resulting in higher levels of self-worth (Deutsch et al., 2001). Because these children had parents who were both actively engaged in their lives, in effect, they had twice the amount of emotional support. As a result, children’s self-esteem was positively affected. With higher self-esteem, children from nontraditional families can have greater confidence, higher self-assurance, and more resilience when overcoming the inevitable obstacles of growing up and facing the world.

**Unconventional Career and Future Aspirations**

Future ambitions and career objectives are markedly different between children from nontraditional families and their more traditional counterparts. In a study conducted by Whiston and Keller (2004), children with working mothers were more likely to choose nontraditional occupations as opposed to children coming from traditional families (as cited in Dunn et al., 2013). Clearly, the choices that children and adolescents make in regard to career development
are largely linked with family experience. Children with working mothers are exposed to more progressive and unconventional values, causing them to be more likely to endorse gender-role free work environments and occupations (Dunn et al., 2013). Likewise, Sinno and Killen (2009) found that although children from traditional families are aware of the changing norms in the working world, they are less likely to endorse these new trends in home and work situations. Even though children from traditional upbringings have an awareness of this increasing equality, they are more likely to maintain traditional expectations and stereotypes, because they are not exposed to untraditional roles (Sinno & Killen, 2009). However, children raised nontraditionally will be more likely to interpret the unconventional roles that they witness within the home as viable options for themselves. The observance of these roles will not only have a positive effect on their future, but it can benefit their current lives, giving them a unique vantage point and perspective of the world. Indeed, multiple studies have shown that nontraditional children have high levels of academic ambition along with enhanced cognitive development, due to their exposure to nontraditional roles within the home (Flaskerud, 2012; Lucas-Thompson et al., 2010; Williams & Radin, 1999; Wills & Brauer, 2012). Less constrained by gender expectations, nontraditionally-raised children grow up embodying more of the roles that they truly desire and less of the roles which are prescribed to them by society. As such, they can be prepared to enter the workforce with drive and determination while also breaking down traditional expectations and beliefs.

Enhanced Behavioral Developments within Children of Nontraditional Families

An expansion of the father’s role, involvement, and interaction with his children directly affects the child’s well-being in both traditional homes and untraditional homes. Many studies have shown that fathers are becoming more involved in the lives of their children (Deutsch et al., 2001; Dunn et al., 2013; Flaskerud, 2012). Today, more than ever before, men are increasingly choosing the role of stay-at-home father as opposed to staying at home due to inability to work (see Figure 1 & Figure 2). Instead of altogether replacing the mother’s role within the home, a nontraditional father manifests
support through the encouragement of his spouse’s career and the shared responsibility of childcare (Rushing & Powell, 2015; Zuo & Tang, 2000). Indeed, some of the behavioral benefits of a more engaged father are that children exhibit enhanced control over their behavior, higher levels of secure attachment to their parents, and an increased ability to express their emotions and exhibit femininity.

**Enhanced Emotional and Behavioral Regulation**

Various studies have demonstrated the benefits of having an engaged and active father within the home. Indeed, some of the most notable behavioral developments of children from nontraditional homes include exhibiting fewer internalizing behaviors, such as anxiety or stress; displaying fewer externalizing behaviors, such as aggression; and demonstrating a more internal locus of control (Lucas-Thompson et al., 2010; Williams & Radin, 1999). Children from nontraditional backgrounds are able to successfully regulate their feelings and manifest behavioral control from within, instead of externally acting out in aggression or anger. Indeed, these traits demonstrate that children from nontraditional families have more authority over their behavior.

While maternal employment has traditionally been believed to negatively impact children, various studies have demonstrated that enhanced behavioral regulation is related to having a more engaged and active father within the home (Flaskerud, 2012; Lucas-Thompson et al., 2010). Indeed, nontraditional children still receive the benefits of a caretaking mother, but acquire enhanced skills demonstrating control and discipline over their behavior, indicating that children’s behavioral development is largely related to other environmental and biological variables, such as social-economic status, family structure, or ethnicity, and not to maternal employment.

Furthermore, in a study conducted by Sayer et al. (2004), present-day mothers, regardless of their working status, participated more in their children’s lives today as compared to the 1960s, when less women were working (as cited in Wills & Brauer, 2012). In conjunction with these findings, a working mother continues to embody the caretaking role within the home, whether she has the traditional role of caretaker or the untraditional role of breadwinner (Deutsch et al., 2001; Dunn et al., 2013). In essence, the role of mother is not being replaced or lost due to mothers’ work schedules, nor are stay-at-
home fathers replacing mothers’ role within the home. Children from nontraditional homes are not disadvantaged by their mother’s career choice but instead develop positive behavioral traits that distinguish them from traditionally-raised children. These positive traits may be largely connected to their nontraditional upbringing with a stay-at-home father and working mother and to the subsequent dynamics experienced within these homes.

**Secure Attachment to Parents**

Another beneficial behavioral difference observed in children from nontraditional families is the extent to which the child is securely attached to his or her parents. Secure attachment can be defined as the degree to which a child feels secure with his or her caregiver, promoting healthy emotional and behavioral development (Brown Mangelsdorf, & Neff, 2012). Because a mother is the primary source of food and comfort for her child beginning at birth, children are more likely to develop a secure attachment to their mother regardless of whether or not she works. In contrast, due to the nature of an infant’s needs, the father is not as likely to naturally form a secure attachment with his child immediately following birth.

Moreover, in traditional families, the mother spends the majority of her time caring for and interacting with her children, while the father is often at work and is much less involved at home (Deutsch et al., 2001). Because of this lack of involvement, children may be less likely to exhibit secure attachments to their fathers. They may even lack the additional social, behavioral, and emotional benefits that come from a secure paternal attachment (Brown et al., 2012). While it is possible for children in traditional homes to have a secure paternal attachment, these circumstances make it harder for a secure bond to form between the father and the child. Indeed, increased paternal involvement often facilitates and is more likely to result in more secure paternal attachment (Deutsch et al., 2001). Deutsch et al. (2001) demonstrated that a secure attachment to one’s father fosters various enhanced developmental traits including empathetic concern, competency, and well-developed social, academic, and emotional lives. Furthermore, in a study conducted by Brown et al. (2012), children who were securely attached to their fathers exhibited greater levels of trust, emotional awareness, and sensitivity, demonstrating the many positive outcomes of devoted paternal parenting. Because
nontraditional families often have highly involved and invested fathers, children from nontraditional backgrounds may enjoy unique benefits from having secure attachments to both parents and may be more likely to exhibit positive behavioral traits associated with these bonds.

**Greater Disposition to Feminine Activities**

Having increased paternal involvement within the home increases the likelihood that children from nontraditional homes are exposed to counter-sex typed activities. Because of the responsibilities of childcare, stay-at-home fathers often engage in many domestic activities traditionally associated with motherhood, including feeding, nurturing, and comforting children. Indeed, Rushing and Powell (2015) found that stay-at-home fathers not only had a heightened ability to express their emotions, they also gained a wide range of parenting skills not typically associated with the role of father. They further found that nontraditional fathers exhibited these nurturing traits, all while maintaining the traditional masculine values of independence and strength (Rushing & Powell). Similarly, Fischer and Anderson (2012) found that masculinity and femininity of stay-at-home fathers and working fathers were not significantly different (see Table 2). Both studies illustrate that fathers gain benefits in parenting their children without actually being more feminine themselves. As nontraditional children observe their fathers doing more traditionally feminine activities, they are less likely to categorize one activity over another as appropriate for or expected of a certain sex.

Additionally, various studies have found that children with stay-at-home fathers and working mothers are more likely to engage in feminine activities and pursuits regardless of their sex (Deutsch et al., 2001; Fischer & Anderson, 2012; Rushing & Powell, 2015). Deutsch et al. (2001) found that male children from nontraditional homes were more likely to endorse and accept femininity when they had fathers who comforted them, participated actively in their upbringing, and valued the expression of their emotions. While traditional children have the emotional support and comfort from their mothers, these children may not as often have the benefit of observing activities that cross gender lines. The unique environment of the nontraditional home provides a setting in which children can explore various activities regardless of their gender. As societal beliefs pertaining to
gender roles decrease in prevalence, nontraditional children may be more able to accept and cross over these lines in the future when they have families of their own.

**Enriched Relationships between Members of Nontraditional Families**

Because nontraditional families exhibit a unique dynamic in which the father stays at home while the mother works, relationships within these families often differ from those of traditional families. As fathers stay at home with their children, they are often more involved in their children’s everyday lives, comforting them, caring for them, and nurturing them (Deutsch et al., 2001; Fischer & Anderson, 2012; Rushing & Powell, 2015). Although one might think working mothers are not as involved in traditional female roles, multiple studies have found that working mothers are not only as involved in their children’s lives as stay-at-home mothers, but their children also derive benefits from these nontraditional dynamics (Deutsch et al., 2001; Dunn et al., 2013; Flaskaerud, 2012; Kramer et al., 2015; Lucas-Thompson et al., 2010; Williams & Radin, 1999; Wills & Brauer, 2012). Familial relationships between nontraditional family members are enhanced as parental cohesion is increased, quality time is enriched, and duties within the home are mutually shared, exposing children to a more cohesive, integrated, and egalitarian approach to family life.

**Increased Parental Cohesion**

Although research evaluating the differences in parental cohesion between traditional and nontraditional families is lacking, multiple studies have found that children within nontraditional families are exposed to high levels of parental cohesion between mothers and fathers (Rushing & Powell, 2015; Zimmerman, 2000). This cohesion is manifested through the shared values of egalitarianism and equality, marital unity, and relationship satisfaction (Rushing & Powell, 2015). In a study conducted by Rushing and Powell (2015), 90% of working mothers reported feelings of trust and support from their spouses, resulting in greater feelings of cohesion. Indeed, fathers and mothers of nontraditional families supported one another through their efforts to remain consistent to their values and were unified within their relationship (Rushing & Powell, 2015). Accordingly, when both parties feel that they are appreciated, supported, and acknowledged in their
efforts to raise children and provide for the home, couples experience more unity. This unity is further demonstrated through adherence and loyalty to one’s values despite societal backlash or misunderstanding.

In addition, Zimmerman (2000) found that strong communication skills and a cooperative spirit contributed to higher levels of marital satisfaction. Higher marital satisfaction results in happier couples, and happier couples result in happier families. Parenting cohesion is important in providing a healthy, reliable environment for children. Dunn et al. (2013) highlighted the importance of raising children within a harmonious, values-based home environment, especially without gender-related stereotypes. When egalitarianism and equality are modeled within the home, children will likely follow in their parents’ footsteps and adopt these beliefs and practices in the future (Deutsch et al., 2001; Dunn et al., 2013). Egalitarian couples may be able to provide consistent parenting to their children who, in turn, benefit from a more stable environment within the home.

Quality Time Enhanced

Because nontraditional families are based less on societal expectations, and more on the practicality of increased earnings and partner suitability for domestic or work-related activities, family time is greatly improved within the home, as both partners are fulfilling the roles that they desire to fulfill. Dunn et al. (2013) found that nontraditional families exhibited an improved home environment, which, in turn, resulted in increased levels of quality time between parents and children. When the parents work together in a unified partnership to create a loving home environment, higher-quality family time results. Accordingly, when partners choose roles based on skills and preferences and not on societal expectations, both parents may feel that they are successfully providing for their children and may put in heightened effort to be a united family. For example, Rushing and Powell (2015) found that, within nontraditional homes, a balanced, consistent routine helped to enhance quality time when the family was all together, such as in the morning before the mother left for work or at night after the mother returned home. Because both the mother and the father consciously put effort into creating opportunities for quality time for the whole family, time together was maximized (Rushing & Powell, 2015). Indeed, working mothers retain their innate desire to be involved in their children’s lives as
mothers and caretakers and find ways to be involved in spite of their work schedule. Although working fathers in traditional families may wish to be more involved in their children’s lives, this desire is often unfulfilled (Fischer & Anderson, 2012). Societal norms do not require that fathers be overly involved, yet the opposite is true for women (Fischer & Anderson, 2012). Through the conscious effort of both parents, children of nontraditional homes receive the benefits of a unified, consistent home in which quality time is maximized and parents’ roles in child-rearing are respected.

**Sharing the Workload within the Home**

Consistent with an egalitarian lifestyle, children from nontraditional households are exposed to a more equal division of labor within the home, in which both the mother and the father contribute to household chores and childcare. Equal division of labor is different for every household and circumstance. Traditionally, women have spent a disproportionate amount of time rearing children and attending to their concerns and well-being as compared to men. Nevertheless, multiple studies have demonstrated that adopting a more egalitarian approach to the division of household labor contributes to higher levels of marital satisfaction and happiness (Deutsch et al., 2001; Zimmerman, 2000). For example, Deutsch et al. (2001) found that when fathers contributed more to their child’s emotional needs, the child exhibited increased self-esteem and came to endorse a gender-free model of family life within the home. When each parent contributes his or her proportionate share to the household and family life, mothers and fathers work together in an equal partnership that benefits their own relationship; additionally, children witness a healthy, complementary relationship within the home. As nontraditional children come to accept a more egalitarian lifestyle, they may be more likely and willing to perpetuate these dynamics for their own families in the future.

**Conclusion**

Prepared to face a world in which gender roles and expectations are constantly and quickly changing, children from nontraditional households exhibit positive cognitive traits, enhanced behavioral developments, and enriched familial relationships due to the unconventional dynamics they witness at home. Cognitively,
nontraditional children endorse less-gendered beliefs, exhibit higher self-esteem, and aspire to unconventional careers that are not limited by gender or circumstance (Deutsch et al., 2001; Dunn et al., 2013; Sinno & Killen, 2009). Behaviorally, these children demonstrate secure attachment to both parents, exhibit behavioral control, and present a preference for feminine activities (Brown et al., 2012; Dunn et al., 2013; Lucas-Thompson et al., 2010; Rushing & Powell, 2015). Socially, nontraditional children have positive familial relationships that are enhanced by witnessing increased levels of parenting cohesion, heightened levels of quality family time, and improved proportions of workload sharing within the home (Deutsch et al., 2001; Dunn et al., 2013; Fischer & Anderson, 2012; Rushing & Powell, 2015). With these distinct benefits, nontraditional children enter society with a unique outlook and perspective of gender expectations and stereotypes.

Interestingly, even though more unconventional attitudes and practices within the home are increasing, many families that have adopted nontraditional roles still feel much of the strain and social stigma associated with crossing over these lines (Dunn et al., 2013; Rushing & Powell, 2015; Zimmerman, 2000). Instead of supporting these couples and families, society often isolates and rejects them because they do not comply with traditional expectations (Rushing & Powell, 2015; Zimmerman, 2000). By understanding the unique benefits that come to children by adopting nontraditional dynamics within the home, perhaps, many of these negative beliefs and uninformed stereotypes may be challenged and eventually changed.

In order to support nontraditional families, society ought to be more accepting and less critical of nontraditional dynamics. Support ought to be offered for working mothers within the workplace as well as for domestic fathers within the home. Hill, Hawkins, Märtinson, and Ferris (2003) found that companies may facilitate greater feelings of commitment and support from their employees by providing specific work-family programs aimed at mediating the conflict between work and family. For example, work-family programs may offer working mothers flexibility and a greater ability to achieve a balance between the demands of work and home (Hill et al., 2003). However, little research has examined the effectiveness of programs designed to help and support domestic fathers within the home. Thus, instead of evaluating families by their circumstances and decisions
Regarding work and childcare, society ought to celebrate these families for their difficult decisions. It is difficult enough to pave new avenues and exhibit nontraditional roles, but it is even harder to do so without the support of others.

Furthermore, it is important to foster understanding pertaining to the benefits of nontraditional familial dynamics. Activities and social roles must be categorized less as appropriate for male or female and more as universally appropriate for either sex. Future research could benefit from examining the longitudinal effects of a nontraditional upbringing on children in order to more fully understand the potential outcomes experienced by children from nontraditional homes. This research could demonstrate and further justify the need for support systems within society for parents exhibiting nontraditional roles and for their children. If society can educate children about all of their options, regardless of gender, celebrate the sacrifices that all parents make in providing for their children, and support all families in their work and household pursuits, then change will likely take place.

While the rest of the world may judge or criticize them, nontraditional couples are able to demonstrate resilience to their children. Despite hardships in the workplace and in the home, these couples model equality that may have implications for generations far into the future. Nontraditional children will likely be able to further gender equality and support a more egalitarian lifestyle through the choices that they make in their own families. In essence, these children may be more prepared to face a society in which gender lines are reevaluated and changed. Perhaps, in the near future, gender will not determine household suitability or workplace fitness, but instead will reflect the unique desires and aspirations that each person has individually, regardless of his or her sex. Maybe the kitchen floor is often dirty and dinner is regularly late, yet, as affirmed by my mother, C. Christensen (2016), nontraditional families are not based on adhering to societal expectations and beliefs. Instead, they are founded on providing the best lives for their children despite the obstacles that lie ahead of them.
References


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**Table 1**

<table>
<thead>
<tr>
<th>Proportion of Gender Stereotype vs. Personal Effort Justifications</th>
<th>Traditional</th>
<th>Nontraditional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mom Cooking Dinner (Personal Effort)</td>
<td>.74 (.44)</td>
<td>.79 (.41)</td>
</tr>
<tr>
<td>Father Cooking Dinner (Personal Effort)</td>
<td>.87 (.34)</td>
<td>.90 (.30)</td>
</tr>
<tr>
<td>Mom Cooking Dinner (Gender Stereotypes)</td>
<td>.26 (.44)</td>
<td>.20 (.40)</td>
</tr>
<tr>
<td>Father Cooking Dinner (Gender Stereotypes)</td>
<td>.10 (.31)</td>
<td>.10 (.30)</td>
</tr>
</tbody>
</table>


**Figure 1.** Percentage of caregiving stay-at-home father households versus unable-to-work stay-at-home father households from 1976 to 1979. Adapted


**Table 2**

<table>
<thead>
<tr>
<th></th>
<th>PAQ Masculinity</th>
<th>PAQ Femininity</th>
</tr>
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<tbody>
<tr>
<td>Stay-at-home fathers</td>
<td>3.7 (.5)</td>
<td>3.9 (.5)</td>
</tr>
<tr>
<td>Employed fathers</td>
<td>3.8 (.5)</td>
<td>3.8 (.5)</td>
</tr>
</tbody>
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A Bi-Directional Association Between Depression and Romantic Relations in Adolescence

Kaelene L. Fenn
Brigham Young University

Abstract

Depression is associated with higher morbidity rates of suicide ideation and increased suicidal risk in adolescents with the presence of romantic relationships. I review research on the predictors of depression in adolescent romantic relationships, specifically, concerning the bi-directional nature of this association, gender differences, and prevention strategies. The focus of adolescent research in recent years has been mainly on depression that emerges during romantic relationships and may have a negative effect on them. For example, adolescent girls are more likely than adolescent boys to be affected adversely by depression that accompanies romantic relationships, whereas adolescents of both genders are susceptible to rejection sensitivity and self-silencing, which may be symptoms of depression. Although researchers have considered both genders, there is a dearth of literature on depression and romantic relationships in adolescent boys. I recommend further research on this issue as well as further research on the moderators of depression in adolescent romantic relationships.
Bi-Directional Association between Adolescent Depression and Romantic Relations: Gender Differences and Prevention/ Intervention Strategies

Over the past two decades, adolescent depression has emerged as a prevalent social issue (Kessler & Bromet, 2013). In 2012, over two million adolescents in America, or 9%, had experienced at least one episode of depression in the past year (Substance Abuse Mental Health Services Administration, 2012). Indeed, researchers showed that depressive episodes increased rapidly after puberty (Thapar, Collishaw, Pine, & Thapar, 2012). More recently, Norona, Roberson, and Welsh (2016) cited adolescent depression as a major public health issue that affects both families and the community at large (see also, Goodman, Slap, & Huang, 2003). It is also associated with higher morbidity rates of suicide ideation and increased suicidal risk (Thapar et al., 2012). Its rapid rise indicates the need for continued research on possible predictors of depression in adolescents so as to develop more effective prevention and treatment programs (Norona et al., 2016).

Several researchers have identified factors associated with adolescent depression. Betts, Gullone, and Allen (2009) found that depressive symptomatology is associated with mood and temperament, parenting styles, and emotional regulation. Millings, Buck, Montgomery, Spears, and Stallard (2012) found associations between depression and school, peer attachment, and self-esteem. Other associations include negative life events (Johnson, Whisman, Corley, Hewitt, & Rhee, 2012), genetic vulnerabilities (Hansell et al., 2012), stunted neural development (Lichenstein, Verstynen, & Forbes, 2016), and romantic relationships (Ha et al., 2014).

Romantic relationships have become a focus of research on adolescent depression, including its relation to romantic competence, or the ability to have healthy relationships in emerging adulthood (Sandberg-Thoma & Kamp Dush, 2014). Positive effects of such relationships include increased social support (Frech & Williams, 2007), positive feelings of self-worth (Connolly & Konarski, 1994; Kuttler, Le Greca, & Prinstein, 1999), and fewer health problems (Waite & Gallagher, 2000). Negative effects have been identified as well, such as increased depression (Davila, Steinberg, Kachadourian, & Fincham, 2004; Haydon & Halpern, 2010; Haynie, 2003; Soller, 2014).

Greater understanding of how depression affects romantic
relationships during adolescence and vice versa may enhance the efficacy of interventions (Weissberg, Kumpfer, & Seligman, 2003).

**A Bi-directional Association**

Whether there is a causal direction in the association between adolescent depression and romantic relationships remains in question. Some researchers have examined the correlation between the two phenomena (Chen et al., 2009; Connolly & McIssac, 2011; Little, Welsh, Darling, & Holmes, 2011), and others have examined depression’s adverse effects on healthy romantic relationships (Coyne, 1976; Ha et al., 2012). Others have speculated that adolescents who already are depressed seek romantic relationships as a means of alleviating depressive symptoms (Davila, 2008).

**Depression as an Effect of Romantic Relationships**

Researchers have most recently focused on depression that results from romantic relationships in adolescence. Adolescent girls are more likely to be diagnosed with severe depression and are more prone to interpersonal stress (Haydon & Halpern, 2010; Soller, 2014). After the age of 14, adolescent girls are at a higher risk for negative emotions within romantic relationships, such as insecurity, whereas adolescent boys are at a higher risk for negative behaviors, such as alcohol consumption, which is consistent with the claim that males tend to externalize their emotions and females tend to internalize them (Chen et al., 2009).

Stroud and Davila (2008) identified three developmental patterns in adolescence: early maturing, on-time maturing, and late maturing. With a sample consisting of 83 adolescent girls, the authors examined the association between pubertal onset and depressive symptoms in adolescence. Only girls, in the on-time maturing category, manifested an increase in depressive symptoms. In addition, in the same group, the researchers found a positive association between the number of romantic experiences a girl reported and the severity of depressive symptoms. These findings contrasted with Davila’s (2008) argument that girls who follow normative developmental trajectories are less likely to be diagnosed with depression. However, additional factors, such as the quality of parent-child relationships and neurodevelopmental variables, may play a role.

Inauthentic relationships are another predictor of depression.
in adolescent girls. Soller (2014) reported a study involving 5,316 adolescent girls in which an inauthentic relationship was defined as one in which the girl’s idealized version of romantic relationships deviated from reality. This definition was similar to that in Rogers’s (1959) theory of congruence. Rogers suggested that having an ideal version of the self, perceiving that one’s ideal-self is manifested in one’s self-image, may increase one’s feelings of self-worth. A discrepancy between the ideal-self and one’s self-image was defined as incongruence. Sollar modified Rogers’s theory to focus on divergence between ideal self and actual self-image in romantic relationships. The degree of divergence was directly correlated with reported depression, suicide attempts, and suicide ideation.

In a study conducted in a non-Western culture, Bajoghli, Joshaghani, Mohammedi, Holsboer-Trachsler, and Brand (2011) found that Iranian adolescent girls’ romantic relationships were unrelated to depressive symptoms. Instead, there was a positive correlation between the symptoms of hypomania, or mildly increased elation and physical activity, and romantic relationships, as well as between the length of relationships and the duration of hypomania. The contrasts between these findings and Soller’s suggest that, in adolescent girls, the relationship between romantic relationships and psychopathology is influenced by social norms.

Predictors Affecting Both Genders

Many predictors of depression, such as negative self-esteem, parental distress, sexual relations, self-silencing (inhibited verbal expression with a romantic partner), age, and psychological maltreatment by one’s partner, occur in both genders during adolescence (Chen et al., 2009; Gallaty & Zimmer-Gembeck, 2008; Harper, Dickson, & Welsh, 2006; Ksobiech, Chiao, & Yi, 2014; Norona et al., 2016). In youth with comorbid risk factors, a negative relationship and an emotional cycle may occur. Negative self-esteem and parental distress are initial catalysts of stressful experiences in romantic relationships (Ksobiech et al., 2014). This finding was congruent with Davila’s (2008) stress-and-coping model in which stressors within the romantic relationships of adolescents predict stronger depressive symptoms in those with poorer coping skills.

Rejection sensitivity often goes hand-in-hand with negative self-esteem. Researchers have reported that higher rejection sensitivity in
adolescent boys is associated with higher depression in their female partner. By contrast, higher rejection sensitivity in adolescent girls is associated with increased self-silencing in both themselves and their male partners (Norona et al., 2016). Self-silencing may also lead to an increased likelihood of a sexual relationship (Little et al., 2011), which may increase self-silencing in a negative cycle, which worsens over time (Harper et al. 2006).

Haydon and Halpern (2010) studied age differences in adolescent relationships and found an increased risk of depression when the romantic partner was two or more years older. Specifically, the younger partner was more likely to participate in high-risk behaviors and substance abuse stemming from the older partner’s pressure and thus became more susceptible to depression.

Gallaty and Zimmer-Gembeck (2008) conducted a study of the romantic partners being psychologically abusive. They defined abuse as being belittled, being the recipient of jealous behaviors, undergoing negative societal and emotional control, being abused verbally, and being disrespected. The authors found the abuse of one partner by the other tended to erode friendships outside the partnership, further increasing the symptoms of depression in the abused partner (Gallaty & Zimmer-Gembeck, 2008).

A close (non-romantic) relationship with another person may moderate the association between depression and romantic relationships in adolescence. Such relationships may lessen the emotional dependence on the romantic partner (Chow, Ruhl, & Buhrmester, 2015). Ksobiech et al (2014) found additional moderators of the association, namely, living with both parents and having high family cohesion.

Depression’s Impairment of Healthy Romantic Relationships

Depression can impair healthy romantic relationships in several ways. One is shortening the relationship (Ha et al., 2012; Steinberg & Davila, 2008), thereby reducing romantic competence and the success of future romantic relationships.

Additional impairments take the form of increased negative emotions, decreased romantic and sexual intimacy, lower positive communication, higher isolation, decreased energy and motivation, and higher dependence and uncertainty within romantic relationships. These symptoms lower the quality of romantic relationships (Steinberg et al., 2012).
& Davila, 2008); however, higher emotional intimacy was reported as a positive outcome of depression (Knobloch, Sharabi, Delaney, & Suranne, 2016).

Bi-directional associations between romantic relationships and depression in adolescence may have lasting impact on subsequent romantic relationships. Sandberg-Thoma & Kamp Dush (2014) found that adolescents engaged in romantic relations and diagnosed with depression are more likely to cohabit and less likely to marry. Depression then may become a barrier for the continued development of relationships. Moreover, Vujeva and Furman (2011) found that the quality of the romantic relationships in emerging adulthood was lower for those who were diagnosed with depression in adolescent romantic relationships.

Prevention and Treatment

Gallaty and Zimmer-Gembeck (2008) and Haydon and Halpern (2010) emphasized the need for research that focuses on the prevention of mental disorders within adolescent romantic relationships. Current prevention programs are focused on teaching sexual-safety strategies, such as abstinence, the use of contraceptives, and sexually transmitted disease (STD) prevention, as well as potential risks. (Byers, O’Sullivan, & Brotto, 2016; Fantasia & Fontenot, 2011; Widman, Golin, Noar, Massey, & Prinstein, 2016). While these provide many benefits, they are inadequate in helping youth have the knowledge and skills to prevent the development of major depression. Other programs, such as interpersonal psychotherapy, mindfulness-based intervention, and cognitive restructuring provide treatment for depression.

Interpersonal psychotherapy can be highly beneficial (Young, Kranzler, Gallop, & Mufson, 2012) when focused on romantic competence in adolescence. Parental training on the attachment process and parent-child interpersonal skills training may also be helpful (Anderson, Salk, & Hyde, 2015). Group therapy and behavioral activation (i.e. introduction of new behaviors) in romantic experiences are additional treatment approaches (Nault-Brière, Rohde, Stice, & Morizot, 2016; Petts, Foster, Douleh, & Gaynor, 2016).

Mindfulness-based intervention is intended to help people identify and accept their thoughts and emotions in positive ways. It may enhance positive emotional regulation, which is the ability to respond
to emotions with socially acceptable and healthy behaviors and to delay responses as needed, thereby countering depression (Kendell et al., 2014; Teper et al., 2013).

Cognitive restructuring is a therapeutic technique in which emotions and thoughts perceived as threats are restructured as challenges to be overcome (Teper et al., 2013). One effect of such restructuring is the reduction of affective polarization (i.e., the experiencing of emotions only in the extreme; Kendell et al., 2014).

**Conclusion**

In this review, I considered the bi-directional association of adolescent depression and romantic relationships, predictors of depression in these relationships, and treatment and prevention programs for depression that are available. Much of the research has involved adolescent girls, who have a high probability of depression in their romantic relationships, starting at age 14 (Haydon & Halpern, 2010). They are also more likely to be vulnerable to interpersonal stressors and to have specific scripts for ideal romantic relationships (Soller, 2014).

An important but understudied area of research is the association between depression in adolescent boys and romantic relationships. Researchers have shown that depression in adolescent boys increases the likelihood of negative behavioral effects within their relationships, including romantic relationships (Haydon & Halpern, 2010).

While it was also found that the presence of depression impairs healthy relationships in many ways, higher emotional intimacy was reported as a positive side effect within a relationship. This indicates a need for further study clarifying this finding (Knobloch, Sharabi, Delaney, & Suranne, 2016). Additionally, depression in adolescents may be a significant indicator of the likelihood of cohabitation later in life (Sandberg-Thoma & Kamp Dush, 2014).

Most of the studies I have cited had small sample sizes and qualitative research. A wide variety of constructs were employed, resulting in a range of definitions. Only a few studies of non-Western adolescents were available. Although their findings may not generalize to adolescents in the US, cultural differences in the development of adolescent psychopathology within romantic relationships are important in providing a larger context.
Current programs provide important knowledge on sexual safety in relationships but are insufficient in teaching emotional safety. There are programs and resources which teach relationship skills as well as many treatment and prevention programs for depression. These are helpful when focused on relationship competency and emotional regulation. Making these, as well as parental training programs, readily available to adolescents would be highly beneficial in reducing the prevalence of depression in adolescent romantic relationships.

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Chronic Pain: Understanding Its Effects on the Spouse

Summer B. Frandsen
Brigham Young University

Abstract

This literature review focuses on how the partner of an individual with chronic pain is affected by that pain. Results from the studies examined have been divided into four different categories of potential effects: household, physical, mental/emotional, and marital. The household consequences include items such as finances and role reversals for household tasks (West, Usher et al., 2012). The physical consequences consist of symptoms such as varying pains and lack of sleep (Martire et al., 2013; Turk et al., 1987). The primary mental/emotional consequence of having a spouse with chronic pain is distress, which can lead to issues such as depression (Ahern et al., 1985; Schwartz et al., 1991). Marital effects include decreased sexual relations and decreased marital satisfaction (Strunin & Boden, 2004). Despite many possible negative effects, the literature indicates that while some spouses struggle with the onset of chronic pain in their partner, many succeed or even thrive (West, Buettner et al., 2012). Spouses may be able to better cope or thrive despite their partner’s chronic pain when they receive support from their partner and from outside sources like psychologists (Subramanian, 1991). Additionally, it is important that spouses are included in creating a plan on how to handle the pain and how to handle the life changes it will bring (Leonard & Cano, 2006). Further research is needed to gain greater insight into what helps patients’ spouses to overcome the challenge of chronic pain in order to help these spouses live satisfying lives despite their partners’ chronic pain.

Keywords: chronic pain; spouse; partner; effects; literature review; thrive
Chronic Pain: Understanding its Effects on the Spouse

Chronic illness is a condition frequently heard of and experienced in the world today. Some common examples include cancer, heart diseases, diabetes, and multiple sclerosis—many of which are life-changing and debilitating. People are very aware of some of these maladies, perhaps because of their outward physical markers, their mortality rates, or the level of media awareness surrounding them. For example, cancer’s prominence in public discussion is demonstrated by recent blockbusters such as “The Fault in Our Stars,” “My Sister’s Keeper,” and “A Little Bit of Heaven,” all of which have focused on the trauma and heartbreak of cancer. The addition of cancer awareness programs has made the disease well-known and widely discussed. However, there are some chronic conditions that remain poorly understood, even though they are prevalent and affect much of the world’s population.

One such ailment is chronic pain. Although people with chronic pain may look healthy on the outside and the threat of death may not be imminent, they are constantly, or at least frequently, in pain (American Chronic Pain Association, 2017). The intensity and range of the pain can vary. It could be widespread pain, such as that found in Fibromyalgia or rheumatoid arthritis patients, or more concentrated pain caused by a phantom limb, back pain, or pelvic pain. (American Chronic Pain Association; Korff, Ormel, Keefe, & Dworkin, 1992).

Research has shown that the constant presence of such pain affects multiple facets of patients’ lives (Flor, Turk, & Scholz, 1987; Subramanian, 1991). Some common results include difficulty sleeping; inability to exercise, perform household chores, participate in recreational activities, or to be employed (which can lead to financial difficulties); depression; and loss of social interaction, including that of close friends and family (Breivik, Collett, Ventafridda, Cohen, & Gallacher, 2006). Although this list is extensive, it only partially covers the extent to which pain alters the world of a person who suffers with it on a chronic basis.

Although many previous studies have focused on the impact of pain on the individual, researchers have now begun to recognize that the struggles of individuals with chronic pain affect members of the family. Multiple studies have focused on understanding the effect that a familial relationship can have on the patient, including how family
interactions positively or negatively impact the patient and their struggle with daily pain (Leonard, Cano, & Johansen, 2006).

It is apparent from studies that the family plays an integral role in how a patient handles their disability. Conversely, it seems logical that the patient’s state would also have a substantial influence on the life of their family. This influence would seem especially potent considering how life altering the onset of chronic pain can be. As researchers have studied the impact chronic pain has on the family unit, it has been shown that a chronic pain patient’s family is deeply affected by the onset of pain in a family member (Kemler & Furnee, 2002).

While having a family member with chronic pain often affects the entire family, this review will specifically cover the literature concerning the wide range of effects that chronic pain can have on the spouse of a person who suffers from chronic pain. The effects discussed can be separated into four categories: household, physical, mental-emotional, and marital. Although many of the studies have found primarily detrimental outcomes of chronic pain on spouses, there has also been quite a bit of insight and research showing that some couples thrive in the face of chronic pain. These studies will be discussed in light of understanding how to help the spouses (and in relation, the patient) to deal with the challenge of chronic pain.

**Effects on the Spouse**

**Household Effects**

Of the four categories of effects that this literature review will cover, household effects are perhaps the easiest to identify because these can be easily measured: filling more roles in the family, finances, and the time spent performing certain activities. Two specific studies showed evidence of “role reversal,” or the taking on of extra roles.

The first study surveyed 50 White adults from the Netherlands who were dealing with chronic refractory complex regional pain syndrome (CRPS) (Kemler & Furnee, 2002). Seven of the participants were single and were analyzed separately. Spouses of people diagnosed with CRPS also completed surveys. Researchers found that because people with CRPS are often unable to perform household chores efficiently, their spouses had to put in more hours to complete the unfinished tasks.

In the second study, West, Usher, Foster, and Stewart (2012)
interviewed nine spouses of persons diagnosed with chronic pain in an effort to better understand the experience of chronic pain for the spouse. One of the significant changes that participants listed was revising roles. The study quoted three spouses who directly addressed this situation; one discussed how he had to take on the daily household duties such as changing beds and doing the washing in addition to working outside the home, and another mentioned how the onset of pain in her partner forced her to go to work. Other research has found similar results (Strunin & Boden, 2004).

Both studies also found that finances became a burden, due to medical bills and lack of employment of the individual with chronic pain and in some cases, the spouse. West, Usher et al. (2012) found that there was a wide range of financial difficulties, including one spouse who recalled that because her partner with chronic pain was unable to work, they had to close their business and sell their house, as they could no longer support themselves. The study by Kemler and Furnee (2002) researched this issue through a cost diary, and reported household income before and after CRPS. Both male and female pain patients saw a significant decrease in the ability to work, in many cases resulting in complete unemployment. For example, among the 13 men who participated in the study, only one continued to work—similar results were found among the 30 female patients. Despite some spouses becoming employed for the first time or taking on extra work, the household income decreased by approximately $2,000 to $4,000 a year ($26,200 to $22,000; $25,500 to $22,500, respectively) due to the unemployment of the partner with pain. Moreover, it is important to note that in the Netherlands, those with disabilities are given 70% of their last salary every year until able to work again. Such a significant decrease in income, even with the provided financial assistance, shows that in countries without such benefits, the decrease in income could be much steeper. On top of this, the mean “out-of-pocket expenses” paid by households with CRPS was $1,350 per year. Experiencing both a decrease in income and an increase in amount spent on medical expenses can create extremely difficult financial situations for the family, which has a direct effect on the spouse.

Another household effect on spouses was the change in how they spent their time. Researchers found that spouses of CRPS patients versus control spouses, spent significantly more time on housekeeping
and household maintenance, while showing significantly less time spent on personal needs and leisure activities (Kemler & Furnee, 2002).

From the findings of role reversal, decreased income, increased financial burdens, and different time allotments, it is easy to see how chronic pain directly affects the spouses and their day-to-day lives. They find themselves in situations that are different from the way they are used to living and are faced with figuring out how to handle their changed lives.

**Physical Effects**

In addition to household effects, spouses have also been found to experience detrimental physical effects from the pain in their partner’s life. Rowat and Knafl (1985) found in interviews with 40 spouses of individuals with chronic pain that 23% described physical complaints such as problems with sleep, appetite, headaches, and blood pressure. Martire, Keefe, Schulz, Stephens, and Mogle (2013) studied sleep disturbances experienced by the spouse through interviews and written logs of daily sleep patterns in 138 couples in which at least one individual was dealing with knee osteoarthritis. The study showed that when the partners were in more pain, the spouses tended to report lower quality of sleep; this was especially true for the couples that had a closer relationship. However, sleep is only one of the ways in which spouses can be physically affected.

In a literature review compiled by Turk, Flor, and Rudy (1987), several studies are described which show that the spouses of those with chronic pain are much more likely to experience actual physical pain. One such study by Block (as cited in Turk et al., 1987) demonstrated an increase in a spouse’s heart rate and skin conductance when watching their partner in pain. Flor, Turk and Scholz (1987) studied this phenomenon further by conducting evaluations with 58 males with chronic pain and their spouses. They contrasted their results with those of patients with diabetes and found spouses of people with chronic pain rated a significantly higher amount of pain symptoms than the spouses of patients diagnosed with diabetes. However, the spouses of people with chronic pain did not experience more physical symptoms (e.g. fatigue, nausea). They also found a correlation between spouses’ depressed moods and their pain symptoms, but it only explained 25.7% of the variance. Surprisingly, the intensity of the pain experienced by the partner...
was not significantly correlated with that of the spouse. This may be because it is more important how the spouse copes with and reacts to the chronic pain in their home than the actual level of pain their partner experiences.

An important item addressed in these studies is the correlation between depression or distress and physical maladies. As will be found throughout, the four different categories of effects are interrelated and affect one another, together creating the total experience of the spouse. Why disturbed sleep and pain are correlated with depression is an interesting question. Are the physical aspects caused by depression, is the depression caused by the physical aspects, or are both a part of the experience? This opens up a lot of opportunity for further questions and studies. Nevertheless, it is clear that chronic pain creates physical problems for the significant other.

**Mental/Emotional Effects**

Considering all that the spouse is experiencing as his or her partner endures chronic pain, it is not hard to recognize that these experiences may also instigate many moods and emotions within the spouse. Rowat and Knafl (1985) found that of the 123 spouses they interviewed, 69% noted an emotional impact such as fear, nervousness, irritability, sadness, and uncertainty. West, Usher et al. (2012) and Schwartz and Slater (1991) report similar findings. These emotions combine to form the overall feeling of distress in the spouse.

Of the studies that have examined the overall distress of the spouse, some have sought to understand what creates this feeling. Geisser, Cano, and Leonard (2005) found that female spouses were more likely to have affective distress. They also found that the higher spouses perceived the physical disability of their partner in pain and the lower their ratings of marital satisfaction, the greater distress the spouse felt. In comparing low and high distress spouses, Rowat and Knafl (1985) found similar findings as Geisser et al. (2005), adding that in their study, 50% of spouses rated their partner’s pain higher than their partner did, in some cases quite significantly.

One important aspect of this distress is the prevalence of depression among spouses of individuals with chronic pain. Many researchers have found a higher number of spouses with depression than typical for a normal sample (Ahern, Adams, & Follick, 1985; Flor, Turk, & Scholz, 1987; Schwartz, Slater, Birchler, & Atkinson, 1991;
Turk et al., 1987). In studying what might help to predict depression in this population, Flor, Turk, and Scholz (1987) found it did not seem to be related to the actual intensity of the pain, but rather to how the partner with chronic pain handled the situation. It was also related to the amount of control the spouse felt he or she had over their life and their satisfaction with the marital relationship. This was also seen in the study by Schwartz et al. (1991). Alternately, Leonard and Cano (2006) conducted a survey of 139 couples with at least one individual experiencing chronic musculoskeletal pain. They found patients’ severity of pain was significantly related to spousal depression. However, it is important to note that of the couples studied, multiple couples reported significant chronic pain in both partners. This is an interesting aspect that might confound the findings of the study, for if the spouse is also in significant chronic pain, they would be more statistically likely to be depressed (Fishbain, Cutler, Rosomoff, & Rosomoff, 1997; Goesling, Clauw, & Hassett, 2013). This could also explain Leonard and Cano’s (2006) finding that when spouses had personal experiences with chronic pain, they were more likely to be depressed. It could very possibly be related to their own pain, rather than their partners’ pain.

These studies show that there are significant emotional and psychological effects associated with chronic pain. However, while some spouses were negatively affected, there are still many that fell into the low distress category, showing that it is possible to have a partner with chronic pain and still be a successful and happy individual.

**Marital and Partner Relationship Effects**

As might be expected, when one or both partners are in constant pain, the couple’s marital relationship is affected (Strunin & Boden, 2004; Subramanian, 1991). Researchers found that one of the most common changes occurs in sexual intercourse. For example, at least 50% of 20 chronic pain patients and their spouses surveyed in a study by Subramanian (1991) reported that their sexual relations had decreased significantly (moderately to severely). Multiple other studies have discovered similar findings, showing that a significant proportion of spouses with chronic pain partners feel that their sexual relations have either been completely discontinued, decreased, or diminished in satisfaction (Flor, Turk, & Scholz, 1987; Schwartz &
Slater, 1991; Strunin & Boden, 2004; Turk et al., 1987; West, Usher et al., 2012). Additionally, multiple studies showed a change in the actual marital relationship and the satisfaction with the relationship (Flor, Turk, & Scholz, 1987; Strunin & Boden, 2004; Turk et al., 1987; West, Usher et al., 2012). West, Usher et al. (2012) summarized that participants “described quite marked changes in the relationships they had now with their partners and significant others when compared with the relationship they had prior to the onset of pain” (p. 3356). In many cases these changes are negative and there is a decrease in relationship satisfaction (Flor, Turk, & Scholz, 1987; Schwartz & Slater, 1991; Strunin & Boden, 2004).

However, in some studies it is clear from the widely varying ratings of marital satisfaction that not all couples that struggle with chronic pain necessarily develop worse or less-satisfactory relationships (Geisser et al., 2005; Polenick, Martire, Hemphill, & Stephens, 2015; Turk et al., 1987). Therefore, scholars have examined what might predict or lead to a decline in the marital relationship (Ahern et al., 1985; Flor, Turk, & Scholz, 1987; Geisser et al., 2005). Flor, Turk, and Scholz (1987) found that the factors that seemed to be the best predictors of a spouse’s satisfaction with their relationship were their own mood and their partner’s satisfaction with the relationship. Combined, these two variables explained 45% of the variance between participants’ outcomes (see also Akbari & Dehghani, 2017).

Several years later, Geisser et al. (2005) performed a study in which 110 couples affected by chronic pain were surveyed in order to further understand factors pertaining to spouses’ moods and marital satisfaction. Some of the clearest associations they found were related to perceived disability, both psychosocial and physical. The greater the perceived difference between the patient and their spouse as to the level of physical disability experienced by the person with chronic pain, the greater the marital dissatisfaction. This seemed to be particularly true when the spouse saw the physical disability of their partner as being greater than the partner did (see also Rowat & Knofl, 1985). Researchers also found that lower marital satisfaction was correlated with higher ratings of physical disability by the spouse, as well as higher perceived levels of psychosocial disability by both the partner with chronic pain and their spouse (see also Cano, Miller,
& Loree, 2009). Interestingly, it was also found that higher reported pain by the patient was related to greater spousal marital satisfaction. Another study found the same result and provided a theory as to why greater pain could lead to a better relationship. They posited that greater pain would lead to more time spent with the partner, which would improve the relationship (Bermas, Tucker, Winkelman, & Katz, 2000).

An important point to note about the effects on the spousal relationship is that while there are obvious downsides that affect a wide majority of partners dealing with chronic pain and their spouses (such as decreased sexual relations), not all couples experience a negative marital relationship (Bermas et al., 2000). This will be discussed further in the next section in order to better understand how to help spouses of those with chronic pain overcome the negative aspects of chronic pain.

How to Help Spouses Thrive

As has been demonstrated through this review, many detrimental consequences of chronic pain affect not only the person dealing with the pain, but also the spouse. There may be some aspects that cannot be avoided, such as pain, finances, role reversal, and the decrease of sexual relations; however, it has been shown that some aspects, such as spousal distress, depression, and satisfaction in the marital relationship are dependent on the situation and couple. For example, Subramanian (1991) revealed that spouses’ scores on the Psychosocial Adjustment to Illness Scale (PAIS) were widely distributed, ranging from 6 to 88 (M=47.15, SD=20.9). This shows that there is a wide variety in spouses’ reactions and in how they handle their situations.

Perhaps one of the most hopeful studies was conducted by West, Buettner, Stewart, Foster, and Usher (2012) who studied the resilience in 31 families dealing with chronic pain. The authors described individual resilience as a way of handling adversity which leads to an individual becoming stronger and having a greater ability to deal with future adversity. Building off of that, familial resiliency is a family’s way of managing adversity which helps them to cope with the crisis and leads to the family becoming more resourceful and a stronger unit. Although the study was conducted on families, the authors stated that the majority of families consisted of merely the
partner with chronic pain and his or her spouse. In addition, one of
the main qualitative parts of the study took information from only
10 families, all of which were only couples. Some important findings
from this study showed that families dealing with chronic pain tended
to be more resilient than the average family. However, even within
this sample of families with chronic pain, there were varying levels
of resiliency. Researchers found that those who were more resilient
tended to be more positive about their family member’s pain and to
handle challenges in different ways. In addition, pain had less of an
impact on families with higher resiliency. This shows that by helping
spouses and couples to become more resilient, they might be able to
have greater life satisfaction and to have a better experience as they
deal with their pain. Furthermore, the 10 couples interviewed stated
unanimously that an important part of staying strong throughout the
chronic pain experience was “commitment from and cohesion with a
partner or soul mate” (p. 3536). Multiple studies also mentioned the
importance of support from the partner (Subramanian 1991; Turk et
al., 1987). From these findings, strengthening the couple’s relationship
would seem to create a better environment for them to thrive.

The idea of resilience suggests that there is a way for couples to
deal with trials and the problem of chronic pain in a healthy way that
leads to better outcomes. This idea is strengthened through studies
which show that using the coping mechanism of catastrophizing—
an exaggerated negative orientation towards the pain which is then
communicated to others—makes spouses more likely to experience
psychological distress and depressive symptoms (Akbari & Dehghani,
2017; Prenevost & Reme, 2017). Studies have also shown that when the
spouse recalled a time when they had helped their partner in pain they
felt less distress and that chronic pain couples who used more humor
tended to have greater marital satisfaction (Monin, Xu, Mitchell,
Buurman, & Riffin, 2017; Johanson & Cano, 2007). These findings
demonstrate that there do seem to be certain ways which can either
mitigate or increase the negative effects of chronic pain. If healthy
coping mechanisms are taught as a replacement for negative coping
mechanisms, it might help couples to become more resilient.

In addition to the suggestion of strengthening couples’
relationships and helping them become more resilient, researchers also
recommend that spouses receive outside support. In the discussions of
a large majority of studies, advice or hypotheses were given regarding the importance of supporting the spouse and involving them in the process of creating a treatment plan for dealing with the pain. This would mean both the partner with chronic pain and the spouse receiving outside help, rather than only focusing on the partner with chronic pain receiving outside support (Ahern et al., 1985; Flor, Turk, & Rudy, 1987; Leonard & Cano, 2006; Rowat & Knafl, 1985; West, Usher et al., 2012; West, Buettner et al., 2012). Subramanian (1991) noted that those spouses who received support from sources such as social workers, psychologists, or psychiatrists rated the amount and quality of support they had received as being much more helpful than other types of support (e.g. extended family, neighbors). However, only 20-25% of spouses from the study had reached out to these sources, demonstrating that spouses rarely tend to turn to these sources. If the practice of spouses of people with chronic pain turning to therapists for outside assistance could be normalized, the lives of these spouses could improve.

One last important idea that has been mentioned by most studies is the importance of integrating the spouse in the process of dealing with the pain (Flor, Turk, & Rudy, 1987; Schwartz et al., 1991; Swift, Reed, & Hocking, 2014; West, Usher et al., 2012; West, Buettner et al., 2012). Miller-Matero & Cano (2015) conducted a study in which they had chronic pain couples sit through a couples’ therapy session which included a motivational assessment and motivational interview. Compared to the control group, the therapy group had significantly higher outcomes including improved marital satisfaction and positive mood, and decreased negative mood and personal distress. In the case example given, following the therapy session the spouse of the individual with chronic pain rated their marital satisfaction 2 points higher, their positive mood 24 points higher, their negative mood 4 points lower and their personal distress 18 points lower. A single therapy session in which the couple worked through the issue of the chronic pain was found to be extremely beneficial to the spouse (see also Miller, Cano, & Wurm, 2013). Chronic pain has such far-reaching effects in the lives of everyone around it that it is important that there is information and help for the spouses. Through this, they can have better feelings of control and support in their situations.
Conclusion

Spouses of those dealing with chronic pain are clearly highly affected by the onset of pain in their partner. They are affected in multiple aspects of their lives, all of which typically interact with one another. These effects include household problems, physical problems, mental/emotional problems, and marital problems. The literature reviewed shows that spouses frequently have to deal with financial concerns, role reversals, changes in lifestyle, and alterations in how they spend their time (Kemler & Furnee, 2002; West, Usher et al., 2012). Additionally, spouses of people with chronic pain may experience increased pain themselves and deal with other physical maladies such as lack of sleep (Martire et al., 2013; Turk et al., 1987). Findings also show that an element of distress affects the spouse, which can ultimately lead to conditions such as depression (Ahern et al., 1985; Rowat & Knafl, 1985; Schwartz et al., 1991). Finally, chronic pain affects marital relationships, causing many spouses to report decreased sexual relations and, in some cases, decreased marital satisfaction (Strunin & Boden, 2004; Subramanian, 1991; West, Usher et al., 2012).

With such a life-altering experience, it is important that support and guidance be provided not only to the partners with chronic pain, but to their spouses’ as well. Support can be provided for spouses by increasing the normalcy of using therapists as they deal with the chronic pain of their mates. It would also be beneficial to strengthen the relationship of the couple and create a treatment plan, not just for the person afflicted by chronic pain, but also for the couple as a unit. As these aspects are provided and as spouses and couples become more resilient, or rather, more able to handle the adversity of chronic pain in a healthy way, the couples may thrive and overcome some of the negative aspects of living with chronic pain.

It is apparent that further research is needed, because the literature is severely lacking in many areas. One such area is the effect of chronic pain on young married adults, since much of the literature focuses on the experiences of older couples. Additionally, further studies are needed to better understand what helps some couples to thrive. This could include topics such as resiliency, coping mechanisms, increasing marital satisfaction, and reports on the various types of therapies, treatments, and support extended to the couple as a whole rather than...
only the person with chronic pain or only the spouse. The more that is understood about how families and spouses are affected by chronic pain, the more help can be offered to them to find greater overall life satisfaction.

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Treating Neuropathic Pain: Mindfulness Meditation Is More Effective Than Pharmacotherapy

Jayden Goodwin  
*Brigham Young University*

Abstract

Neuropathic pain is severe chronic pain with no single source and, for that reason, is difficult to treat. I review two treatments for neuropathic pain: pharmacotherapy and mindfulness meditation. In pharmacotherapy, psychotropic drugs are the main form of treatment. Although it is currently the treatment of choice, relying solely on drugs can result in unwanted side effects, including drug tolerance. Mindfulness meditation, a therapy designed to help the patient achieve self-understanding and self-regulation, avoids these effects. For these reasons, mindfulness meditation should be recommended as an alternative to psychotropic drugs when treating neuropathic pain.
Treating Neuropathic Pain: Mindfulness Meditation Is More Effective Than Pharmacotherapy

Physical pain can be viewed as warning the body of tissue damage and helping it avoid further harm until the damaged tissue is repaired. When stimuli cross the threshold of nociceptor primary sensory neurons (PSNs), pain is elicited (Woolf & Mannion, 1999). These neurons have receptive fields throughout the surface of the body and eventually synapse in the dorsal horn of the spinal cord (Hogan, 2010).

Neuropathic pain (also known as chronic pain) is the result of damaged PSNs. Damage can occur in the peripheral or central nervous system and results in spontaneous pain, pain hypersensitivity, or both (Woolf & Mannion, 1999). The complexity of neuropathic pain is increased by the large number of causes, including infection, trauma, metabolic abnormality, chemotherapy, surgery, irradiation, neurotoxins, inherited neurodegeneration, nerve compression, inflammation, and tumor infiltration (Dworkin et al., 2003). The multiplicity of origins and manifestations of neuropathic pain make it difficult to treat and, thus far, impossible to cure.

Chronic pain is not only physically limiting but produces severe psychological repercussions as well. Gore, Brandenburg, Hoffman, Tai, and Stacey (2006) surveyed 265 patients with neuropathic pain and found that patients not only reported substantial, daily pain but also increased anxiety, depression, sleep disturbance, and impaired quality of life because of the unrelieved pain. This chronic pain compromises all aspects of the lives of those affected and the lives of their significant others (Turk, Wilson, & Cahana, 2011).

The pharmacotherapeutic treatments for neuropathic pain have limited effectiveness and usually result in a host of unwanted side effects (Dworkin et al., 2003). Mindfulness meditation, an inexpensive, nondrug treatment, has been shown to relieve the symptoms of chronic pain without harmful side effects (Kabat-Zinn, Lipworth, & Burney, 1985). It also effectively mitigates the psychological consequences of neuropathic pain (Pepping, Walters, Davis, & O’Donovan, 2016). Because of these benefits, mindfulness meditation should be considered a viable alternative to pharmacotherapy.

Limitations of Pharmacotherapy

Currently accepted medical alternatives to pharmacotherapy
include surgery, neuro-augmentation, somatic, behavioral, and rehabilitative treatments, though the effectiveness of these methods remains inconsistent (Turk et al., 2011). If a particular medication is ineffective in treating neuropathic pain, rather than turning to alternative forms of treatment, the currently accepted approach is to continue prescribing medication until an effective one is found (Dworkin et al., 2003; Moulin et al., 2007). One problem with this approach is the adverse side effects of this medication. Another that will be considered is the diminished effect of drugs with continued use (drug tolerance).

**Side Effects of Medication**

Adverse side effects associated with analgesic drugs include dizziness, gastrointestinal problems, inflammation, skin reactions, constipation, sedation, and nausea (Dworkin et al., 2003). These effects may be exacerbated when multiple medications are prescribed, especially since the average number of medications taken each week to manage chronic pain is 3.8 (Gore et al., 2006). These medications include opioids, anti-inflammatory drugs, antidepressants, anticonvulsants, skeletal muscle relaxants, and topical agents (Turk et al., 2011). Treating the many symptoms of neuropathic pain with multiple prescriptions is costly, inefficient, and invites a host of unwelcomed side effects.

**Poor and Diminishing Effect of Analgesics**

Another limitation is the growing ineffectiveness of drugs. Because neuropathic pain is chronic, it outlasts the interval in which drugs may be effective (Dworkin et al., 2003). Moreover, to restore effectiveness, larger dosages are required, thereby intensifying the side effects (Trang et al., 2015). Kingery (1997) reviewed 92 drug trials for 48 different medications for neuropathic pain and concluded that none produced more than minimal long-term effectiveness.

**Benefits of Mindfulness Meditation**

A preferable alternative to pharmacotherapy is mindfulness meditation, the “intentional self-regulation of attention to present moment experience, coupled with a non-judgmental and accepting stance toward whatever may arise” (Pepping et al., 2016, p. 1). Mindfulness meditation differs from traditional pain-reduction
Neuropathic Pain

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https://scholarsarchive.byu.edu/intuition/vol12/iss2/16

Page 79 of 80

Treatments in its primary goals of self-regulation, self-liberation, and self-exploration, all of which conduce to self-understanding (Shapiro, 1992). The use of mindfulness meditation may not only reduce pain but also prevent pain from interfering with daily life.

Mindfulness meditation is most commonly practiced through mindfulness-based stress reduction (MBSR), an 8–10 week program that includes mindful scanning of one’s body, sitting and walking forms of meditation, and basic yoga (Shigaki, Glass, & Schopp, 2006). The MBSR coach encourages patients to be increasingly mindful of everyday activities (to be “aware of the moment”) and to practice meditation between sessions (Kabat-Zinn, 1990).

A Holistic Approach

Mindfulness meditation provides a focus on the psychological problems associated with neuropathic pain as well as relief from the pain itself (Kabat-Zinn et al., 1985; Pepping et al., 2016). When Kabat-Zinn et al. (1985) analyzed the effectiveness of mindfulness meditation in 90 chronic pain patients enrolled in a 10-week stress reduction and relaxation program, they found significant reductions in present-moment pain, negative body image, pain-induced inhibition of activity, mood disturbance, and psychological symptoms. More recently, Pepping and colleagues (2016) reported that, of 190 participants whom they interviewed, the primary reason given for commencing and continuing mindfulness meditation was to alleviate emotional stress and enhance emotional regulation.

Effectiveness

Not only is mindfulness meditation as effective in treating neuropathic pain as traditional psychopharmacological treatments, but is, in some cases, more effective than comparable psychological treatments such as cognitive behavior therapy (CBT). This is especially noticeable in terms of effect size, a standardized measure of differences between treatment groups (Cohen, 1977). Veehof, Trompetter, Bohlmeijer, and Schreurs (2016) conducted a meta-analysis consisting of 27 studies to determine the effectiveness of acceptance and mindfulness-based interventions in treating chronic pain. They found significant effect sizes for therapies designed to reduce pain interference (of daily tasks) and for therapies designed to reduce pain intensity. By contrast a meta-analysis of the effectiveness
of CBT for chronic-pain performed by Williams, Eccleston, and Morley (2012) resulted in small effect sizes for pain intensity, pain-inference, and mood. Because this treatment treats both the interference and the intensity of pain, research supports that mindfulness meditation may be more effective in treating neuropathic pain than traditional treatments such as CBT and pharmacotherapy.

A more direct comparison of mindfulness meditation to pharmacotherapy can be seen in Kabat-Zinn and colleagues’ (1985) study. They compared the outcomes in 90 chronic-pain patients who were treated with mindfulness meditation with those in a comparable group of patients who were treated with physical therapy, analgesics, and antidepressants. In a 10-week follow-up, those in the former group reported significant reductions in anxiety (65%), depression (59%), hostility (57%), somatization (physical symptoms without a known cause; 30%), and lack of self-esteem (45%), while those in the latter group reported smaller reductions in the same measures (29%, 18%, 7%, 0%, and 34%, respectively). Mindfulness meditation therefore shows significant promise in treating neuropathic pain more effectively than pharmacotherapy does.

**Cultural Preference for Pharmacotherapy**

Despite the demonstrated effectiveness of mindfulness meditation, pharmacotherapy is still the most common treatment for neuropathic pain (Dworkin et al., 2003). There are a number of reasons why this is the case, many of which may be due to patient preferences. Patients are more familiar with taking medication than they are with practicing mindfulness meditation. This is likely because meditation is not a common part of American culture and is usually associated with East Asian cultures (Kabat-Zinn et al., 1985). Conserving time and energy are also concerns; it is arguably much quicker and easier to take a pill than to spend 45 min meditating every day (Kabat-Zinn et al., 1985). The lack of physicians trained in mindfulness meditation is another notable reason for a preference for pharmacotherapy (Baer, 2003). These preferences indicate that, although scientific evidence supports mindfulness meditation as a practical alternative, custom and social preference still holds significant sway in favor of pharmacotherapy as the treatment of choice for neuropathic pain.
Conclusion

Mindfulness meditation is a form of treatment for neuropathic pain that is focused on helping the patient accept the existence of the pain while also limiting the pain’s interference with the patient’s overall well-being (Kabat-Zinn et al., 1985). The evidence I have reviewed supports mindfulness meditation as an acceptable, and sometimes preferable, alternative to pharmacotherapy (Kabat-Zinn et al., 1985; Veehof et al., 2016). The latter usually results in multiple prescriptions that cause serious side effects and have diminished effectiveness over time (Kingery, 1997; Trang et al., 2015). Mindfulness meditation, however, is a more holistic approach, one that addresses the psychological effects of neuropathic pain on the quality of life (Pepping et al., 2016). Those who suffer from neuropathic pain should be aware of both forms of treatments and their comparative benefits and liabilities so that they can choose the best approach to not only relieve their pain but also reduce its interference in living healthy, meaningful lives.

References


Teacher Expectations and the Black-White Scholastic Achievement Gap

Jacob Johnston
Brigham Young University

Abstract

Decades after the desegregation of schools, a Black-White achievement gap remains in the American school system. Researchers have given many possible explanations, including socioeconomic factors and teachers’ expectations of their students. In this paper, I summarize some of the literature on racial prejudice in teacher expectations and its impact on students’ academic and personal lives. I also analyze the role of stereotypes and other factors in teacher expectations and the communication of explicit and implicit expectations through teaching practices and nonverbal behavior. Finally, I discuss the use of teacher workshops as a possible means for narrowing the ethnic achievement gap.

Keywords: teacher expectations; academic achievement; African American students; self-fulfilling prophecy; ethnic achievement gap
Teacher Expectations and the Black-White Scholastic Achievement Gap

After the historic case of Brown v. The Topeka Board of Education (1954), the desegregation of schools led to a more equal distribution of financial and other resources, and the academic achievement gap between Blacks (African Americans) and Whites (Caucasians) began to narrow. This trend continued until the 1990s, when the gap began to widen again (American Psychological Association, 2012; Lee, 2002). Data from the 2012 Program for International Student Assessment (PISA) showed that African Americans scored an average of 8.33% lower than Caucasians in the basic subjects of reading, mathematics, and science. The most common explanation for these results involves students’ socioeconomic status (SES) and how it affects lifestyles and access to resources. However, though SES is a contributing factor in student achievement, there are others (Lee, 2002; Steele, 1997). Differences in scholastic achievement exist even when African-American and Caucasian students come from similar socioeconomic backgrounds (Rubie-Davies, Hattie, & Hamilton, 2006; Steele, 1997). Fryer and Levitt (2004) pointed out that children in both ethnic categories enter kindergarten with similar cognitive capabilities, but, within two years of schooling, a gap appears in their test scores on standardized achievement tests. This phenomenon suggests that in-school factors need to be examined in order to explain the achievement gap.

In 1968, Rosenthal and Jacobson published a now-famous study titled “Pygmalion in the Classroom.” In this study, the authors told teachers before the school year began that certain students were expected to experience a year of substantial intellectual growth compared to the other students. At the end of the study, the researchers found these students were, in fact, performing significantly better than their peers were. Given that the students had been selected randomly at the outset, the only difference that existed between these students and the others is that the teachers believed they would perform better. Rosenthal and Jacobson (1968) called the effect a self-fulfilling prophecy, a term that Merton (1948) had coined 20 years earlier and defined as “a false definition of the situation evoking a new behavior which makes the originally false conception come true” (p. 195). The school-based finding, now known as the Pygmalion effect,
was quickly replicated in dozens of other studies (see Raudenbush, 1984). Babad, Inbar, and Rosenthal (1982) also found what they called the *Golem effect*, a corollary to the Pygmalion effect used to describe the detrimental influences of negative expectations on student performance. That is, teachers’ expectations could impact students’ achievement in either a positive or a negative direction.

Expectations can form in many ways, but ethnicity affects expectations during first encounters (Devine, 1989). This happens because most people default to familiar stereotypes when making judgments about others because it is cognitively easier to do so (Fiske & Neuberg, 1990). In the United States, there is a history of labeling African Americans as intellectually inferior, and this stereotype persists explicitly and implicitly today. Furthermore, many teachers observe the achievement gap in their own classes or in policies addressing the gap. The frequent mental pairing of minority students with lower scores supplies the stereotype (Peterson, Rubie-Davies, Osborne, & Sibley, 2016), which may remain largely intact despite teachers’ inclusion in conferences, workshops, and in-service training that addresses multicultural appreciation and diversity (Parks & Kennedy, 2007).

Teachers’ prejudices, even if only implicit, can lower their expectations of students’ performance, resulting in lower academic achievement as the students conform to the expectations they perceive in their teachers. In this literature review, I will analyze the impact of teachers’ expectations on students, factors that promote ethnic prejudices in teacher’s expectations, and how these expectations are communicated to the students. I will also address possible mediating factors, such as students’ self-concept, SES, and teacher ethnicity. Finally, I will propose possible means for reducing the effects of teacher expectations on the achievement gap.

**The Impact of Teacher Expectations on Student Achievement**

Because teacher expectations impact student performance positively and negatively, those expectations can predict differences in students’ academic achievement at the end of the school year, even when the students begin the year with similar academic records and performance (Friedrich, Flunger, Nagengast, Jonkmann, & Trautwein, 2015; Rubie-Davies et al., 2006). Given that ethnicity is one of the
most significant factors influencing teacher expectations, the gap between African-American students' achievement and that of their Caucasian peers is understandable (Pigott & Cowen, 2000). Teachers consistently rate the former lower than the latter when evaluating student presentations, even when the only difference presented in the students' responses is ethnicity (Glock, 2016; Shepherd, 2011). When cumulated across the school year, the difference can result in lower grades and lower standardized test scores for African-American students (Friedrich et al., 2015).

It may also be the case that African-American students are more likely to conform to their teachers' underestimations of academic ability and less likely to benefit from overestimations (McKown & Weinstein, 2002). Americans have a long history of dictating African Americans' behavior (e.g., slavery, segregation, and redlining). As a result, it is possible that, over time, African Americans internalized these ideas of inferiority (Anderson-Clark, Green, & Henley, 2008). McKown and Weinstein (2008) proposed that others' expectations can lead to ethnic differences through internalization, as occurs when students perceive what their teachers expect of them and adjust their behaviors and beliefs accordingly. This internalization may also affect students' self-perceptions and their performance at school and elsewhere (McKown & Weinstein, 2008). Although children can form their own conceptions of self based on what they have previously accomplished, oftentimes their self-concepts are heavily influenced by teacher evaluations of their performance, especially when they are younger (Marsh, Craven, & Debus, 1998). Rubie-Davies (2006) tracked the effects of teacher expectations on students' self-perceptions and found that high expectations were correlated with slight improvement in self-perception over the school year, but low expectations were correlated with lower self-perception, sometimes dramatically lower.

**The Development of Expectations in Teachers and Students**

Understanding how expectations are formed is vital to recognizing prejudices and preventing them. The process can also be useful in developing and implementing means to diminish the achievement gap. Stereotyping and school factors play some of the largest roles in the formation of expectations in teachers and students.
Stereotyping

Stereotypes are a form of generalized knowledge about the attributes of the members of a specific group. It often occurs unconsciously in order to expedite the processing information about an individual (Fiske & Neuberg, 1990). Classroom teachers have been shown to rely on stereotypes when evaluating a student’s potential for success in the classroom and beyond (Parks & Kennedy, 2007). When a person observes someone who does not confirm the stereotype of the group she or he is perceived to belong to, a more effortful processing of information is required, which may result in the observer’s reevaluation of the stereotype and an analysis of the person as an individual (Fiske & Neuberg, 1990). Glock (2016) examined stereotypical expectations in teachers’ judgments of students, with the stereotype being that African Americans perform less well than their Caucasian peers do. She found that teachers rated African-American students lower than their Caucasian peers in language proficiency, but, when presented with an above-average African-American student who disconfirmed the stereotype, teachers actually rated that student higher than her or his Caucasian peers. The author proposed that teachers rated the exceptional student higher in this case because she or he exceeded the teachers’ expectations relative to their Caucasian peers.

Ethnicity of teachers. It seems reasonable that teachers would be more capable of identifying with students of their same ethnicity and that their expectations would not be influenced as much by ethnic stereotypes, but researchers have shown that this is not the case (Anderson-Clark et al., 2008; Pigott & Cowen, 2000). African-American teachers tend to have higher expectations and to rate their African-American students higher than their Caucasian counterparts, but they still consistently rate their Black students lower than their White students, indicating that teachers of congruent ethnicity do not act as buffers against racial stereotypes (Anderson-Clark et al., 2008; Pigott & Cowen, 2008).

Student self-concept and stereotype threat. As already mentioned, students’ self-concept can be heavily influenced by the expectations of others due to internalization (Marsh et al., 1998). Stereotypes can also affect students in a way known as stereotype threat. According to Steele and Aronson (1995), “Stereotype threat is being at risk of
confirming, as self-characteristic, a negative stereotype about one’s group” (p. 797). The fear of confirming the negative stereotype may produce stress and thereby impede one’s abilities to perform, thus potentially confirming the stereotype. Steele and Aronson found that this fear impaired African-American college students’ performance on a test of diagnostic ability. However, when told in advance that the same test was not representative of intellectual ability, African-American students performed no differently than Caucasians did.

**SES as a mediating factor.** SES can also be influential in stereotypes, as African Americans are more likely to belong to a lower socioeconomic class (Speybroeck et al., 2012). However, even when students come from similar socioeconomic backgrounds, ethnic differences in expectations and academic achievement still exist (Rubie-Davies et al., 2006). Nevertheless, SES can play a major role in determining the quality of schooling available for students, which also can influence teacher expectations and lead to greater disparities in ethnic achievement.

**School Factors**

Schools often have reputations, and enrollment at a particular school can influence how its students are perceived. Private schools are usually more prestigious than public schools, which may lead to higher expectations by parents and teachers of the private-school student’s academic achievement. By contrast, inner-city schools are often associated with a lack of resources, a poor quality of education, and unmotivated students, thus lowering the expectations of their achievement. Teachers may form their expectations of new students who attend a particular school based on their previous associations with other students there. They view the students collectively rather than individually (McKown & Weinstein, 2008).

**Student body diversity.** Researchers have reported that the student-body composition and the academic reputation of a school also affect expectations (Brault, Janosz, & Archambault, 2014). Teachers may judge schools based on encounters with its students just as many people base their judgments of an organization on its members. Schools with a preponderance of African-American students tend to have lower teacher expectations (Brault et al., 2014; McKown & Weinstein, 2008). In classrooms with only one or two African-American students, teachers generally are more inclined to form
expectations of these students based on their individual performance, whereas, in classrooms with more African-American students, teachers may judge students as a whole instead of as individuals.

**Academic reputation.** The achievements of individual students and of student bodies in general appear to have the most influence on teacher expectations, completely removing the differences found in the socioeconomic compositions of schools (Brault et al., 2014). For example, teachers may talk to colleagues who teach students at lower grade levels to learn if any of their incoming students are likely to be problematic during the upcoming school year. Other teachers may volunteer who they believe the brightest students are. As the new teacher listens to these reports, they will already be forming their own expectations of the child without ever meeting him or her, making it more difficult for the student to change. Another factor, already mentioned, is that teachers may form expectations on the basis of a school’s overall academic performance. Schools with a history of problems may be associated with lower teacher expectations for students at or from that school, in turn leading to lower achievement and perpetuating the self-fulfilling prophecy.

**The Communication of Expectations**

Each classroom teacher communicates his or her expectations differently. Some provide explicit, individualized instructions for their students to follow, such as using a reading chart with daily assignments. Others may not be as clear but still convey to their students an impression of what they expect.

**Explicit Expectations**

Explicit expectations are those that teachers intentionally and overtly share with their students (Peterson et al., 2016). Stereotypes and prejudices do not always influence explicit expectations (Devine, 1989), making them more accurately reflective of actual student performance while remaining unreflective of what teachers may actually believe.

Teachers typically prefer students who perform above average (Glock, 2016) and treat them differently from other students in the classroom. This differential treatment contributes to the accelerated performance of such students (Brophy, 1983; Peterson et al., 2016; Rosenthal & Jacobson, 1968; Rubie-Davies et al., 2006; Rubie-Davies,
Peterson, Sibley, & Rosenthal, 2015). For example, teachers provide more learning opportunities to students for whom they have high expectations (Peterson et al., 2016). Brophy (1983) provided a list of seventeen ways in which teachers respond differently to students of whom they have low expectations than to students of whom they have high expectations, including giving the former less time to answer questions, criticizing them more, paying less attention to their comments, demanding less of them, and even treating them differently in personal interactions, such as being less likely to start a conversation with them or being less likely to produce good feedback to them. Teachers have reported that students who fall into the two categories of expectation need to be taught differently in order to learn (Rubie-Davies et al., 2015).

**Implicit Expectations**

In recent years, researchers have begun to use implicit measures to more accurately identify teachers’ prejudices (Peterson et al., 2016; Van den Bergh, Denessen, Hornstra, Voeten, & Holland, 2010). Implicit measures may be more accurate because explicit measures are often distorted by social desirability (Van den Bergh et al., 2010). Implicit expectations are often influenced by biases. Though teachers may avoid explicitly expressing their biases, they nevertheless communicate them to their students unconsciously and spontaneously as nonverbal behavior (Asendorpf, Banse, & Mücke, 2002).

Many nonverbal cues are universal, and most people are capable of interpreting them from a young age. Babad and Taylor (1992) found that 10-year-old students in New Zealand could identify the high or low expectations of an Israeli teacher for his or her students after only 10 seconds of video, despite being unable to understand what the teacher was saying. If teachers are not clear with their explicit expectations, students may turn to nonverbal cues in order to understand what teachers expect of them (Peterson et al., 2016). When teachers have internalized stereotypes or implicit prejudices that lead to lower expectations of African American students, those students may readily identify and adopt these expectations, even if the teacher tries to suppress them.
Recommendations

Teacher workshops can draw attention to the ways in which teachers interact differently with students of whom they have low or high expectations. This may prompt teachers to consciously adjust their teaching methods and body language in order to express consistently positive expectations of all students (Rubie-Davies et al., 2015). Researchers have found that, when teachers complete such workshops, their students’ scores on academic achievement tests may increase by an amount equivalent to three additional months of schooling (Rubie-Davies et al., 2015). These findings suggest that one possible way to narrow the achievement gap would be for teachers to express high expectations for all their students. When teachers are explicit about what they envision their students being capable of, their students may become less attentive to the teacher’s nonverbal cues, thereby diminishing the influence of implicit prejudices or biases and possibly reducing the Black-White scholastic achievement gap (Peterson et al., 2016).

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Chronic Illness and Functionality: How It Affects Adolescents Academically and Socially and How They Can Cope

Emilee King
Brigham Young University

Abstract

This paper explores the prevalence of chronic illness in adolescents, and its effects on academic and social functionality. When diagnosed with a chronic condition, adolescents must often make lifestyle changes that can put substantial pressures on some, or even all, areas of life. Many adolescents report needing help to make the changes necessary to manage their illness. Chronic illness affects millions of adolescents worldwide, and these individuals need understanding, support, and guidance to succeed. The aim of this paper is to review the literature examining psychosocial aspects of chronic illness in adolescents and to examine healthy coping styles, accessibility to assistance, and the beneficial effects of external support for adolescents with chronic illness.
Chronic Illness and Functionality: How It Affects Adolescents Academically and Socially and How They Can Cope

The prevalence of chronic illness has grown exponentially in the last decades: about 50% of citizens in America have one chronic illness, 26% have two or more, and 13% have a disability (Bauer, Briss, Goodman, & Bowman, 2014). Sadly, that population also includes adolescents. Studies have found that the number of people 17 years of age and younger that have one or more chronic health condition associated with body function, activity, or participation has risen to approximately 43% (Compas, Jaser, Dunn, & Rodriguez, 2012). These conditions could be a myriad of things such as “autism spectrum disorders, developmental delay, asthma, diabetes, epilepsy or seizure disorder, or brain injury” or could be defined as any condition that lasts six months or more (Denny, de Silva, Fleming, Clark, Merry, Ameratunga, & Fortune, 2014; Kim, Amtmann, Salem, Park, & Askew, 2014, p. 96). Technological advances over the years have increased treatment opportunities and therapy options, beneficially aiding the lives of so many that are afflicted with chronic conditions. These advances have also led to improvement in surgical procedures, which have helped and will continue to help those with health concerns. However, the intense and invasive nature of these procedures run the risk of permanent damage and can lead to impairment which increases the number of people with chronic pain or disability. Currently, 26% of adolescents report recurrent pain while a third of those have severe pain that disables them (Wojtowicz & Banez, 2015). In this review, a chronic condition or illness will refer to all kinds of chronic disease, chronic disability, and chronic pain. Adolescents struggling with a chronic condition may find it difficult to adjust their lifestyle or manage their own well-being in the face of such a burden.

The burden of chronic illness may seem even larger to those in relatively early stages of life. When diagnosed, adolescents are often required to make lifestyle changes that can put significant pressure on areas of life that may have been easy, manageable, even non-existent, prior to the diagnosis (Casier, Goubert, Gebhardt, De Baets, Van Aken, Matthys, & Crombez, 2012). In addition, financial stability can often be a concern as most chronic illnesses involve prolonged medical attention, medication, therapy, and possibly special equipment. The strain on physical health is an obvious effect as well; however,
adolescents with chronic conditions are also more susceptible to emotional health issues, most commonly anxiety and depression, than adolescents without a chronic illness (Denny et al., 2014). Research has shown that having a chronic illness in adolescence leads to increased risk of mental illnesses; behavioral, cognitive, and impairment issues; and general functioning difficulties, such as difficulties with physical and social ability (Casier et al., 2013). Research that examines the functioning of chronically ill adolescents claims that many teens need help in one or more of the following categories: socialization, school, family, daily activities, and mood regulation (Denny et al., 2014). These results and insights suggest that it is more the impact or burden of the chronic illness, rather than the illness itself, that causes lower quality of life for those diagnosed (Denny et al., 2014; Kim et al., 2014). These adolescents’ lives often revolve around their experiences of pain, fatigue, and emotional distress that adversely affect their well-being and functioning (Kim et al., 2014). The complexities and difficulties that come from and are exacerbated by their conditions are causes for distress, isolation, confusion, and hopelessness—all of which are detrimental to a person’s growth and development.

Moreover, chronic illness can have a profound effect on a person’s social and academic functioning—two key aspects of life for adolescents. This review will first explore the effects chronic illness has on academic functioning and will examine social functioning, how adolescents can cope, and why it is important to receive support from others.

**Functioning with Chronic Illness**

The symptoms and effects of chronic illness can greatly impair adolescents’ functioning in several areas of their lives. For this report, functioning encompasses both performance and competence in a certain area (Pinquart & Teubert, 2012). There may be many contributing factors to an adolescent’s quality of life, or the level of comfort, satisfaction, happiness, and general well-being a person experiences; nonetheless, studies have concluded that for chronically ill patients, the higher level of sleep problems, fatigue, pain, or other symptoms reported, the lower the functioning in school and social activities, support from peers, and overall satisfaction with their life (Kim et al., 2014). As most adolescents with chronic problems deal
with at least one of these factors—if not more or all of them—it is clear why a chronic diagnosis can greatly disrupt someone’s life.

In a study involving adolescents with chronic conditions, Pinquart and Teubert (2012) found five reasons why patients may function more poorly than their healthy peers. First, some chronic conditions limit adolescents’ choices of and participation in activities, contact with peers, and school attendance; second, their conditions could impair them academically or socially because of cognitive problems, pain, or reduced motivation and energy; third, side effects of medication or therapy may hurt or reduce their capabilities; fourth, reactions from others can influence lifestyle, such as overprotective parents or peer rejection and bullying; and fifth, behavioral issues that can come from chronic conditions, such as depression or aggression, can negatively impact functionality. When an adolescent with a chronic condition cannot function properly, or as well as he or she would like, he or she can fall into even further isolation with higher negativity regarding self-image. This review will focus on two main aspects of an adolescent’s functioning—academics and sociability—and why functionality in those areas is necessary.

Effects on Academic Functioning

When students function well academically, they show behaviors that ultimately lead to academic success such as mastery of subjects, high test scores, and writing ability. These behaviors could be anything that contributes to motivation, working hard, and performing well in educational endeavors (Pinquart & Teubert, 2012). Academics play a major role in lifestyle, especially for adolescents who are in the middle of their educational career. Those in their adolescent years are often faced with decisions about their education and future as they are heading into that time of life, and functioning well academically is crucial. However, as Forrest, Bevans, Riley, Crespo, and Louis (2011) point out, the quality of school hinges on more than grades: school is also a factor in a student’s feelings of adequacy, control, and level of belonging, which all contributes to motivation, engagement in learning, and, ultimately, success. Both performing well and being able to function academically are important in an adolescent’s life; these expectations can cause problems for those who are not able to function as well due to chronic illness. Apart from lifestyle and educational success, studies have also shown
that there is a direct association between the ability to accomplish schoolwork and adolescents’ self-esteem (Myers, Willse, & Villalba, 2011). This association is important to understand, especially for students with a chronic illness that may not be able to perform well in school, as underperforming or excessive struggling with education will contribute to the feelings of despair and impairment that these students already feel.

Studies have shown that there is an identified link between chronic health problems in adolescents and lower educational attainment overall. In 2015, Champaloux and Young conducted a study illustrating this link. They found that those who reported a chronic illness had significantly lower odds of completing high school or getting their General Education Development (GED) equivalent by age 21 compared to those who did not have a chronic illness, and this also applied to the odds of going on to get a job. The results pointed to low functionality due to their symptoms such as depression, fatigue, treatments, concentration difficulties, emotional turmoil, or pain, among others. A huge part of this rests on school attendance, as research has pointed to the idea that cognitive ability and actual grade point average (GPA) may be less important for functionality than being able to be in class (Champaloux & Young, 2015). This suggests an important factor in education that parents, teachers, and physicians should be more aware of and strive for.

**Attendance issues and effects on academics.** Chronic illnesses can often cause students to miss school more frequently and for longer time periods than students without a chronic illness. Absences can cause two major problems, according to Boonen and Petry (2011): first, missing class can disrupt cognitive development, as school plays a huge role in that—especially for those who experience cognitive difficulties because of their illness and/or treatment, which can lead to weaker academic functioning; second, the problem involves reducing normalcy for the student, which is important for psychosocial well-being. Positive school experiences can give students a feeling of adequacy and control, boost self-esteem, promote good relationships with peers, and reduce emotional trauma from their illness (Boonen & Petry, 2012). Staying in school is also important because students do not have to face returning after being out, especially for an extended period of time. Chronically ill students can be more susceptible to
succumbing to phobias, anxiety, problems with body image, self-esteem, separation, peer rejection, and may face harder transitions because of learned feelings of helplessness and despair (Boonen & Petry, 2011; Emerson, Distelberg, Morrell, Williams-Reade, Tapanes, & Montgomery, 2015). These negative emotions can further impact their academic functioning, and may adversely affect their return to school, or keep them from wanting to return at all, exacerbating the problem and catching students in a negative cycle.

For those students who cannot return to school, homebound instruction may be a possible avenue. Boonen and Petry (2011) conducted a study involving homebound instruction for students with a chronic illness that could not make it to school. They set up a homebound education program with teachers coming to the students’ home with teaching material that was completed and collected. Both parents and students gave very positive feedback regarding the system. However, previous studies have found that both parents and students have been largely dissatisfied and had serious problems with homebound instruction programs (Boonen & Petry, 2011). The researchers made sure students in their study were given extra hours of help from both paid teachers and volunteer tutors. This may be a good point for further research to determine how much support is needed for a student with a chronic illness to succeed academically when completing education from home because they currently aren’t getting it.

For those students who have chronic health problems and are able to make it to school the majority of the time, the literature stresses staff education and support (Grier & Bradley-Klug, 2011; Kucera & Sullivan, 2011; Wyckoff, Hanchon, & Gregg, 2015). Schools should have compassionate staff that are willing and able to aid a student struggling due to illness. Both Grier and Bradley-Klug (2011) and Kucera and Sullivan (2011) discuss the need for strong support from school psychologists—making sure they are easily accessible to students and promoted in a way that students don’t feel ashamed, embarrassed, or stigmatized for getting help. School nurses should also be equipped to handle and help students with a chronic condition that are struggling academically or in extracurricular activities and teachers should be sensitive, considerate, and willing to work with those students who are chronically ill (Kucera & Sullivan, 2011;
It is vital that students with a chronic illness receive the support that they need so they are able to function academically, as education can have lasting consequences for years to come.

Effects on Social Functioning

Social functioning can cover a wide range of behaviors and skills, but it is defined as the general quality of someone’s ability to make friends, hold conversations, and have social experiences (Pinquart & Teubert, 2012). As adolescents with chronic illness often struggle with symptoms, treatments, and side effects, it is crucial to note how valuable social functioning and support can be for them. However, the idea of a social support network can be a direct contrast to automatic tendencies if adolescents react to their chronic illness problems by feeling isolated and withdrawn. Emerson et al. (2015) found that those with a chronic illness diagnosis often feel excessively different, stigmatized, and less socially competent than their peers. In a study examining how adolescents with chronic illnesses are received and how that may affect their future social functioning, teachers reported that students with chronic illness were less disruptive and aggressive by nature; however, those students received less best-friend nominations and did not have as many reciprocated friendships as their peers without chronic illness (Noll, Kiska, Reiter-Purtill, Gerhardt, & Vannatta, 2010). Interestingly, reports from teachers and peers illustrated that they believed those with chronic illness had no social competence problems, but the patients themselves and their parents believed that they struggled with social functioning. This self-image of inadequate or dissatisfactory social functioning may further feelings of isolation and difference.

In a similar study, Denny et al. (2014) discovered a correlation between students who have a chronic condition and their emotional well-being; however, it was only among those who reported that their condition had an effect on their ability to participate in activities and socialize. Of course, this effect could be directly derived from mental/emotional disorders, avoiding or being unable to attend social activities and/or situations, or lack of school attendance or involvement in extracurricular activities all due to the impact of the chronic illness. As previously mentioned, the nature of these illnesses often causes diagnosed adolescents to withdraw from those and the
world around them. As they are more susceptible to depression and anxiety, among other mental illnesses, this isolation can be even further exacerbated, and the isolation can cause further depression, withdrawing, and other harmful behaviors. The ability to participate and be an active participant in life—in whatever form that takes from person to person—is a huge part of positive self-imagery, feelings of adequacy, and sense of self.

This may also be a result of parenting: studies have indicated that parents are more willing to send their child to school when health is stabilizing or improving, but they are less likely to do so for social activities even when social functioning increases (Emerson et al., 2016). Because of the impact of the illness or repercussions of it, such as mental illness or physical limitations, social functioning can be minimal or reduced.

Psychologists have studied whether social support is greater among those who have the same chronic condition. Helms, Dellon, and Prinstein (2015) found that among adolescents with cystic fibrosis, 43% had at least one friend that also had cystic fibrosis. The friendships with common conditions, however, were rated as having lesser quality than friendships with someone who did not have a similar chronic condition. Regardless, all expressed the need for social support. Further research may help discover exactly what causes social dysfunction based on certain illnesses and symptoms, and what can be done to manage and/or overcome these issues so that adolescents with chronic health conditions can receive the support and love they need.

**Coping With Chronic Illness**

Acceptance is a huge part of living a successful life with a chronic illness. This involves how individuals evaluate their illness and lives, recognizing the need to adapt as needed, and having the ability to tolerate and handle the unpredictability and adverse nature of these diseases (Casier et al., 2013). Thus, being able to accept a chronic illness diagnosis is a major factor in well-being and coping. To be the most effective, acceptance and coping needs to happen on an internal and external level.

**Coping on a Personal Level.**

Myers et al., (2011) did a study regarding wellness factors and how they influence self-esteem in adolescents. In the study, they used the
Indivisible Self Model of Wellness that was broken down into different sections of the self: creative, coping, social, essential, and physical. They found that the Coping Self was the only factor that consistently related to all four parts of self-esteem (general, social, home, and school). Defined, the ‘Coping Self’ refers to the way individuals regulate their responses to life events and the means used to rise above negative outcomes or effects (Myers et al., 2011). The authors called for more research to examine what aspects of the Coping Self contribute to self-esteem and why.

It is also important to note the other factors of self, mentioned in the study discussed above: creative, social, essential, and physical. As discussed earlier in this review, a chronic illness can greatly influence or undermine an adolescent’s sense of social self and/or physical self (Denny et al., 2015). Emotional or mental disorders derived from chronic conditions have the potential to negatively affect the creative sense of self (thinking, emotions, control, positive humor) and the essential sense of self—spirituality, identity, and self-care (Myers et al., 2011). Should the chronic illness affect one or more—or perhaps all—of these factors of the self, it is easy to see why adolescents may struggle with every aspect of life when diagnosed.

However, one should never assume there is no hope. Lansing and Berg (2014) argue that self-regulation is a way to manage difficult chronic conditions. They explain that “as adolescents set goals to manage their chronic illness, they must regulate their cognitions (thoughts about pain), emotions (embarrassment with managing disease around friends), and behaviors (checking blood glucose), toward the goal of achieving health” (p. 1092). This means adolescents must be able to recognize and be cognitively aware of problems, emotions, and behaviors, then be able to organize a response that is beneficial to them. This includes goal setting, maintaining social connections, and establishing meaningful activities (Allison, Baune, Roeger, Coppin, Bastiampillai, & Reed, 2013). However, the study notes that adolescents with poor coping and self-efficacy struggle with self-regulation practices. Learning to accept and cope with a chronic condition is a personal expedition, but outside support can be beneficial—even crucial—in aiding adolescents with coping.

**Outside Support Aids in Coping.**

Adolescence marks a transitional phase in people’s lives in
which they become more independent and tend to rely more on their peers than family, though parents continue to make an important contribution in their life; when parents make their adolescents feel valuable and competent, adolescents tend to have better psychological functioning (Oris, Seiffge-Krenke, Moons, Goubert, Rassart, Goossens, & Luyckx, 2016). This is also true of those with chronic illness. In the same study by Oris et al. (2016), they found that negative parental support attributed to depression and loneliness—issues adolescents with chronic conditions already face (Emerson et al., 2016). Thus, parental support, and family support in general, has shown to be a huge factor in whether adolescents with a chronic problem function positively. Studies have shown that social support—especially from family—is the strongest predictor of positive mental health (Myers et al., 2011; Oris et al., 2015). The authors do call for more research, however, to explore what about family support is so critical and what it can offer separate from non-family members.

Peer support has also been said to be important in coping. Those who had access to strong social support clusters reported better psychological functioning than those who were not part of such a group (Myers et al., 2011). These findings suggest that therapists should focus on all aspects of support, whether it be from parents, family, or peers. Regardless of who it is, it is important that adolescents have access to and feel that they have the support they need, as positive, consistent, and reliable support can help them function and cope better than they would be able to on their own.

Conclusion

Chronic illness greatly affects an adolescent’s academic and social functioning. This can contribute to many problems in life presently and in the future. School attendance issues related to chronic illness can have major negative effects on adolescents’ academic performances, and symptoms or side effects from the illness can influence learning (Boonen & Petry, 2012; Emerson et al., 2016). Studies have found a link between the ability to accomplish schoolwork and adolescents’ self-esteem, thus it is important adolescents are still able to perform well in school (Myers et al., 2011). Apart from academics, adolescents with chronic illness can be limited in their social functioning, whether because of stigma, self-image, mental illness, or
because they don’t have the physical ability to be with others (Denny et al, 2014; Emerson et al. 2016; Noll et al., 2010).

Despite all these obstacles, there are things that can help adolescents with chronic illness, both on an external and internal level. Research suggests that implementing programs in schools that are directly for those with chronic conditions confer significant benefits (Boonen & Petry, 2011; Champaloux & Young, 2015). These programs may include accessibility centers where students can have access to tutors and find resources to help them combat their symptoms and perform academically. Knowledgeable and compassionate staff should be available to aid students academically, physically, and emotionally (Grier & Bradley-Klug, 2011; Kucera & Sullivan, 2011; Wyckoff, Hanchon, & Gregg, 2015). On either a school or community level, there should be social support groups put in place for diagnosed adolescents to attend and find help, as well as easy access to licensed therapists and/or psychologists (Grier & Bradley-Klug, 2011; Kucera & Sullivan, 2011). More research is needed to explore positive staff experiences and what contributes to them, as well as homebound instruction programs, including how to make them more effective and widespread. Further benefit can come from researching what part of the impact of chronic illness directly affects an adolescent’s social functioning, and in what scenarios that may be helped in. Of course, more research is always needed in the physical aspect of these illnesses, whether by finding cures or ways that can ease symptoms and lead to a better quality of life. Psychologists should also research those who report coping well with chronic illness, and what parts of their lives may be attributed to that so that others may follow suit.

Further knowledge and aid for adolescents with a chronic illness will also benefit future generations who receive a chronic illness diagnosis. If the proper programs are put in place now, they will be there for those who need it in the future. Also, the adolescents who receive the help that is needed to cope with their illnesses will be able to help those that come after them, passing it down to create a line of well-adjusted people. Catering to this group of struggling adolescents will help them to feel less isolated, create a place where they will get the aid and positivity they need, and will create a more empathetic and safer world to live in, benefitting everyone.
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Virtually Free Speech: The Problem of Unbridled Debates on Social Media

Brandon Parker
Brigham Young University

Abstract

How individuals communicate on the internet has been influenced by the rise of social networking and the introduction of Web 2.0. Contentious sociopolitical arguments containing false polarization and confirmation bias, accompanied by egocentric and ethnocentric thinking, are common. Ideological radicalization has also increased, as evidenced by the prevalence of ISIS and White supremacists on sites such as Twitter and Reddit. One consequence is the online practice known as flaming—intensely aggressive, personal verbal attacks. To reduce its occurrence, both macro- and micro-solutions should be implemented. On the macro-level, social networks and related online organizations should establish and enforce guidelines while not threatening free speech. On a micro-level, individuals can reduce the tendency to negatively react to oppositional viewpoints by participating in self-affirming activities. Self-polarization bias can be reduced by being aware of the similarities between ideologies across groups and individuals.
Virtually Free Speech: The Problem of Unbridled Debates on Social Media

On March 23, 2016, Microsoft released an artificial intelligence (AI) chatbot on Twitter known as Tay. Mimicking the behavior of a modal millennial social-media user, it learned from conversations with human users. The more Tay interacted with them, the more readily it was mistaken for an 18-to-24-year-old. Tay’s existence began with a simple tweet, “helloooooo world!!!” (a phrase common among computer programs), yet the inclusion of an emoji of the earth and the emotive spelling and punctuation made the tweet seemingly adolescent (TayTweets, 2016). Tay’s tweets were initially benign and playful but later morphed malignantly. Along with malicious comments, feedback, and requests, Tay began praising Hitler, advocating the genocide of certain races, and posting offensive images and content. Two days after releasing Tay, Microsoft deleted the tweets and took Tay offline earlier than anticipated (Lee, 2016). What was meant as an advance in social AI technologies became a window into an alarmingly dark world on social media.

With 1.71 billion monthly users on Facebook and 313 million on Twitter, humans across the globe have never been more connected (Facebook, 2016; Twitter, 2016). Individuals of all races, backgrounds, lifestyles, and cultures have joined hands electronically. Social networking sites were originally designed to “make the world more open and connected” by helping people “stay connected with friends and family…discover what’s going on in the world, and…share and express what matters to them” (Facebook, 2016). Although social networks have benefited humankind, there is mounting evidence of their facilitating increased aggression.

Researchers found that the language used on microblogging sites (like Facebook and Twitter) has become more intense and emotional during the last five years (Ranellucci, Poitras, Bouchet, Lajoie, & Hall, 2016). The use of online surveys and of data mining on social networking sites and online surveys has allowed researchers to identify patterns of online social behavior and to better understand the changes that are occurring on the internet.

The rise of social media has created online communities and a space wherein individuals can freely express their own emotions (Schuschke & Tynes, 2016). This is due in part to the “Web 2.0
revolution,” a term referring to the shift toward social networking and user-generated content (Ranellucci et al., 2016). According to Schuschke and Tynes (2016), when online, individuals express their shared views to communities they are a part of, thus promoting “online deliberation [that] mainly reinforces preexisting views” (Halpern & Gibbs, 2013, p. 1160). This reinforcement may lead to stereotyping of certain groups and ethnicities and may incite heated exchanges, colloquially known as flaming (Halpern & Gibbs, 2013).

Displays of egocentrism and ethnocentrism are common on social media and may be responsible for the growing acceptance of such orientations (Hmielowski, Hutchens, & Cicchirillo, 2014). Sociocentrism is apparent in individuals who believe their social groups to be superior to others. Such centricity can be productive of ideological radicalization and conducive to terrorist-group recruiting (Blaker, 2015). Moreover, antisocial behavior is becoming more prevalent online, thus ironically undermining the original goal of social media. Although social media is a tool designed to bring individuals closer, analyses of linguistic patterns have demonstrated that contentious, online sociopolitical exchanges have intensified and that radicalization is prevalent.

**Psychosocial Changes Associated With Social Media**

As a new medium of expression, social media has transformed the way individuals communicate, but it has also increased sociocentrism and radicalization. These factors have always existed in face-to-face interactions, but social networking has intensified them. According to Richards and Gutekunst (2016), 63% of American adults attribute increased sociopolitical incivility to social media. Flaming and firestorms have emerged as new forms of interpersonal communication due in part to social media, including microblogging (Halpern & Gibbs, 2013).

**Sociocentrism**

On social networking sites, sociocentric expression stems from the assertion that certain ideologies, racial groups, or cultural groups are superior to others (Schuschke & Tynes, 2016). Social media encourages individuals to focus inward because it replaces traditional conversation in which two or more people sit, stand, or otherwise join together in a physical space for conversation. Though those engaged in
conversation took care to present themselves well, the pressure to do so is intensified by much larger and unseen audiences on social media (Chiou & Lee, 2013). This potential preoccupation may well promote more concentrated self-absorption and egocentric thinking (Chiou & Lee, 2013).

**Egocentrism**

Self-focused thinking contributes to the failure to understand other perspectives and thereby inflames exchanges with others (Chambers & De Dreu, 2014). Not only do individuals favor their own perspectives, but they tend to caricature opposing viewpoints as radical, dangerous, or evil (Keltner & Robinson, 1993; Paresky, 2016). Doing so may produce the overestimation of differences between viewpoints (Chambers & De Dreu, 2014) and discourage prosocial behaviors (Chiou, Chen, & Liao, 2014).

**Ethnocentrism**

In addition to egocentrism, social networking sites are also host to ethnocentrism (Schuschke & Tynes, 2016). It may be expressed in racial, political, or social terms. Individuals in LGBTQ communities, for example, may find it difficult to remain on social-media sites in the face of abusive and unceasing condemnation. Individuals may avoid discussing controversial, emotionally-charged topics for fear of being attacked verbally or otherwise. Richards and Gutekunst (2016) reported that 75% of American adults consider such muting destructive to civil debate. Moreover, in the face of rejection by the larger audience, individuals may gravitate to online micro-cultures where they are validated and feel comfortable expressing their thoughts (Halpern & Gibbs, 2013).

Confirmation bias also spurs rejection of alternative views and selective exposure to viewpoints that affirm one’s own (Halpern & Gibbs, 2013; Stroud, 2010). Knobloch-Westerwick, Johnson, and Westerwick (2015) found that internet users spend 64% more time viewing content they considered congenial with their personal views than content which was contradictory to their views. The selective consumption of favorable content may lead to polarization (Stroud, 2010). As in an echo chamber, the favorable content reverberates and is amplified.
Radicalization

Beyond polarization, there is the risk of ideological radicalization. As social media becomes a collection of self-contained communities, individuals are marginalized in the process and may become the potential targets of recruitment by radical groups, including terrorist groups, such as the Islamic State of Iraq and Syria (ISIS). The propaganda is attractive to the millennial-age group. An estimated 3,000 individuals from Western nations have pledged allegiance to ISIS (Blaker, 2015). Although leading social media have begun to censor radical propaganda, extremist groups still infiltrate them to share their messages (Alarid, 2016). Twitter has proven to be especially vulnerable. According to a tweet analyst, ISIS sympathizers have been among the most prolific users, sharing on average of 2,612 tweets per user over one 3-month period (Klausen, 2015).

White supremacists and anti-Semitic groups have used social media to grow by more than 22,000 users since 2012 (see Figure 1; Berger, 2016). The emergence of more extreme political ideologies has sometimes attracted otherwise well-meaning supporters of conservative political candidates and movements to share far-right extremist propaganda on social networks. Moreover, social media can be used to mobilize terrorist cells to instigate radical demonstrations and carry out murderous attacks (Kende, van Zomeren, Ujhelyi, & Lantos, 2016).

Firestorms

Radicalization is also evident in the online phenomenon known as firestorming or, more specifically, firestorm debates. They are typically characterized by large-scale surges of social-media use directed to specific topics or sociopolitical events and are marked by contentious rhetoric (Hutchens, Cicchirillo, & Hmielowski, 2015). Like wildfires, they are unpredictable and uncontainable, spreading rapidly, and disabling online connectivity. Fan, Zhao, Chen, and Xu (2014) conducted an emotional-language analysis of 70 million posts on the Chinese microblogging site, Weibo, and found that angry posts were shared faster and more widely than what they termed “joyful” posts. Online interaction has been linked to increased contention, given that individuals use language and mannerisms different from those used in face-to-face, in-person interactions—a phenomenon known as the
online disinhibition effect (Kiesler, Siegel, & McGuire, 1984; Suler, 2004). Individuals who are inclined to verbal aggression may perceive the internet as an appropriate place for unbridled expression (Hmielowski et al., 2014; Suler, 2004). Social media adds additional layers of interaction and communication, and polarization and confirmation biases can amplify emotional intensity. This also makes ad hominem attacks more likely (Hutchens et al., 2015). Flaming shares many of the same characteristics as cyberbullying, but often involves individuals who have no prior acquaintance.

**Flaming**

Egocentric and ethnocentric behaviors and attitudes fuel hostile exchanges on social media. Because computer-mediated communication typically lacks non-verbal cues, including vocal tone (Moor, Heuvelman, & Verleur, 2010), their absence may cause individuals to misinterpret the messages they receive (Suler, 2004). Limited comprehension is characteristic of egocentric thinking (Sassenrath, Sassenberg, & Scholl, 2014).

The case of YouTube. YouTube, a video-sharing site, is notorious for its uncivil and contentious Comment sections. Each video published by its creator is accompanied by a section wherein other users may critique the video. Flaming is prevalent, as some individuals use the comment section to personally attack the author of the video and other commentators.

Moor et al. (2010) conducted a survey of individuals who commented on videos or interpreted comments on YouTube. Most respondents were not familiar with those they either sent comments to or interpreted comments from. Senders were more likely to perceive their own words as opinions, whereas interpreters were less likely to perceive comments as opinions. Similarly, interpreters were more likely to perceive comments as offensive or provocative in comparison to senders. Interpreters were slightly more likely to perceive comments as flaming than senders were.

In the same study, when respondents were asked to rate their experiences using a Likert scale (1, disagree; 5, agree) most reported that flaming was common, that it was annoying, and that it was an issue for some users on YouTube (Moor et al., 2010).

YouTube has introduced measures to reduce incivility in comments. A new initiative, called “YouTube Heroes,” rewards users...
who flag inappropriate comments and promote healthy discussions (Kastrenakes, 2016). In addition to the Heroes program, YouTube is giving channel owners and content creators more control over the responses to their videos. Owners and creators have the ability to pin constructive comments at the top of the comment section as well as the heart symbol (❤️) on comments as a token of gratitude and praise for civil behavior (Statt, 2016).

Overcoming Psychosocial Barriers in Social Media

A variety of solutions has been discussed and solutions are presently being implemented by companies and institutions in order to effectively promote healthy exchange on social media.

Macro Solutions

These solutions reside at the structural level (Williams, 2016). Social networks can themselves set standards for a more civil internet.

The contrasting cases of Imzy and Reddit. Imzy is a new social network whose founders seek to humanize computer-mediated communication. Imzy does not rely on online advertising as a revenue source like other social networks do and seeks to establish forums for constructive debate among specialized communities of individuals who share similar interests and values. Imzy’s approach requires individuals to request permission to join a community and, after joining, they must remain active, civil participants (Robertson, 2016).

Imzy is the antithesis to Reddit, which also feature communities. Reddit has moderation measures in place, but they have been largely ineffective in preventing discriminatory flaming. For example, a specific community named “Fat People Hate” had over 100,000 members, who participated in shaming, ridiculing, and targeting overweight individuals. When moderators intervened, members turned their hatred toward the moderators (Moreno, 2016).

The risk of online censorship. As technology companies establish guidelines to reduce antisocial behavior, censorship becomes an issue. The First Amendment to the Constitution of the United States pronounces basic freedoms, among them the freedoms of speech and the press. Further legal interpretations have excluded threats of violence, pornographic content, and inciting comments from constitutional protection (Heins, 2014). The definitions of these protections are vague, and as social networks become liable to
constitutional regulation (just as with the rise of mass media), the risk of censorship increases.

**Micro Solutions**

The effective promotion of constructive online exchange ultimately must come from individuals in communities. The problems of egocentricity, ethnocentricity, intolerance, aggression, and intimidation that infect social networks are largely rooted in individual perceptions and are better resolved at micro-levels of interaction (Stroud, 2010).

**Relational awareness.** In egocentric thinking, individuals unthinkingly put on the biasing lenses of their own understanding rather than trying to understand perspectives they consider alien. A bogus polarization follows as the latter perspectives continue to be ignored, thus effectively reducing and even eliminating the chance of cooperative, civilized exchange (Chambers & De Dreu, 2014). Individuals should be encouraged to identify the inevitable similarities in viewpoints, that is, they should be encouraged to develop relational awareness. Individuals can produce eventual consensus while still affirming different perspectives. A study by Puccio (2003) found false polarization in students at Stanford University and the attendant over-exaggeration of differences. When students permitted opposing viewpoints to be heard, their perception of the differences between opinions more closely approximated the actual differences. Moreover, after debating both sides of the affirmative-action issue, for example, the students were more confident that agreements could be reached.

**Self-affirmation.** When individuals and groups express an ethnocentric pattern of thought online, they necessarily bar themselves, even aggressively, from ideas and arguments that are unfavorable to their own. (Halpern & Gibbs, 2013; Stroud, 2010). According to self-affirmation theory (Armitage & Rowe, 2016), an individual with a healthy self-image reacts to opposition and challenges to his or her identity in a less defensive manner than those whose self-image is ill-defined (Cohen & Sherman, 2014). Armitage and Rowe (2016) examined conflict-resolving behavior in children and adolescents and found that those participants who exhibited stronger self-concepts after participating in self-affirming activities were less aggressive in their communication (Armitage & Rowe, 2016). If self-affirming practices were widely available and widely endorsed on the internet more-civil interaction may well increase.
Conclusion

The creation of a more connected and open world is a modern goal. Social media is widely considered one of the most effectual means for achieving the goal. But with their wide acceptance has come a rising tide of prejudice, hate, radicalization, and false polarization (Knobloch-Westerwick et al., 2015; Schuschke & Tynes, 2016; Stroud, 2010).

Radicalized political ideologies and polarized viewpoints increased during the 2016 US presidential primaries and general election (Sanders, 2016). Immediately after the results of the general election on November 8, 2016 were announced, individuals took to social media with emotional expressions ranging from elation to devastation. Firestorms and flaming ensued as individuals refused to accept the results and vilified those who had voted for the winning candidate (Sanders, 2016).

Additional research on the effects of social media should be conducted on the use of relational awareness, self-affirmation, and other prosocial behavior to enhance civil interaction online. Newer platforms, such as virtual and augmented reality, should be included in that research.

References


youtube-pinned-comments-moderation-tools-harassment


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**Figure 1.** Recent growth of White supremacists using Twitter (Berger, 2016).
Understanding Reactive Attachment Disorder in Children

Chaz Anthony Rich
Brigham Young University

Abstract

Reactive Attachment Disorder (RAD) is recently new to clinical literature. RAD is a “Stress and Trauma-Related Disorder” that stems from an inability for a child to attach to a caregiver. Aside from some psychoanalytic foundations, most of what is known about RAD is based off John Bowlby’s attachment theory. As research has developed, RAD has been considered its own diagnosis in the DSM-5 rather than labelled under the umbrella term of “attachment disorder.” A biopsychosocial model of RAD argues that RAD is primarily formed and exacerbated by neglect from a caregiver that can infringe upon the child’s ability to form relationships later in life. Being a new diagnosis, current and detailed prevalence and prognosis of RAD are unknown. In addition, legal implications of maltreatment further contribute to the under-diagnosis of RAD. Currently, holding therapy is the most prominent treatment for RAD. Because so little information is known about RAD, more study and experimentation is necessary for better treatment and understanding.
Understanding Reactive Attachment Disorder in Children

Reactive attachment disorder (RAD) is a recently identified disorder that is included in the DSM-5 category of “Stress and Trauma-Related Disorders” (American Psychiatric Association, 2013; Lehmann, Breivik, Heiervang, Havik, & Havik, 2016). RAD is commonly diagnosed in children and involves an inability to create attachments with a caregiver at an early age, which may impair the formation of relationships at a later age (Mizuno et al., 2015). Although understudied because of its recent entry into the DSM 5 (Shi, 2014), I will argue that RAD is a difficult-to-treat disorder.

Theory and Evolution of RAD

Before the mid-20th century, aside from Freudian psychoanalysts, not much attention had been given to psychological disorders in young children, especially attachment disorders. John Bowlby, a prominent child psychiatrist, became a pioneer in the study of such disorders (Follan & McNamara, 2014). Bowlby (1969) theorized that attachment is crucial in the development of an infant’s ability to socialize and self-regulate (Vasequez & Stensland, 2016). The infant creates attachment with a biological parent—usually the mother—to enhance comfort and survival (Mikic & Terradas, 2014). Like Bowlby, Shi (2014) argued that maladaptive behaviors in childhood and continuing on to adulthood may result from failed attachment. With this perspective, many psychologists now approach the etiology and treatment of RAD using Bowlby’s perspective.

RAD was not specifically categorized and distinguished from other disorders until the DSM-5 appeared. General symptoms were first listed in the DSM-III, based on the literature of deprived and institutionalized children (Mikic & Terradas, 2014). The idea of an attachment disorder was introduced in the DSM-IV-TR in 1994 (Vasquez & Stensland, 2014). It was separated into two subtypes: (a) emotional detachment from caregivers or the inhibited type and (b) indiscriminate towards caregivers or the disinhibited type. New criteria for the diagnosis of attachment disorder were introduced in 2000 as part of the Bucharest Early Intervention Project (BEIP), which was a study of foster care as an intervention for abandoned children in Romania. In the DSM-5 attachment disorder is described as two
separate disorders based on the DSM-IV-TR’s subtypes: (1) reactive attachment disorder (inhibited type) and (2) disinhibited social engagement disorder (disinhibited type; Lehmann et al., 2016; Mizuno et al., 2015).

Criteria for attachment disorder in the DSM-IV-TR included exposure of the infant to pathogenic caregiving, such as the disregard of emotional needs and basic needs, as well as caregiver turnover (Mikic & Terradas, 2014; Vasquez & Stensland, 2014). Also, the onset of the disorder must be evident before age five (Shi, 2014). To further clarify RAD as its own diagnosis, more criteria were added in the DSM5, namely, that the child has reached a developmental age of at least 9 months and that criteria for autism spectrum disorder are not met.

Currently, the characteristics and implications of RAD in older children and adults are unknown (Mizuno et al., 2015). One of the largest issues is the prevalence of RAD in the adolescent and adult population. In fact, the prevalence of RAD in children remains unknown (Mayo Clinic Staff, 2017; Minnis et al., 2013). Because one of the criteria for the diagnosis of RAD is neglectful or abusive caregiving, reports of RAD are not likely to be reported to psychologists or other healthcare professionals. Given the existing legal penalties for maltreatment of children, RAD remains a disorder that is understudied and underreported and, therefore, undertreated (Mizuno et al., 2015).

A Biopsychosocial Model of RAD

Like many other psychological disorders, the etiology of RAD is influenced by biological, psychological, and social factors. Only limited research has been done on the biological basis of RAD, but there is much research on psychological and social influences.

Biological Factors

Shi (2014) stated that human beings are biologically driven to seek and maintain proximity, that is, to become attached to others. Mizuno and colleagues (2015) argued that these attachments lead to the creation of new neural connections in the brain. Thus, as a child ages, the brain networks are influenced by his or her attachments or the lack thereof (Vasquez & Stensland, 2016). Zeanah, Cheshire, and Boris...
(2016) also found that children diagnosed with RAD have difficulties with the regulation of their amygdala—the emotional control center of the brain.

**Psychological and Social Factors**

As previously indicated, most mental-health professionals accepted the etiology of RAD proposed by Bowlby (Follan & McNamara, 2014). With the help of caregivers, the infant learns meaning and begins to understand the world. When caregiving relationships do not develop or caregivers negatively affect the infant through neglect or abuse, the child may perceive the world as unsafe and dangerous and view herself or himself as unloved or unimportant (Vasquez & Stensland, 2016).

**The Treatment of RAD**

Because RAD is a new clinical disorder most of the research on its treatment has focused on psychological and social factors that are identified in Bowlby’s attachment theory (Buckner, Lopez, Dunkel, & Joiner, 2008; Shi, 2014). Attachment therapies, like holding therapy, have been the most utilized for treatment of RAD.

**Attachment Therapy**

Attachment therapy is used for a diversity of disorders (Shi, 2014). For RAD, the focus of attachment therapy is fixing the central problem—creating and enhancing attachments between children and their caregivers. The therapist works with the caregiver and the child to establish a relationship and may focus on changing the perspective of the child as unloved by teaching the caregiver to be more affectionate and attentive to the child. Because the incidence of RAD is unknown, relapse rates are only estimated (Vasquez & Stensland, 2016).

**Holding Therapy**

The most publicized form of attachment therapy for children is holding therapy (Buckner et al., 2008). Its focus is to remove the aversion to “noxious stimuli” (p. 290), such as tickling or poking and restraint. According to Bowlby, healthy attachment is achieved when the child’s aversion to noxious stimuli is extinguished by graded exposure to the stimuli while the caregiver holds the child. Currently, no research or statistics are available for the effectiveness or relapse of
patients who participate in holding therapy, especially with the legal implications of maltreatment for infants (Vasquez & Stensland, 2016; Buckner et al., 2008, p. 290).

Conclusion

RAD is new to the clinical literature, and thus there is a need for more research in order to improve understanding and treatment. To date, the biopsychosocial model for RAD is primarily based off John Bowlby’s attachment theory, which posits that the relationship between infant and primary caregiver is essential for the infant’s formation of social relationships in adulthood and self-regulation. When the infant is exposed to negative treatment such as neglect or abuse, a child is unable to form attachments. These attachments—or lack thereof—create specific and influential neural connections that influence emotional behavior. Bowlby’s attachment theory is focused on interactions between child and caregiver. Psychotherapy is the most widely used treatment for RAD. Specifically, attachment therapy, like holding therapy, brings an emphasis on neutralizing the trauma that resulted from the child’s exposure to the caregiver. RAD is characteristically difficult to treat because improvement is dependent on the relationship between child and caregiver, a relationship that may be resistant to modification.

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Isolated Insanity: The Damaging Effects of Solitary Confinement

Stephanie Ringwood
Brigham Young University

Abstract

Solitary confinement is a popular form of punishment in prisons. However, it often results in the deterioration of the inmate’s mental health, especially when it is prolonged. It may lead to severe mental illness or self-harm, including suicide. In addition to the mental health effects, solitary confinement inhibits the rehabilitation process as it limits or eliminates exercise, visitation hours, medical treatment, and group recreation. Without these, many inmates lose their sense of identity and their hold on reality, thereby reducing the odds of successful reentry into society. To improve solitary confinement conditions, prison administrators should provide accessible psychiatrist treatment and limit the duration of time inmates spend in isolation.

Keywords: isolation, mental health, solitary confinement
Isolated Insanity: The Damaging Effects of Solitary Confinement

In October 2015, the Brigham Young University women’s soccer coach received a package from the Utah State Prison in Gunnison, UT. In the package there was a large crocheted blanket and a handwritten letter that ended with the following: “I will never get to see a game in person. So please [accept] this blanket as a token of my appreciation, it is for the entire team” (J. Rockwood, personal communication, October 2015). A prisoner serving a lifetime sentence, a man who would never experience another day of freedom, was the giver. Nearly six months later, the coach received a letter from another prisoner in Gunnison. Prior to the second letter, the soccer coach had related the earlier event during a televised speech, and the second inmate (the cellmate of the first) was watching and shared the news with his cellmate. The second inmate sent a letter to inform the coach that his cellmate was overjoyed to see that his blanket and letter were accepted and appreciated. The coach recounted that the most genuine acts of kindness she had ever received were not from fans, players, or staff members, but from criminals—that is, from dangerous men (J. Rockwood, personal communication, October 2015).

While the above prisoners appear to have made progress toward the goal of rehabilitation, many inmates are dehumanized, tortured, and isolated in the name of rehabilitation (Applebaum, 2015; Arrigo & Bullock, 2008; Grassian, 1983; Haney, 2003; Mears & Reisig, 2006; Metzner & Fellner, 2010; Pizarro & Stenius, 2004). Further, they are likely to develop and be diagnosed with mental disorders in the process (Haney, Weill, Bakhshay, & Lockett, 2016). In solitary confinement, an inmate is isolated in order to eliminate any human contact (Shalev, 2011). Solitary confinement is a standard feature of “supermax prisons,” where inmates are housed in isolated cells and are not eligible for educational, religious, or rehabilitation programs (Pizarro & Stenius, 2004). In supermax prisons, inmates spend their entire sentence in solitary confinement, isolated for 23 hours every day.

According to Haney (2003), current prison systems in the US still operate in much the same way they did in the 19th century, including the use of solitary confinement. According to the Mental Health Director at Rikers Island, a prison complex in New York City, officials are “severely addicted to solitary confinement” as a way to manage
crowded jails rather than utilizing it for disciplinary purposes (Haney et al., 2016, p. 127).

Because mentally ill prisoners often fail to adjust to incarceration, often exhibiting nonconformity and extreme anxiety, they are at greater risk of being placed in solitary confinement (Haney, 2003). This inhibits their opportunities for successful rehabilitation and their return to normal life, including the increased probability of being rearrested (Haney et al., 2016). Although solitary confinement may be successful in separating dangerous prisoners, its negative impact on mental health rehabilitation is reason for reevaluating its use.

**Solitary Confinement and Mental Health**

The risk of developing mental illness or the risk of intensifying already-existing mental illness increases when inmates are isolated and alone. It is not unusual for them to be forced to occupy a 60-to-80-square-foot cell for many years (Haney, 2003; Shalev, 2011). The cells typically have a small window with limited sunlight, little fresh air, and a slotted door to allow food and medications to be dispensed (Shalev, 2011). Researchers have shown that isolation is a psychological stressor that can become as distressing as physical torture (Metzner & Fellner, 2010), and may be especially damaging in mentally ill prisoners.

**Symptoms of Deteriorating Mental Health**

Psychological stressors may result in the following: anxiety, depression, obsessive compulsive disorder, paranoia, anger, perceptual distortions, psychosis, panic, insomnia, hallucinations, self-mutilation, suicidal behavior, violence, emotional breakdowns, and withdrawal (Andersen, Sestoft, Lillebaek, Gabrielsen, & Hemmingsen, 2003; Grassian, 1983; Haney, 2003; Haney et al., 2016; Metzner & Fellner, 2010; Pizarro & Stenius, 2004; Shalev, 2011). Anderson and colleagues (2003) reported that a higher risk for mental disorders exists in solitary confinement inmates than in those not exposed to solitary confinement. In studies of the psychological consequences of solitary confinement, Haney (2003) utilized both case studies and personal accounts of mental health workers in supermax prisons. He concluded that there is not a single study wherein inmates placed in solitary confinement for more than 10 days did not present negative psychological symptoms (see also, Applebaum, 2015).
Grassian (1983) identified a psychopathological condition termed Security Housing Unit (SHU) syndrome. It is characterized by generalized hyper-responsiveness to external stimuli, perceptual distortions, difficulty concentrating and remembering, problems of impulse control, and the emergence of ego-dystonic fantasies—fantasizing about revenge, torture, and the mutilation of prison guards (Grassian, 1983). As disturbing as these symptoms are, the author found that all of them remitted within hours following the inmate’s release from isolation, and the severity of their effects varied directly with the degree of isolation.

**Mentally Ill Inmates in Confinement**

Although mentally healthy inmates are susceptible to the negative consequences of solitary confinement, inmates with preexisting mental disorders have a higher probability of being sent to solitary confinement, where it may have substantial adverse effects, including refusing to leave their cells, setting fire to themselves or their cell, destroying property, smearing urine and feces on themselves and walls, and harming themselves otherwise (Applebaum, 2015; Arrigo & Bullock, 2008; Haney, 2003; Haney et al., 2016; Metzner & Fellner, 2010). Also, the longer inmates are forced to stay in solitary confinement, the greater their risk of permanent mental disorders (paranoia, withdrawal, panic psychosis, etc.). The majority of mentally ill inmates require psychiatric hospitalization in order to reduce their symptoms, but treatment is often unavailable while an inmate is in isolation (Arrigo & Bullock, 2008; Haney, 2003; Metzner & Fellner, 2010).

Improvements in mental health services, such as allowing inmates with mental illnesses to meet with psychiatrists, are occurring in prisons as the American Psychiatric Association and the National Commission on Correctional Health Care (NCCHAC) develop guidelines for such. However, the majority of visits, when they occur are not face-to-face (Metzner & Fellner, 2010). Although the NCCHC and human rights experts have formally stated that mentally ill prisoners need to be excluded from solitary confinement, their statement is generally viewed as a recommendation (Metzner & Fellner, 2010). Furthermore, federal judges have ruled against the segregation of mentally ill inmates, but only a small fraction of prisons are governed by the decisions and elected officials have been reluctant...
to pass laws that would accommodate the decisions (Metzner & Fellner, 2010)

**Increasing Numbers of Mentally Ill Inmates Are Placed in Solitary Confinement**

As the proportion of inmates with mental illnesses continues to grow, the number placed in solitary confinement also grows (Applebaum, 2015). Even though it is estimated that two-thirds of mentally ill prisoners are undiagnosed, researchers have shown that, on average, 15% or more of the inmates in each prison have a diagnosed mental illness (Haney et al., 2016; Metzner & Fellner, 2010), and over 50% of the inmates in solitary confinement have diagnosed mental disorders (Haney et al., 2016; Metzner & Fellner, 2010). Moreover, the U.S. Justice Department’s own investigation in 2013 showed that on any given day, 15% to 25% of juveniles in incarceration were in solitary confinement and, of these, 71% had been diagnosed with mental disorders (Haney et al., 2016).

**Suicide and Self-Harm in Solitary Confinement**

Due to the mental deterioration associated with solitary confinement, inmates engage in suicidal behavior and self-harm (Arrigo & Bullock, 2008; Haney, 2003). Self-harm is the leading cause of death among inmates and was described by Kaba et al. (2016) as an act that an individual perpetrates on him or herself that may result in physical injury, disability, or death. The absence of freedom, the presence of a rigidly enforced schedule, and the absence of opportunities for human interaction that define solitary confinement are obvious severe psychological stressors and may readily conduce suicide.

Marcus and Alcabes (1993; as cited by Haney et al., 2016) examined the New York City jail system and found that 42% of suicides occurred within the first 30 days of solitary confinement, and that 52% of inmates who committed suicide suffered from mental illness and were serving their sentence in isolation. A more recent study of the New York City jail system by Kaba et al. (2014) included the analysis of data from prison intake and documented acts of self-harm between January of 2010 and December of 2012. They analyzed 1,303 inmates’ records and found that 2,182 acts of self-harm had occurred during the two-year period, including laceration (34%), ligature (28%),
swallowing a foreign body (15%), and overdose (14%). Moreover, 7.3% of the inmates had spent time in solitary confinement, and 4% of these inmates had been diagnosed with a severe mental disorder while in solitary confinement. The authors also reported that 53.3% of the acts of self-harm and 45% of the acts of potentially fatal self-harm occurred within this group of inmates (Kaba et al., 2014)

**Solitary Confinement Inhibits Rehabilitation**

Solitary confinement also inhibits inmates’ rehabilitation. They are denied access to recreation, regular visitation hours, and proper psychiatric treatment (Haney, 2003; Haney et al., 2016; Pizzaro & Stenius, 2004; Shalev, 2011). Without these vital programs that enhance their living state, inmates will often struggle to adapt to regular society upon their release from prison (Haney et al., 2016). Solitary confinement is harming society: it takes away vital programs from the prisoners and eliminates their human contact, which lessens their ability to adapt to life outside the prison system and increases the likelihood that they will commit additional crimes and re-enter the jail system.

Prison administrations throughout the US are required to provide activities for inmates as well as visitation hours and contact with the outside world—they still retain rights as members of society. However, Pizarro and Stenius (2004) found that when inmates were sentenced to solitary confinement, within a supermax prison or elsewhere, these rights were limited extensively. Inmates were typically limited to three to seven hours of exercise per week in a small, isolated space that was often indoors (Pizarro & Stenius, 2004; Shalev, 2011). An inmate in Rikers compared it to being in a cage at a zoo: “No weights, no basketball, no sports, no nothing” (Haney et al., 2016, p. 139). Only about 1 in 10 inmates in isolation exercises each day, and they report feeling degraded when they are searched and shackled in the course of moving into the isolated area for recreation (Haney et al., 2016).

In addition to exercise, other limitations apply to education, work, group recreation, therapy sessions, medical treatment, and visitation hours. One inmate recounted that, in order to receive medical treatment for his toothache, he had to slice his wrists so that the
attending officer would respond and take him to the doctor (Haney et al., 2016).

Pizarro and Stenius (2004) reported that the visitation hours varied across prisons, some allowing only one hour per month and other allowing a few hours per month. The inmates often were not allowed to have direct contact with the visitors but spoke to them instead through video or an intercom (Pizarro & Stenius, 2004).

Many inmates who endure isolation and the restriction of activity exhibit increased social withdrawal, which likely inhibits their rehabilitation (Pizarro & Stenius, 2004). Haney (2003) divided the transformation that an inmate typically experiences in solitary confinement into five segments: (a) dependency on the prison system; (b) inmate loss of focus; (c) loss of their sense of reality; (d) fear of social interaction and subsequent withdrawal; and (e) extreme frustration.

The transformations were illustrated in the case of Kalief, a 16-year-old sent to Rikers Island for allegedly stealing a backpack (Haney et al., 2016). He struggled to adjust to the prison environment and was placed in isolation, where he became increasingly depressed and attempted suicide. After doing so, he spent time in the prison hospital but, upon recovery, was immediately returned to solitary confinement. After three years in prison, the last 17 months in isolation, Kalief was unexpectedly released when a judge decreed that he was innocent. After his release, his friends and family noticed that he was different. He paced around his room and preferred to be alone. He attempted suicide multiple times, and as he continued to struggle with depression and paranoia, he explained, “I’m not all right. I’m messed up. There are certain things that changed about me and they might not go back” (p. 128). He later hanged himself.

**Arguments in Support of Isolation**

Deterrence is a prominent component of arguments in support of solitary confinement, that is, inmates behave better because of the fear of returning to isolation (Mears & Reisig, 2006; Pizarro & Stenius, 2004). Placing inmates in solitary confinement also serves as a threat to the other inmates (Mears & Reisig, 2006). The existing research on deterrence has not demonstrated that the use of isolation decreases prison violence (Mears & Reisig, 2006).

Concern for safety—theyir own and others’—is another common
reason for placing inmates in solitary confinement. Applebaum (2015) acknowledged that high security is required for dangerous inmates who are a threat to other inmates and officers. However, Applebaum asserted that most inmates placed in isolation are not dangerous. Instead, they are disruptive. Applebaum also found that vulnerable inmates are placed in isolated security for their own protection. Inmates who are transgender, mentally ill, or have developmental disabilities are frequently in this category. If an inmate is in isolation for her or his protection, it seems reasonable that she or he should not have the same restrictions that apply to others in isolation.

Despite the absence of clinching evidence that inmates in solitary confinement are more likely to have been diagnosed with mental disorders and to experience intensification of the symptoms (Glancy & Murray, 2006), when they are transferred from solitary confinement to the general prison population, their symptoms typically subside (Anderson et al., 2003). Ironically, there is widespread agreement about the damaging psychological effects of war, including those of prisoners of war or hostages who are kept in isolation. In contrast, prison inmates, whose institutional isolation may be equally as extreme are viewed differently (Haney, 2003).

**Conclusion**

Adjustments need to be made to solitary confinement policies and procedures in order to improve isolated inmates’ mental health and rehabilitation. Two adjustments that are promising: improving the conditions of solitary confinement, including limiting the duration of time spent in isolated cells and increasing opportunities for recreation and visitation; and increasing the availability of psychiatric treatment for those who are confined and whose existing mental illness likely was a major factor in their assignment to isolation.

The current psychiatric treatment in prisons consists of “walk-bys” (the psychiatrist walking by each cell and asking how the inmate is feeling) and occasional personal meetings (Haney, 2003; Haney et al., 2016). Prison administrators should hire additional psychologists, psychiatrists, and mental health workers in order to allow inmates more frequent treatment. Indeed, the enhanced provision of mental
health care may be the most beneficial approach to reducing prison population.

Even though solitary confinement may be successful in separating particularly dangerous inmates from each other and the rest of the prison population, the majority of inmates in isolation are not dangerous and have been placed there as a means of social control (Haney et al., 2016). Researchers generally agree that solitary confinement is counterproductive and has damaging and possibly lasting effects on the mental health of those confined to isolation, to say nothing of impairing their odds of successful rehabilitation.

References


Animal Hoarding by Humans: A Literature Review

Corina L. Schroeder  
Brigham Young University

Abstract

I review the origin and treatment of animal-hoarding disorder in humans and its relation to hoarding disorder and obsessive-compulsive disorder, showing that it seems to be more closely related to object hoarding. The disorder often originates in a traumatic life event, which triggers a psychological vulnerability to compulsively collect animals. In some cases, the hoarding individual was neglected by parental figures at a young age and developed relationships with animals in order to cope with the neglect. Some theories that proposed to explain the neglectful behavior in animal hoarding include dissociation, delusion, and dementia, viewing the animals as self-objects, or viewing them as extensions of themselves. I also consider recommended treatments for animal hoarders.
Animal Hoarding by Humans: A Literature Review

Obsessive-compulsive disorder (OCD) is characterized by intrusive thoughts, images, or urges (obsessions) that the sufferer actively tries to avoid with actions aimed to suppress and to provide relief from the intrusion (compulsions) (Barlow, & Durand, 2015). The subtypes of OCD include symmetry, which is discomfort with misalignment or disarray, forbidden thoughts or actions, contamination and cleaning, and hoarding.

Hoarding is the least common subtype of OCD and is characterized by the compulsive need to collect items and difficulty in discarding anything because of its potential future use or sentimental value. The hoarded material may fill most of the affected individual’s residence and may cause significant distress, reduced functioning, or both because of the excessive amounts of clutter sufferers collect. The symptoms must persist for at least six months to be diagnosed as hoarding disorder (Andrews-McClymon, Lilienfeld, & Duke, 2013).

The hoarding of animals is characterized by collecting animals in such numbers that the hoarder can no longer maintain even minimal standards of personal hygiene, let alone take care of the animals (Gahr, Connemann, Freudenmann, Kolle, & Schonfeldt-Lecuona, 2014). Animal hoarders are usually unaware of the problems produced by hoarding. Between 700 and 2,000 cases of animal hoarding are reported every year, but the prevalence may be increasing. Because hoarders are typically reclusive and socially isolated, many cases go undetected (Nathanson, 2009).

Symptomatology

Approximately 76% of animal hoarders are female and the median onset of hoarding occurs in late adulthood (Patronek & Nathanson, 2009). The most commonly hoarded animals are dogs. Other commonly hoarded animals include horses, birds, and cats. It is not uncommon for an individual to hoard more than one type of animal (Joffe, O’Shannessy, Dhand, Westman, & Fawcett, 2014). The median number of hoarded animals is 39, but it is not uncommon for the number to exceed 100 (Nathanson, 2009). Consequently, squalid living conditions are common, including extreme filth, pests, mold, precarious debris, animal excrement, non-functioning bathrooms and other living spaces, clutter, and animal carcasses (Andrews-McClymon et al., 2012).
et al., 2013; Nathanson, 2009). Those with this disorder often continue to compulsively collect animals despite the incapacity to provide for them. The hoarded animals often suffer disease, starvation, and death; however, the hoarder is often unaware of the animals’ hunger or pain and may become defensive if criticized for deficits in caregiving (Brown, 2011; Campos-Lima et al., 2014).

The neglect that typifies this disorder is not necessarily intentional. In fact, hoarders often report a deep attachment to their animals, considering them to be like children (Campos-Lima et al., 2014). Rather, their neglect may be because the hoarders neglect themselves as well as their animals, thereby possibly reflecting comorbid personality disorders (Arluke, Frost, Luke, Messner, Nathanson, & Patronek, 2002; Nathanson, 2009).

**Animal Hoarding and Object Hoarding**

Animal hoarders generally find it difficult to relinquish their animals and, in many cases, form attachments that impair personal functioning (Barlow & Durand, 2015). Object hoarders find it difficult to discard anything, even if it has no real sentimental value or use, such as food wrappings, to the point that it overtakes their living space, rendering it unlivable. In both animal hoarding and object hoarding, the affected individuals may not realize that they have a problem until they are confronted by public-health authorities, often following a report from a family member or neighbor. Unlike animal hoarders, object hoarders typically exhibit Axis I and Axis II personality disorders while animal hoarders only show the latter (Frost, Patronek, & Rosenfield, 2011). Thus, they share relationship difficulties, deviant personalities, and social dysfunction, such as reclusiveness. They typically live alone. Notable differences between animal and object hoarding include early onset of the latter, usually occurring in childhood or early adolescence, while animal hoarding usually begins in adulthood (Frost et al., 2011). Animal hoarders also tend to live in distinctly more unsanitary conditions, which is not necessarily the case for object hoarders. Instead, they are threatened by safety incidents of obstruction, unstable stacking, or other arrangements of hoarded items.

The methods of hoarding are also different. Object hoarders may spend compulsively or collect free or discarded items. Animal hoarders may also spend compulsively on items to provide care for the hoarded animals, often far too many to provide adequate care.
hoarders collect their pets either actively or passively (Frost et al., 2011). Sometimes they develop a reputation for accepting unwanted animals or fail to spay or neuter those they hoard, so they multiply through uncontrolled breeding. They acquire some of their animals by taking in lost animals they find, adopting them, or finding them through ads and notices. In some cases, they advertise themselves as animal shelters or rescue groups.

Animal Hoarding’s Relation to OCD

Symptomatology

It is difficult to define animal hoarding as a single disorder because it may, in fact, result from the confluence of several pathologies (Patronek & Nathanson, 2009). Some researchers have asked whether animal hoarding is a subtype of hoarding disorder and not similar to OCD. According to Campos-Lima et al. (2014), animal hoarding and OCD share an excessive felt responsibility and anxiety that something terrible will happen if they do not follow through. However, in the case of animal hoarding, the anxiety may not be unfounded if the animals will be euthanized otherwise.

Campos-Lima and colleagues (2014) studied 16 patients diagnosed as animal hoarders in a clinic treating OCD and found that the two groups differed substantially. For example, the patients diagnosed with OCD presented obsessions that caused anxiety, fear, or shame and actively sought to resist or avoid such emotions by compulsive actions. Animal hoarders welcomed such emotions as motives for their hoarding. Moreover, patients diagnosed as animal hoarders did not respond to treatments for OCD treatment. And in fact, patients diagnosed with OCD rarely present the symptoms of animal hoarding, suggesting that they are not closely related.

Etiology

The onset of animal hoarding is often preceded by a traumatic life event such as physical or sexual abuse in which something was taken from the individual by force or in the loss of a stabilizing relationship or the advent of a serious health issue (Patronek & Nathanson, 2009). If the individual already has a vulnerability to a personality disorder, a severely stressful event will have greater effect. Animals have a soothing effect on their hoarders, especially if the animals are
perceived as focusing on the hoarder, alert to nonverbal cues and present to listen to them, so they may rely on them after a stressful event.

One theory to explain the origins of animal hoarding is that animals serve as self-objects for the hoarder, thereby stabilizing the hoarder’s sense of self (Patronek & Nathanson, 2009). The animals fulfill a psychological need such as vitalization or support, so they feel the animals are essential to them or even their primary reason for life. Despite this attachment, the hoarder may view the animals as being there to meet the hoarder’s own needs instead of the other way around and consequently feel no responsibility to care for them.

Another theory proposed by Patronek and Nathanson (2009) is that hoarders may view their animals as extensions of themselves instead of separate beings, so they are unable to empathize with them or understand that they have needs of their own. Because the hoarder usually neglects himself or herself, he or she does so with the animals, which may explain why they do not see the animals’ poor state of health (see, also, Brown, 2011). It is also possible that animal hoarders experience dissociation, that is, they live in an alternative reality and are insensitive to the degradation in their personal lives and those of their animals. There is also evidence for frontal lobe dysfunction in animal hoarders, which may result in lack of empathy and inhibition, leading to neglect of their animals (Patronek & Nathanson, 2009). Reinisch (2008) proposed an addiction-based model of animal hoarding based on hoarders’ preoccupation with animals, their denial of having a problem, and making excuses for their condition. Impulse control is impaired in hoarders, similar to addicts: they compulsively acquire more animals even though they cannot provide for them. Other theories of its origins include a dementia model because they lack the empathy or insight to recognize poor conditions and a delusional disorder because of their belief that they have a special ability to understand and care for their animals; they claim their animals are well-cared for despite obvious neglect, showing they have unrealistic perception.

**Treating Animal Hoarding**

Most states in the US have anti-cruelty laws mandating that owners of animals provide sufficient food, water, and shelter.
for them. Because animal hoarders do provide some level of all three requirements, although insufficient, it may be convenient for governmental agencies to turn a blind eye (Berry, Patronek, & Lockwood, 2005). Social-services and mental-health agencies may be similarly unresponsive (Arluke, Frost, Luke, Messner, Nathanson, & Patronek, 2002). Even when legal authorities deal with the situation, they may naively assume that the problem ends when the animals are removed, but the rate of repeat offenses is nearly 100% if no longer-term arrangement is in place to address the underlying problems (Berry et al., 2005). Mandatory therapy has become more common as a condition for probation after receiving a sentence of animal cruelty, but authorities may not follow-up to ensure these conditions are met, and, as there is no established treatment for persons diagnosed as animal hoarders, therapists may deal with the disorder ineffectively (Patronek & Nathanson, 2009).

Although little is known about successful treatment for animal hoarders, social therapy and cognitive-behavioral interventions such as those used for object hoarding disorder have been recommended as components of a multidisciplinary approach (Barlow & Durand, 2015; Castrodale et al., 2010; Gahr et al., 2014; Kress, Stargell, Zoldan, & Paylo, 2016). Since animal hoarders often have comorbid disorders, cognitive behavioral treatment may have more success if these are treated simultaneously (Patronek & Nathanson, 2009). Arluke and colleagues (2002) suggested that, because of the high rate of recidivism associated with removing all of the hoarded animals, hoarders might be allowed to keep a small number of them if they consent to spaying or neutering the animals and to regular monitoring to ensure better standards of care.

Conclusion

I have described the existing literature on animal hoarding. Its characteristics are more closely related to the general hoarding disorder than to OCD (Campos-Lima et al., 2014). The lack of effective clinical treatments for animal hoarders is problematic because its prevalence may be increasing (Nathanson, 2009). Developing effective treatments will reduce recidivism and promote the health and well-being of hoarders and animals alike.
References


The Use of Positive Psychological Methods by Religious Leaders and Their Effects on Depression in the LGB Community

Bayleigh Serage
Brigham Young University

Abstract

Depression among lesbians, gays, and bisexuals (LGB individuals) is a complex issue involving many possible factors, including internalized homophobia and discrimination. Religiosity and religious leaders can exert both protecting and risk-inducing influences on LGB depression, depending on how liberal or conservative the congregation’s stance is. The more conservative and non-gay-affirming a congregation is, the more likely an LGB individual is to develop depression (Gattis, Woodford, & Han, 2014). Positive psychology may help decrease the impact of intolerance on LGB individuals (Burckhardt, Manicavasagar, Batterham, & Hadzi-Pavlovic, 2016; Vaughan & Rodriguez, 2014). Through the use of positive psychology methods, such as reappraisal, acceptance, and problem-solving (Burckhardt et al., 2016), religious leaders may more effectively reduce symptoms of depression in the LGB population of their congregations. These adaptive emotional regulation strategies have potential to impact not only the LGB community but also the religious society as a whole.

Keywords: depression, homosexuality, religiosity, congregations, positive psychology
The Use of Positive Psychological Methods by Religious Leaders and Their Effects on Depression in the LGB Community

In a culture where liberal mindsets are increasingly dominating political, religious, and social discussions, the acceptance of sexual minorities appears to be making the world a more tolerant place for the lesbian, gay, and bisexual (LGB) community. However, many conservative religions within the United States and other countries are placing those with same-sex attractions at risk for poor mental health due to the religions’ treatment of LGB individuals and the approaches used when religious authorities counsel these minorities (Barnes & Meyer, 2012). Although there are conservatives who support the LGB community, for the purposes of this article, “liberal” refers to the group that is accepting of LGB individuals, and “conservative” refers to the group that is unaccepting of the group. To change this mindset among conservative religious congregations, the leaders of the groups must first be educated on why and how their viewpoints and treatment of LGB individuals are influencing their congregations and how they can positively influence not only the congregations but the entire LGB community. If the religious leaders can alter their perspective, eventually some congregational members will be influenced by the shift. Even though there is a powerful movement from the LGB community for this country to be more accepting of them, society still has deep reservations about embracing that lifestyle.

Historically, homosexuality has been considered a taboo in Judeo-Christian developed societies. Until recent years, as the Gay Pride movement has gained momentum, many people assumed lesbians, gays, and bisexuals were suffering from a psychopathological disorder (Hickey, 2011), while others simply viewed homosexuality as a sin that must be forsaken (Subhi & Geelan, 2012). However, there is no determined cause of same-sex attraction, although there are many theories, including genetics, prenatal hormones, and environmental influences (Joslyn & Haider-Markel, 2016). In response to these theories and mindsets, different approaches have been taken by healthcare professionals and religious groups to combat homosexuality tendencies in society (Nicolosi, 2016; Stephenson, 2000). Conversion therapies were developed in order to modify sexual orientation to be more “acceptable” (Nicolosi, 2016), and religious groups condemned those with same-sex attractions as sinners in
danger of eternal damnation (Stephenson, 2000). While, on average, modern views are less extreme, faith-based viewpoints still influence many today and may create environments in which LGB individuals are at greater risk for mental health problems, such as anxiety, stress, and specifically depression (Grigorio, 2011).

Depression is a clinical disorder with many causes (Mayo Clinic, 2016). Along with hormone imbalances and genetic predisposition, environment plays a role in how much someone is at risk for depression. An unsympathetic or disapproving environment with high levels of antagonism from religious groups can trigger depressive genes in LGB individuals (CNRS, 2011; Lemogne et al., 2011) and can place LGB people at an extremely high risk for depression. A conservative religious group may potentially foster such an environment due to the constant pressure on LGB individuals to hide, ignore, or change their sexuality (Crowell, Galliher, Dehlin, & Bradshaw, 2014).

Faith leaders can alter an LGB individual’s likelihood of depression depending on what they preach to their congregations (Baruth, Bopp, Webb, & Peterson, 2014; Hamblin & Gross, 2011). Pastors, ministers, priests, and other evangelical leaders have a large amount of sway on religious topics among their congregations (Baruth et al., 2014; Quinn, Dickinson-Gomez, & Young, 2016). According to Baruth et al. (2014), many religious leaders are only somewhat conscious of the impact that their preaching has on congregations. This influence can be positive as Virgil Amundson, a pastor in a small Wisconsin town, demonstrated by encouraging his congregation to reach out to those with a difficult past (Shanklin, 2017). However, leaders can also have a negative impact on their members. The infamous story of Jim Jones and his community shows how leaders can persuade their followers to extreme, unethical, or deadly acts (Gritz, 2011). Even though over half the U.S. population supports marriage equality (Holmes, 2015), LGB individuals are still twice as likely to attempt suicide as compared to heterosexuals (see Figure 1). Considering that statistic, religious leaders should search for new resources that will help them prevent religious atmosphere-related stress, anxiety, and depression in the LGB members of their congregations (Crowder & Kemmelmeier, 2014; Holmes, 2015; Kerr, 2016). By implementing positive psychology techniques in their sermons and teachings, religious leaders have a
chance to possibly reduce depressive symptoms in their congregation’s LGB community (Baruth et al., 2014; Goodmon, Middleditch, Childs, & Pietrasiuk, 2016) .

While positive psychology (the study of human prospering) is relatively new in the field, it has potential as an effective treatment of depression in LGB individuals. Because the contemporary field of positive psychology was established in 1998, researchers still have questions about its effectiveness (Taher, 2016). The goal of positive psychology is to teach participants to have a better outlook on life, to reduce stress levels, and to increase overall satisfaction in life (Gibson et al., 2016). Recent studies have shown that positive psychological therapy is effective in reducing symptoms of depression, anxiety, and stress (Burckhardt et al, 2016; Vaughan & Rodriguez, 2014). Because LGB people in anti-gay environments exhibit more depressive symptoms (Denny et al., 2014; Gattis et al., 2014; Hamblin & Gross, 2011), psychologists ought to more closely examine the effects that positive psychological techniques may have on members of the LGB community since the methods have the potential to protect those individuals from the impact that a hostile environment may have on them.

Depression among LGB Individuals and the Environmental Components

Internalized Homophobia

A non-gay-affirming environment can cause LGB people to develop internalized homophobia, which can result in destructive behavior (Barnes & Meyer, 2012). A risk factor for depression and suicide, internalized homophobia develops when LGB individuals assimilate the stereotypes, myths, and misrepresentations about their orientations and believe them (Walch, Ngamake, Bovornusvakool, & Walker, 2015). Consequences of internalized homophobia include maltreatment of other LGB individuals, displays of heterosexual behavior, and depression (Walch et al., 2015). A story about a young man displays these repercussions. Omar Mateen had a wife and children, and most considered him to be heterosexual; however, that came into question on June 12, 2016, when Mateen shot and killed 49 people at a gay nightclub in Florida. After the tragedy, investigators began to look into the reasons behind the attack, and
they came up with one plausible theory—that Mateen was suffering from internalized homophobia (Lang, 2016). Clearly, internalized homophobia has dire results. In addition, those at risk for internalized homophobia are often found in high-stress situations (Lick, Durso, & Johnson, 2013; Newcomb & Mustanski, 2010). Furthermore, non-gay-affirming groups may discriminate against LGB individuals, greatly increasing stress levels (Walch et al., 2015). While religious heterosexuals might find their environment to be uplifting and constructive, LGB people might feel disheartened because of the conservative theology often preached in congregations. This theology thus causes internalized homophobia and aggravated depression and it should be approached with caution.

**Conservative Religious Environments and Resulting Depression**

When examining the effect of a conservative, non-gay-affirming religious group on an LGB individual, one of the primary results is depression. Although Barnes and Meyer (2012) showed little to no correlation between internalized homophobia in LGB people and the extent to which their beliefs supported homosexuality, one study showed that conservative religious stances will create more negative views on homosexuality in the general population (Gattis et al., 2014). Barnes and Meyer (2012) also reported that other environmental factors, such as home life, region, education, and gender, contribute to distress among LGB individuals, including the degree of liberalism or conservatism among their group. Research evidence reveals that the more conservative a congregation is, the more likely an LGB member is to have internalized homophobia (Barnes & Meyer, 2012). Therefore, LGB people who have not revealed that they are a sexual minority or are experiencing opposition within their congregation have a higher risk of depression. As depression can place one at a high risk for suicide (Crowder & Kemmelmeier, 2014), religious groups should be made aware of the danger they may be creating for LGB individuals. This can be done by implementing certain licensing requirements for psychologists, creating seminars for religious leaders, or making a website for psychologists, leaders, and LGB people to learn from each other. These communications are not only important for the welfare of the LGB community and religious congregations, but are very possible to put in place.
Potential Impact of Positive Psychology on Congregations

Crowell et al. (2014) showed that, while many Christian faiths are becoming more accepting of same-sex attractions, there is still a negative bias toward LGB individuals in many of the denominations. Even though more conservative religions are preaching tolerance, LGB people are considered sinners by many conservative religious groups because of the stigma surrounding homosexuality within religious contexts and the common conception that heterosexuality is divinely ordained (Crowell et al., 2014), a stance that could lead to internalized homophobia (an LGB individual’s internalization of stereotypes (Newcomb & Mustanski, 2010)) and psychological distress. However, sexual minority adults seem to have less psychological distress when they have strong religious affiliation owing to the increased sense of community (Gattis et al., 2014). Still, religious affiliation can cause mental distress when the religion has a negative view on LGB individuals (Gattis et al., 2014). A correlation between good and poor mental health can be found when examining the acceptance of sexual minorities within the congregation as a whole; religiosity in an accepting environment can reduce mental distress while religiosity in an antagonistic environment can increase distress. With the understanding that the previous studies done with positive psychology have not examined a religious aspect, the techniques need to be applied to a religious setting in order to understand the potential influence.

Positive Psychology in Religious Contexts

Defining and Using Positive Psychology

An effective way of preventing the potential stress of antagonistic religious environments is through positive psychology (Ayten, 2012; Day, 2010). Positive psychology practices can include showing gratitude, performing acts of kindness, and creating a sense of meaning in life (Goodmon et al., 2016). The idea behind these methods, specifically reappraisal, acceptance, and problem-solving, is to increase well-being and self-awareness in the individual, which would greatly benefit sexual minorities who may be struggling with internalized homophobia or reduced self-esteem.
Reappraisal. Changing how a situation is interpreted can be extremely beneficial in regard to congregations’ understanding of the LGB community (Burckhardt et al., 2016; Goodmon et al., 2016; Vaughan & Rodriguez, 2014). Instead of teaching that lesbian, gay, and bisexual individuals are sinners, religious leaders utilizing reappraisal might characterize LGB individuals as people with a great deal to offer society. By teaching that everyone sins differently, evangelical leaders do not single out any specific group. In doing this, religious leaders would not categorize their congregations into sinners and non-sinners; rather, they would be showing that each member has his or her own struggles and must be treated with respect and love.

Acceptance. The positive psychology technique of acceptance has the potential to engender the most change within a group (Burckhardt et al., 2016; Gattis et al., 2014). The welcoming of LGB individuals into a religious congregation could provide sexual minorities an environment wherein they feel welcome instead of rejected and judged. This acceptance does not mean that a conservative religious person should be accommodating to something that he or she considers a sin. Acceptance of a person and approval of a behavior are not the same thing (Warren, 2014). The Christian cliche “love the sinner, hate the sin” still encourages discrimination. “Love sinners” would be more appropriate, because it addresses the Christian belief that everyone sins and judgment is reserved for God, according to many Christian interpretations of scripture (1 Corinthians 4:5, King James Version; John 5:21–31).

Problem-solving. Because religious leaders have a duty to listen to the individual, problem-solving is one technique that may generate a major change (Baruth et al., 2014; Burckhardt et al., 2016; Quinn et al., 2016). Listening to an LGB person who feels like an outcast and knowing that the congregation is partially responsible should inspire evangelical leaders to learn to preach acceptance and to help individuals learn how to modify their own situations. A single LGB individual does not have the power to change the congregation, but a religious leader might (Baruth et al., 2014; Goodmon et al., 2016; Quinn et al., 2016). That knowledge places evangelical leaders in a position to change the perspective of the congregation, thus partially solving the problem.

Even though only 3.6% of U.S. adults currently identify as lesbian,
gay, bisexual, or other (Ward, Dahlhamer, Galinsky, & Joestl, 2014), this small percentage is growing and should encourage mental health professionals to research depression specifically within that community. Similarly, the general population should be more aware of the impact that their attitude toward and treatment of sexual minorities has on LGB individuals. Although conservative religious leaders usually argue against same-sex relations, they should adopt a more positive tone when discussing homosexuality within their congregations, because those with same-sex orientations are at a higher risk of developing depression when living within an anti-gay religious environment (Gattis et al., 2014). An examination of depression among LGB individuals and its environmental components, the impact religious leaders have on congregations, and the potential impact positive psychology has on congregations and LGB people will expose the need for change. These changes would not require leaders to change their beliefs—just the way they approach preaching about LGB individuals.

Impact That Religious Leaders Have on Congregations

While most people accept that their pastor, bishop, rabbi, or other religious leader influences the overall morality or religiosity of their congregation, what is less often considered is their influence on the congregation’s health, social lives, or political views. Baruth et al. (2014) wrote that faith leaders have a significant sway on their congregation’s opinions on health issues and participation in well-being programs. One story shared in the study explains that a leader spoke about the importance of vaccines and other health issues and then there was an increase in vaccinations in the congregation (Baruth et al., 2014). Another study highlights that pastors advocating homosexuality as a sinful act can create tension within their congregations toward LGB people and thereby limit interaction with that branch of the congregation (Quinn et al., 2016). In a Baptist congregation in Wisconsin, the pastor, who preached love and acceptance, refused to reach out to the LGB members who had contracted HIV. The congregation followed the example and did not reach out with those members as they might have with a heterosexual individual (Quinn et al., 2016). Understanding the impact religious leaders have on their congregations should encourage leaders
to educate themselves on LGB depression risks and learn about possible ways to reduce the impact of a non-gay-affirming religious environment. This education would be difficult to implement, as freedom of speech allows religious leaders to voice their opinions, whatever they may be. The easiest and most cost-effective way would be for the leaders themselves to read articles such as this one to understand the depth of their influence.

**LGB Individuals’ Relationship with Religiosity**

Religiosity plays a key role in how sexual minorities view themselves and it influences their risk for depression and internalized homophobia because of the impact religion has on perceptions of right and wrong. Some argue that the LGB community is predominantly liberal and has minimal religious interaction; however, research shows that approximately 48% of U.S. LGB individuals consider themselves Christian and 11% practice a religion other than Christianity, potentially exposing them to negative environments (Cruz, 2015). These risks of depression, internalized homophobia, and suicide create a need for religious leaders to become more accepting of the homosexual community within their congregations. Rather than preaching to love sinners and condemn sins, leaders should be more accepting with their congregation by using positive psychological methods because they can influence how positive or negative their congregation’s attitude is toward homosexuality (Barnes & Meyer, 2012). One way to encourage acceptance among conservative congregations would be to implement positive psychology methods in their outward treatment of and statements regarding homosexuality.

**“Strong Minds” Program and Adaptive Emotional Regulation Strategies**

Before positive psychology methods can be applied to religious settings, we must understand that positive psychology has on the general population in a more generic environment. A study in Australia examined the adaptive emotional regulation strategies often used in positive psychology and the effect they had on adolescents’ mental health (Burckhardt et al., 2016). Productive strategies are outlined in the study called “Strong Minds,” which showed a negative association between adaptive emotional regulation strategies and poor mental health in high school students (Burckhardt et al.,
The strategies include reappraisal, the modification of how a situation is interpreted to reduce the emotional impact; acceptance, the acknowledgement of the emotional experience, as opposed to suppressing it; and problem-solving, the modification of the situation itself to reduce the emotional impact (Burckhardt et al., 2016). LGB individuals in an anti-gay environment are not given a strong opportunity to implement these strategies for several reasons. Internalized homophobia makes modifying interpretation nearly impossible, as LGB people have integrated the stereotypes into their thoughts. Furthermore, there is almost no acceptance toward them, making it difficult for them to accept their own orientation, and they have little chance to problem-solve because they cannot change how others around them behave (Burckhardt et al., 2016; Crowell et al., 2014). These failures to adapt can result in greater internalized homophobia in LGB individuals, which may contribute to a depressed state of mind.

According to the “Strong Minds” study, there is a positive correlation between poor acceptance and mental disorders (Burckhardt et al., 2016). In the study, the treatment group underwent acceptance and commitment therapy combined with positive psychology. Those who completed all 16 sessions showed a statistically significant improvement in their mental health with a majority of participants showing fewer symptoms than the control group (Burckhardt et al., 2016). Each session focused on a different aspect of the positive psychological model, including identifying values, assertiveness, kindness, and relationships. Symptoms of depression, anxiety, and other stress-related disorders were significantly reduced, while overall well-being was improved. While some may interpret these findings as an indication that LGB individuals are the only ones who can ultimately repair their mental health, it may be more appropriate to look at the potential of positive psychology as a way for the general population to improve its approach to the LGB community. Just as congregations have a small percentage of members who are LGB, the Strong Minds study included teenagers who identified as lesbian, gay, or bisexual. The solution offered by positive psychology and acceptant therapy are based on changing the environment in which these minorities live and therefore help change any depressive mental states.
Bringing It All Together

As previously described, LGB individuals in antagonistic religious environments are more likely to develop internalized homophobia, depression, or both (Barnes & Meyer, 2012). Because this non-gay-affirming setting has roots in the doctrinal teachings of Judeo-Christianity (Leviticus 20:13, King James Version; Robinson, 2010), there may be difficulty in shifting the stance on those theologies to accommodate sexual minorities. Additionally, this type of environment is sometimes influenced by the personal viewpoints of the congregational leader, whose opinion on social matters impacts the opinion of the congregation. Because of this authority, faith-based leaders have a responsibility to ensure that their congregation is progressing. However, by alienating sexual minorities, these leaders are both hindering LGB individuals’ potential faith progression and fostering an environment in which LGB people are more susceptible to depression (Baruth et al., 2015; Quinn et al., 2016; Subhi & Geelan, 2012). The trend can be changed with the use of positive psychology in congregations, starting with the leaders.

How to Implement Positive Psychology

Although research on positive psychology’s impact is still being conducted, the possibility of its results should be taken seriously. Considering the prevalence of depression among LGB individuals (one study estimates approximately 50% of LGB individuals have felt depressed at some point), extra precautions should be taken to ensure the mental health of these minorities (Kerr, 2016). Positive psychology has been shown to increase happiness levels and decrease depression and stress symptoms in both hetero- and homosexual youth (Burckhardt et al., 2016; Vaughan & Rodriguez, 2014). The techniques mentioned in the “Strong Minds” study are some of the best ways to improve the environment for these individuals in religious communities. Reappraisal, acceptance, and problem-solving may be tools with which religious leaders can help LGB people fight their vulnerability to depression.

Conclusion

Religiosity has potential to be a protective factor against depression in LGB people; however, due to discrimination, conservative religious groups increase the likelihood of an LGB
individual developing internalized homophobia or depression. According to rates of depression and suicide, LGB individuals are over two times more likely to develop depression and attempt suicide than heterosexual individuals (Crowder & Kemmelmeier, 2014; Shore, 2010). Depression in LGB people increases if they are placed in non-gay-affirming environments (Barnes & Meyer, 2012). Conservative religious groups may foster such an environment (Barnes & Meyer, 2012; Subhi & Geelan, 2012), raising the chance that an LGB member will develop internalized homophobia or depression. The leaders of these conservative groups have a considerable sway on the opinions of their congregation; therefore, these religious leaders could reduce depression within the LGB community by integrating positive psychological methods into their preaching and their interactions with both the congregations and the LGB individuals.

The implications of positive psychological research findings have the potential to affect many future generations following the LGB Gay Pride movement. When examining the potential impact of positive psychology in religious contexts, a powerful possibility arises—the opportunity to change the relationship between LGB individuals and conservative faiths. Viewed as “at odds with each other,” the LGB and religious communities historically have not sought common ground; however, the incorporation of positive psychology could bridge the gap between these two groups. Positive psychology also has an opportunity in this context to demonstrate its place within the field. Many people, not just LGB people or religious members, stand to gain from the growth of positive psychology. Those struggling with depression, anxiety, and other mental health issues have benefited from the use of positive psychology, yet the methods still are being criticized among professionals because of its recent emergence into the field and the scarce amount of valid research examining the topic (Goodmon et al., 2015; Kristjánsson, 2013).

More research examining the relationship between positive psychology, religion, and the LGB community is needed to determine whether positive psychology, as a new methodology, has enough of an impact to make a difference. Freedom of religion and speech must also be considered. Even though a religious leader might be educated on LGB depression, may be fully aware of the impact he or she has on congregations, and might understand positive psychological methods,
he or she may choose to continue preaching the same way based on his or her own opinion. Similarly, members of congregations have the right to their own opinions, regardless of what their religious leaders teach.

Overall, the influence society has on the LGB community should not be overlooked, especially the impact of conservative religious congregations. The risk for depression among LGB individuals rises when the environment is hostile toward same-sex orientations (Barnes & Meyer, 2012; Gattis et al., 2014). Because of the increased risk for depression and suicide among these individuals, researchers should be searching for ways to reduce the impact of the antagonistic environments, including the implementation of positive psychology by conservative religious congregations.

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Suicide Attempt Differences Between Heterosexuals and Sexual Minorities

Figure 1. Heterosexual suicide attempts make up about 33% of attempts while sexual minority suicide attempts are nearly double, making up approximately 67% of attempts (Denny et al., 2016; Kerr, 2016).
Abstract

In this paper, I provide a comprehensive review of recent literature (published since 2010) regarding the relation between academic success and participation in extracurricular activities. I examine the direct effects—both positive and negative—that such participation has on the academic performance of students of all grade levels. Subsequently, because sports constitute a large portion of the extracurricular spectrum, I also examine studies that analyze the effects of physical activity on academic performance. These studies suggest that extracurricular activities may have a positive effect on academics, especially when they contribute to a balanced life, self-confidence, an increased sense of personal duty and contribution to the school, and feelings of belonging. Meanwhile, extracurricular activities may have a negative effect when they produce an overloaded personal schedule and cause students to define themselves primarily by their activities rather than as students. Studies regarding the general effects of physical activity included both positive and negative correlations with academic success; however, most studies lacked a layer of depth necessary to form any definite conclusions concerning the relationship. I also discuss the presence of confounding variables in the research, practical applications for parents of the students, and provide suggestions for future research.

Keywords: extracurricular activities, physical activity, academics, academic success, academic performance
Effects of Extracurricular Activities and Physical Activity on Academic Success

Parenting could be characterized as a never-ending conundrum of decisions about how to provide one’s child with the best life possible. Parents face the ever-present task of setting rules, making guidelines, and otherwise teaching their children lessons that will help them become successful, self-sufficient adults. For this reason, it is important that parents acquire the knowledge they need to make wise judgments.

Accordingly, some of the most important decisions parents make are those related to their children’s academic success. Considering the amount of time that each young person spends in school or doing related activities, as well as the impact these academic endeavors will have upon their opportunities for success later in life, these types of decisions deserve attention. It is important that parents understand how to foster an environment wherein children can thrive academically.

In this paper, I will explore one of the factors that affect academic success, namely, participation in extracurricular activities. Specifically, I will examine recent literature studying the direct effects—both positive and negative—that participation in extracurricular activity has on academic performance. Additionally, considering that sports constitute such a large portion of the extracurricular spectrum, I will also examine studies which analyze the effects of general physical activity on academic performance. By doing so, I seek to provide parents with information needed to make informed decisions regarding their children’s participation in extracurricular activities and suggest possibilities for future research.

Direct Effects of Extracurricular Activities

Several recent studies have contributed to a growing body of knowledge on the subject of extracurricular activities and academic success. These studies analyze ways in which extracurricular activities can positively affect students, as well as ways in which they can negatively affect students.

Positive Effects

In an effort to highlight the positive effects of extracurricular activities on academics, Burrows and McCormack (2011) conducted a
case study involving a successful secondary school in New Zealand. This all-girls high school boasted a high rate of participation in sports, consistently outranked most other schools in the region on national exams, and prided itself on producing well-rounded graduates. The study included personal interviews with students and staff members, detailed observations of activities both in and out of the classroom, documentation of aesthetic features of the school itself, and intense studying of school documents, policies, and so forth. Ultimately, the authors suggested several ways in which extracurricular sports contributed to academic success: by providing balance, promoting self-confidence, increasing a sense of contribution and duty, and cultivating feelings of belonging.

Providing balance. A balanced life could be characterized as a way of life in which a healthy balance between work, leisure, and other personal pursuits is maintained. For developing adolescents, life balance and leisure activities are positive predictors of academic achievement and may help students maintain an optimal level of efficiency (Bergin, 1992). Burrows and McCormack (2011) suggested that extracurricular activities could be an important contributor to a student’s life balance. By taking a break from academic endeavors, students have the opportunity to be social, release energy, and have fun. More specific research is needed to confirm the theory that extracurricular activities truly provide this balance, but it is plausible these activities promote a balance that is vital to development and are important in maximizing academic efficiency.

Self-confidence. Burrows and McCormack (2011) also suggested that extracurricular activities provide a way to build self-confidence, which can have a positive effect on academic performance. By achieving personal goals, receiving recognition for accomplishments, and regularly interacting with others in an intricate social system, students were better able to feel productive and self-efficacious. Previous literature provides further support for this claim, ultimately stating that the self-esteem gained through extracurricular activities motivates and drives success, which often extends to other facets of the student’s life, including academics (Cosden, Morrison, Gutierrez, & Brown, 2004; Mahoney & Cairns, 1997).

Sense of contribution and duty to one’s school. Burrows and McCormack (2011) also found that extracurricular activities created
a greater sense of connection to one’s school. As students competed under the name of the school, they were increasingly motivated to give back and represent it well, both in academics and other activities. Again, previous literature supports this claim, reporting that this sense of duty often seems to carry over into the academic realm, resulting in lower drop-out rates and higher academic achievement (Cosden et al., 2004; Mahoney & Cairns, 1997).

**Sense of belonging.** Consistent with the previously mentioned ideas, one could also reasonably hypothesize that the more a student feels that he or she belongs at school, the more likely that student will perform well academically. Moreover, considering that extracurricular activities provide a social atmosphere where students are encouraged to achieve in the name of the school, it is reasonable to conclude that extracurricular involvement might provide an ideal setting to feel that belonging. Ultimately, the results of several studies appear to support these hypotheses. Knifsend and Graham (2012) discovered a curvilinear relationship between sense of belonging, academic performance, and the number of extracurricular activities a student chose to engage in. This suggests that a student’s sense of belonging and academic achievement may be highest when the number of extracurricular activities is moderate. Involvement in too many activities may result in an overloaded schedule, but involvement in too few may result in missed opportunities. However, a moderate amount of activities (about two) may provide a perfect setting to learn skills, find one’s place, and maintain enough time to focus on schoolwork. Additionally, Fox, Barr-Anderson, Newmark-Sztainer, and Wall (2010) found that participation in school sports teams encouraged students to identify with their school and its values, which, in turn, was associated with higher grade point average (GPA).

Notably, an enhanced sense of belonging may depend on the types of extracurricular activities a student engages in. (Martinez, Coker, McMahon, Cohen, & Thapa, 2016). For example, a student in an art club might feel more connected than a student athlete would, or vice-versa. The connection might depend on the quality of the program, values of the school or community, or other social factors. Unfortunately, there is little information in that area at this time, and future research is needed.
Negative Effects

Few studies have found negative correlations between extracurricular activity and academic achievement. There are, however, two factors sometimes caused by participation in these activities that may produce negative effects: an overloaded schedule and a narrow sense of identity.

**Overload.** Those who oppose participation in extracurricular activities often call attention to the possibility that extracurricular activities might interfere with time that could be spent doing schoolwork. Knifsend & Graham (2012) confirmed this time interference as a factor in determining academic success. As noted previously, they found that a high number of extracurricular activities (three or more) was detrimental to academic performance. This decline in academic performance can likely be attributed to overload, as students devote so much time to extracurricular activities that they are rendered unable to keep up academically. However, they also found that a moderate number of extracurricular activities (about two) contributed positively to academic performance. Thus, extracurricular activity may only produce a negative effect if the student is left with insufficient time and energy to devote to academics.

**Narrow identity.** Some students choose to define themselves by their extracurricular activities and place little emphasis on their roles as students, which also may be detrimental to academic success. Two studies support the legitimacy of this effect. Beron and Piquero (2016) found that the only situation in which the relationship between identity and GPA was consistently negative was when the student identified himself or herself primarily as an athlete, rather than as a student. Similarly, Bimper, Harrison, & Clark (2012) observed successful African-American collegiate athletes and found that the athletes were encouraged to identify as athletes more than they were encouraged to emphasize any other “pertinent role” (p. 19). One individual in the study asserted, “The White athlete comes to school to get a great education and hopefully be a good football player. The Black athletes . . . are taught to come to be a great football player and go to class because that’s what keeps you eligible” (p. 14). The authors later implied that casting off such a narrow identity was an important factor in determining their academic success. The results of this second study should be applied with caution, due to the fact
that this study focused largely on race, which could be a limiting factor. The consistency of results between the two studies, however, supports the idea that identity plays an important role in determining academic outcomes. This concept may be applicable to other domains of extracurricular activity as well; when students allow any non-academic activity to define who they are, negative academic results may be expected to follow.

**Physical Activity and Academic Achievement**

While there are numerous types of extracurricular activities students can participate in, many of the activities offered to students are sports. For this reason, it is appropriate to briefly examine the effects that physical activity has on academic success. Several recent studies have analyzed the relationship between these two variables, and both negative and positive correlations were reported.

**Positive Outcomes**

Several studies reported positive associations between physical activity and academic achievement. Three studies indicated that the more physical activity the students participated in, as well as the more fit they were, the more likely they were to get good grades (Ayan, Carral, & Montero, 2014; Morita et al., 2016; Pellicer-Chenoll et al., 2015). A fourth study found a positive correlation, so long as the physical activity was at a moderate or high intensity (Ardoy et al., 2013). Additionally, Koivusilta, Nupponen, and Rimpela (2011) asserted that students who are physically active during their adolescent years tend to achieve higher levels of education and better socio-economic status as adults.

**Negative Outcomes**

Meanwhile, two studies found negative correlations between physical activity and academic success. Dijk et al. (2014), reported a negative correlation between physical activity and academic success only among middle school students. The authors speculated that middle school students might be more prone to prioritizing physical activity over school-related work. In the second study, researchers used accelerometers to objectively measure physical activity in a sample of 1,778 students aged 6-18 and found a weak but negative correlation between the physical activity and academic success.
The use of objective measures gives this study credibility; however, the authors did not categorize participants in different age groups, which raises the question of whether one group (for example, middle school students) may have skewed the results. However, regardless of the outcomes of the studies, most of the studies failed to analyze the many layers and facets of their material deeply enough to form any definite conclusions concerning physical activity and academics. Given the contradiction between negative and positive results, it seems there must be more that factors into this debate. Taking all of these studies and ideas into account, research seems to indicate that the relationship between physical activity and academic achievement is more complex than simply stating that physical activity yields a better (or worse) academic performance.

Confounding Variables

In order to ascertain the relationship between physical activity and academic achievement, it is therefore important to examine the potential role of other variables that might affect the relationship—or in other words, confounding variables. In general, most of the studies examined the relationship without factoring in confounding variables, an oversight which weakens their arguments. Future researchers must include more extensive explorations of these variables if they wish to fully expose the issue. However, a few studies did take some of these alternative variables into account, namely age, intensity, and type of physical activity.

Age. Only one study (Dijk et al., 2014) examined results based on different age groups. As noted above, the authors only found negative correlations between physical activity and academic performance in middle school students. All other studies (Ayan et al., 2014; Esteban-Cornejo, Tejero-González, Martinez-Gomez, Cabanas-Sánchez et al., 2014; Jaakkola, Hillman, Kalaja & Liukkonen, 2015; Koivusilta et al., 2011; Morita et al., 2016; Pellicer-Chenoll et al., 2015) either focused solely on one age group or failed to distinguish between age groups. Based on the relationship found by Dijk et al. (2014) and the lack of related research in the other studies, age could have a significant effect on the value of physical activity in an academic context. For this reason, I recommend that future studies should include longitudinal research designs in order to identify the relation between physical activity and academic achievement.
activity and academic achievement as a function of students’ age.

**Intensity.** Research suggests that the intensity of the physical activity also plays a role in the academic consequences. Three studies looked into this phenomenon, and the results suggest that higher intensity activities equate with increased academic performance (Ardoy et al., 2013; Ayan et al., 2014; Phillips, Hannon, & Castelli, 2015). Ayan et al. (2014) suggested that moderate and intense physical activity activates certain areas of the brain, which can lead to increased attention, concentration, and general cognitive functioning. Future research should account for this relationship and focus on determining the upper and lower thresholds at which physical activity might affect academics.

**Type of physical activity.** The type of physical activity also affects academic outcomes. One particularly revealing article found that activities promoting cardiorespiratory capacity and motor ability benefitted students’ academic performance, but activities promoting muscular strength were not significantly correlated with such performance (Esteban-Cornejo, Tejero-González, Martinez-Gomez, Del-Campo, et al., 2014). Similarly, Jaakkola et al. (2015) found that fundamental movement skills (basic movements such as stretching, throwing, kicking, and running) predicted academic performance in 9th grade students, suggesting that activities promoting those skills might be beneficial to students as well. This process works similarly to those described in the section concerning intensity. Some physical activities seem to activate neural pathways that lead to better cognitive functioning while others do not (Jaakkola et al., 2015). Again, future research should focus on different kinds of physical activity and the way they might affect academic performance.

**Conclusion**

The purpose of this paper was to provide a comprehensive review of recent literature studying the effects of extracurricular activity and physical activity on academic achievement. Research seems to suggest that extracurricular activities do more benefit than they do harm, provided that the student does not allow those activities to control his or her life (Knifsend & Graham, 2012). Parents should monitor the time and effort their children devote to these activities and play an active role in promoting a healthy balance between the activities...
and academic endeavors. Given these circumstances, parents should feel reasonably assured that allowing their children to participate in extracurricular activities would not ruin their children’s academic lives, but rather may benefit their children’s academics.

Meanwhile, research does not yet provide consistent conclusions concerning physical activity’s effect on academic achievement. The relationship is affected by a wide variety of confounding variables that need to be taken into account before definite conclusions can be reached.

Future research is necessary concerning both extracurricular activity and physical activity. Such research should examine confounding variables like those listed above, as well as other variables, such as the duration of the activity and the time of day the activity is performed. Additionally, a more holistic approach to the relationship between extracurricular activity and academics would also be beneficial, as there are many factors related to extracurricular activities that affect academic performance and one can reasonably believe that a combination of these factors determines the academic outcome.

Furthermore, future research should employ more sophisticated measures of physical activity. Self-report measures were commonly used to measure physical activity, but better methods of measurement would likely secure more accurate results.

The relationship between physical activity and academics, as well as the relationship between other extracurricular activities and academics, is complex. Nonetheless, these relationships deserve attention, because in a sense, these relationships are about more than activities and grades—they are about the well-being of the children that will go on to shape the future. Their success deserves undivided attention.

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Can Self-Compassion Reduce Depression and Anxiety in Adolescents?

Kelsi Wilson  
Brigham Young University

Abstract

Self-compassion has been explored as a new intervention strategy for adolescents suffering from depression and anxiety. These two mental illnesses are increasingly prevalent among this age group due to a variety of factors, including transitional difficulties and social stressors (Muris, Meesters, Pierik & de Kock, 2016; Neff & McGehee, 2010). Studies have shown that individuals who practice self-compassion have fewer symptoms of depression and anxiety (Bluth & Blanton, 2015). Conversely, insecure attachment, low self-esteem, and belief in the personal fable, symptoms common in depressed and anxious individuals, negatively correlate with self-compassion (Bluth & Blanton, 2015; Muris et al., 2016; Neff & McGehee, 2010; Raque-Bogdan, Ericson, Jakson, Martin, & Bryan, 2011). The components of self-compassion—namely self-kindness, common humanity, and mindfulness—appear to combat the negative psychological processes associated with depression, supporting the possibility of self-compassion as an effective intervention strategy for adolescents (Van Dam, Sheppard, Forsyth, & Earleywine, 2011). Additional research suggests that self-compassion is a more effective strategy than self-esteem interventions for combatting adolescent depression and anxiety (Marshall et al., 2015).
Can Self-Compassion Reduce Depression and Anxiety in Adolescents?

Two of the most common mental illnesses among adolescents are depression and anxiety (Muris, Meesters, Pierik, & de Kock, 2016). In fact, recent statistics suggest that approximately one out of every four high school students suffer from anxiety or depression (Bluth et al., 2016). Though several factors contribute to this high statistic, common traits correlated with depression include self-criticism, isolation, negative self-evaluation, and high stress levels (Bluth & Blanton, 2015; Bluth et al., 2016; Shapira & Mongrain, 2010). Between the ages of 12 and 17, individuals can be especially affected by feelings of negative self-evaluation because of the transition process and self-identification that takes place during these years (Neff & McGehee, 2010). Studies have explored numerous coping strategies and interventions counteract depression and anxiety, including distraction, cognitive reappraisal and acceptance, and mindfulness (Diedrich, Grant, Hofmann, Hiller, & Berking, 2014; Edwards, Adams, Waldo, Hadfield, & Biegel, 2014; Muris et al., 2016; Odou & Brinker, 2015; Van Dam, Sheppard, Forsyth & Earleywine, 2011). Self-compassion has also received research attention as a technique for reducing depression and anxiety.

Self-compassion is described by Neff and Dahm (2015) as comprising three components: kindness towards self, awareness of common humanity, and mindfulness. Self-compassion embodies an attitude of kindness towards one’s own weaknesses, an acknowledgement of the similar challenges and weaknesses common to all humanity, and a consciousness of one’s present state. Research on the effects of self-compassion is relatively new, with most major research occurring within the last decade (Neff & Dahm, 2015). However, studies on the effects of mindfulness (a trait closely related to self-compassion) have been underway for more time and show that mindfulness helps to combat negative effects associated with depression and anxiety, such as low self-esteem and stress (Bluth & Blanton, 2015; Bluth et al., 2015; Neff & Dahm, 2015; Neff & McGehee, 2010). Mindfulness is defined as “being open and present to one’s own suffering” (Bluth, Gaylord, Campo, Mullarkey, & Hobbs, 2015, p. 480). Self-compassion is positively correlated with mental well-being and positive traits (Bluth & Blanton, 2015). This
literature review will examine the effectiveness of self-compassion in combatting the negative effects of low self-esteem, depression, and anxiety. This review will first explore several variables that confer risk for psychological maladjustment in adolescents, including transitional struggles and life stressors. It will also summarize negative psychological processes associated with depression and anxiety such as low self-esteem, insecure attachment, and the personal fable. Finally, the review will inspect positive psychological strategies associated with self-compassion such as self-worth, mindfulness, and connectedness.

Adolescent Development and Psychopathology

Transitional Difficulties

As a part of the transitional progression between childhood and adulthood, adolescents are engaged in the process of identity formation (Neff & McGehee, 2010). As part of this developmental stage, teenage minds often find it difficult to distinguish both between their own thoughts and those of others, and between mere thought and truth (Muris et al., 2016). This difficulty may lead to a tendency to internalize and over-associate these issues with themselves as people (Muris et al., 2016). For example, a teenager may experience loneliness and, rather than view this as a temporary emotion, he or she may create a longstanding belief that he or she is truly unloved and unwanted. This pattern may help to explain adolescents’ seemingly limited self-compassion, as they tend to magnify negative beliefs and lack objective, kind behavior toward themselves. Furthermore, the developmental stage is often accompanied by a heightened vulnerability to negative self-evaluation and stress, which can grow into deeper, more harmful emotions (Muris et al., 2016).

Social Stressors

This developmental stage also brings with it various stressors unique to adolescents which may increase depression and anxiety (Muris et al., 2016). Some stressors that (although not unique to adolescents) are especially prevalent during teenage years include body image, peer and family relationships, and academic expectations (Edwards et al., 2014; Muris et al., 2016; Neff & McGehee, 2010). Relationships with family members can be a particularly potent source
of stress, depending on circumstances and the quality of relationships. Neff & McGehee (2010) assert that stable family relationships are likely associated with the presence of self-compassion, while dysfunctional family relationships are associated with negative self-views and low self-compassion. Adolescents coming from minority groups may experience even more stressors because of the presence of discrimination and lower income households (Edwards et al., 2014). Clearly, external factors play a major role in the presence of self-compassion.

Another prevalent stressor is the negative self-evaluation that often accompanies many adolescent mindsets (Bluth et al., 2016). Vulnerability to depression may partially stem from negative self-evaluation and stress that accompany the developmental phase (Bluth et al., 2015; Neff & McGehee, 2010). This negative self-evaluation can be linked to the transitional process and self-identification that take place during the teenage years (Neff & McGehee, 2010). Bluth et al. (2016) reported that negative psychological stress responses are triggered by negative self-evaluation and threatened social status (Bluth et al., 2016). These results indicate that resulting stress is not an imagined effect but a tangible presence. Social stressors have been shown to exacerbate depression and anxiety (Bluth et al., 2016; Edwards et al., 2014). The difficulties associated with transitional stressors can therefore serve as predictors for depression and anxiety, and thus can present potential areas for intervention. As self-compassion has been shown to act as a protective agent against some of the negative effects caused by life stressors, its implementation can, by extension, be presumed to combat the onset of depression and anxiety in teenagers (Van Dam et al., 2011).

### Negative Traits Correlated with Depression and Anxiety

#### Insecure Attachment

Attachment styles describe habits of codependency that stem from early parent-child relationships (Raque-Bogdan, Ericson, Jackson, Martin, & Bryan et al., 2011). According to attachment theory, early childhood relationships affect the way humans connect with others throughout their lifetimes as well as their perception of their own worth (Raque-Bogdan et al., 2011). Secure attachment has consistently shown a positive correlation with the possession of self-compassion.
Research also supports a correlation between attachment style and well-being: secure attachment style shows a positive correlation with well-being, and anxiety and avoidance attachment shows a negative correlation (Raque-Bogdan et al., 2011; Wei et al., 2011). In other words, individuals are more likely to both see and treat themselves in positive and caring ways when raised by nurturing parents or guardians (Raque-Bogdan et al., 2011).

Avoidance attachment is characterized by a tendency to withdraw from social relationships, while anxiety attachment is often accompanied by an overpowering worry about relationships (Raque-Bogdan et al., 2011). Because the ability to connect socially with others is thought to significantly enhance well-being, both avoidance and anxiety attachment styles can have negative effects on mental health (Wei et al., 2011). Secure attachment indicates an absence of both avoidance and anxiety behaviors, and may be a happy medium between avoidance and anxiety attachment styles (Raque-Bogdan et al., 2011).

Results from multiple studies support Neff and McGehee’s (2010) explanation of the negative correlation between insecure attachment styles and self-compassion. Neff and McGehee stated that those with insecure attachment styles likely have a lessened ability to exhibit kindness towards themselves because they received limited kindness during childhood (Raque-Bogdan et al., 2011; Wei et al., 2011). Thus, levels of self-compassion tend to be lower with those who have insecure attachment compared to those with secure attachment. Research additionally supports a correlation between high anxiety or avoidance tendencies and low levels of mattering—a belief that one is cared about and depended upon by other people—which may further affect levels of self-esteem and mental well-being (Raque-Bogdan et al., 2011). As previously stated, self-esteem plays a large role in a person’s well-being.

Low Self-Esteem and Negative Self-Evaluation

Self-esteem can be defined as “a person’s overall cognitive and emotional evaluation of his or her own worth across various domains” (Muris et al., 2016, p. 609). Low levels of self-esteem often accompany depression and anxiety, as well as suicide risk (Marshall et al., 2015; Muris et al., 2016). In contrast, high levels of both self-esteem and self-
efficacy are negatively associated with depression and anxiety (Muris et al., 2015). In a study conducted by Marshall et al. (2015), adolescents exhibiting low self-compassion were most affected by low levels of self-esteem as shown by greater mental health decline. Conversely, those with high levels of self-compassion did not seem to be significantly affected by either high or low self-esteem levels (Marshall et al., 2015). Thus, self-compassion can be seen as a buffering agent against the negative effects of low self-esteem. While self-compassion did not yield significant results among adolescents who were not lacking in self-esteem, it did appear to regulate the mental health of those that were. Furthermore, these results were supported over a six-month period, supporting the idea that self-compassion produces greater long-term effects than self-esteem (Marshall et al., 2015). This indicates that self-compassion contributes more to adolescents’ well-being than self-esteem.

Direct interventions geared at increasing self-esteem have been attempted, yet have often failed due to the difficulty of influencing self-esteem and the relatively short-term effects that result (Neff & McGehee, 2010). Self-esteem interventions have also tended to increase egotistical tendencies and decrease healthy social relationships in adolescents (Marshall et al., 2015; Neff & McGehee, 2010). On the other hand, self-compassion is thought to be an alternative point of intervention that can be more easily influenced, produce greater long-term effects, and increase resilient and compassionate tendencies (Marshall et al., 2015; Neff & McGehee, 2010). Self-kindness, as one of the three components of self-compassion, may act in direct opposition to self-criticism and negative self-evaluation, thereby counteracting a factor of depression risk. Self-compassion has also been shown to rely less on external circumstances than self-esteem, making it a more stable strategy for change (Van Dam et al., 2011).

Personal Fable

Mindsets that are focused on increasing self-esteem tend to produce more egotistical inclinations. When one is egotistical, he or she may experience what many call “the personal fable”: the idea that one’s experiences are completely unique, and that one is therefore completely alone in his or her challenges (Bluth & Blanton, 2015; Neff & McGehee, 2010). The personal fable often comes as a result of an inability to distinguish correctly between one’s own
perspectives and those of others, and is partially due to a lack of full development (Bluth & Blanton, 2015; Neff & McGehee, 2010). As a result, adolescents often confuse others’ thoughts with their own and perceive that they are constantly being watched by an audience. This can further lead to feelings of being misunderstood, which can lead to isolation and anxiety (Bluth & Blanton, 2015).

Part of self-compassion is the idea of common humanity—the belief that one is not the only individual experiencing certain things, such as pain or loneliness. Studies have demonstrated that adolescents who believe they are completely unique in their circumstances—in other words, those who favor the personal fable—exhibit more signs of depression and suicide risk (Neff & McGehee, 2010). On the other hand, research suggests that individuals with high self-compassion appear better able to depersonalize unpleasant feelings and experiences rather than catastrophize their feelings (Bluth et al., 2016). Furthermore, high self-compassion individuals seem to possess a buffering agent that offsets feelings of anxiety that may come from over-associating themselves with weaknesses (Bluth et al., 2016). Therefore, the presence of self-compassion acts as a protective agent against egocentric tendencies to associate experiences too heavily with oneself, which may aid in combatting adolescent depression.

Positive Traits Correlated with Self-Compassion

When the positive traits correlating with self-compassion are nurtured or encouraged, they help combat depression, reduce anxiety, and lead to possible interventions that enhance self-compassion. Traits such as compassion and joy have recently been shown to increase resilience and mental well-being (Van Dam et al., 2011). As mentioned before, the traits of self-kindness, mindfulness, and common humanity are building blocks to self-compassion. Along with these components are positive attributes that will be addressed as potential points of intervention, including self-worth, mindfulness, and social connectedness.

Stable Sense of Self-Worth

Self-compassion has shown to be associated with a stable sense of self-worth that is both more powerful and longer-lasting than high self-esteem (Neff & McGehee, 2010). As discussed before, the possession of self-esteem often denotes an egocentric characteristic in
which one’s worth is dependent on one’s qualities or accomplishments (Marshall et al., 2015; Neff & McGehee, 2010). In comparison, self-compassion may draw from a less egocentric point of view as it promotes the use of self-kindness and common humanity, both of which allow an individual to accept weaknesses and dissociate personal failings with his or her value as a person. Both self-esteem and self-compassion appear to contribute to adolescent well-being; however, self-compassion is viewed as the more stable predictor (Muris et al., 2016). Another related predictor is self-efficacy, which measures an individual’s belief in his or her ability to accomplish something. Muris et al. (2016) conducted a study measuring the relationship among self-compassion, self-esteem, and self-efficacy in adolescents, and found a positive relationship among the three. Self-worth appears to be influenced by all three self-concepts, although in different ways. Where self-esteem and self-efficacy tend to focus on more egotistical views of self-worth, self-compassion employs the common humanity aspect which aids in eluding comparison. Nevertheless, the three appear to work together to construct positive self-concepts in adolescents, helping to ward off anxiety and depression (Muris et al., 2016).

Another measure of self-worth can be seen in the possession of mattering. Mattering is the belief that one is important to other people, and is positively correlated with the possession of self-compassion (Raque-Bogdan et al., 2011). Along with self-compassion, mattering has been found to have a mediating effect on negative mental health caused by unhealthy attachment styles (Raque-Bogdan et al., 2011; Wei et al., 2011). Interventions focused on enhancing self-worth and mattering may therefore be used to combat the onset of anxiety and depression.

**Mindfulness**

Self-compassion promotes mindfulness (a purposeful and objective view of one’s own thoughts and surroundings) and vice versa (Edwards et al., 2014; Van Dam et al., 2011). As one is kind to oneself, one tends to be more aware of one’s surroundings, allowing for a distance between self and thoughts (Neff & Dahm, 2015). In the previously mentioned study by Muris et al. (2016), mindfulness was found to be the most influential of the three components of self-compassion in terms of helping treat anxiety and depression. This
strategy may also diminish the personal fable belief by minimizing the potency of personal thoughts. Mindfulness can help prevent negative response patterns to thoughts which, according to Muris (2015), affect one’s wellbeing more than the thoughts themselves. Mindfulness and self-compassion are concerned with broadening perspectives rather than avoiding unpleasantness, making them proactive strategies that are focused on promoting rather than resisting (Marshall et al., 2015). Because of this broadening of perspectives, people who possess these traits may be better able to greet challenges and successfully handle difficult circumstances in healthy and effective ways.

Mindfulness and self-compassion interventions have also shown to regulate negative effects of stress and increase self-compassion. A study conducted by Edwards et al. (2014) examined the effectiveness of a mindfulness intervention among Latino adolescents. After an eight-week period of participating in mindfulness activities, the adolescents showed significant increases in mindfulness and self-compassion, and decreases in levels of stress. Other successful mindfulness interventions support that mindfulness and self-compassion can work hand in hand to combat anxiety and depression (Neff & Dahm, 2015).

Social Connectedness

Social connectedness has shown a positive correlation with self-compassion (Bluth et al., 2016; Neff & Dahm, 2015; Neff & McGehee, 2010) and constitutes another predictor of mental well-being (Wei et al., 2011). The ability to connect with others and obtain social support provides protection that has been shown to lessen amounts of physiological stress that accompany threatened social status (Bluth et al., 2016). Self-compassion may also influence one’s ability to show compassion toward others as these two traits stem from a similar place in the brain (Neff & Dahm, 2015). In a study by Welp and Brown (2014), self-compassionate individuals were found to respond with greater compassion to an individual in need, particularly when that person was thought to be at fault for his or her own situation. It appears that self-compassion influences an ability to view others in a similar context to that in which one views oneself. A self-compassionate individual sees the responsibility and weakness of other human beings but tends to display compassion despite human failings. This tendency appears to follow the pattern of the common
humanity component of self-compassion, which accepts weaknesses and failings as part of the human experience.

As mentioned previously, early parent-child relationships provide an important basis for lifelong patterns of social connection. Secure models of attachment are associated with strong social connections with childhood parental figures, while withdrawal from others often stems from relationships with unresponsive parents (Wei et al., 2011). The enhanced psychological well-being associated with secure attachment can lead to increased abilities to respond to and obtain social support, thereby creating a chain effect of positive coping strategies. Additionally, secure attachment can lead to positive self-other working models (Raque-Bogdan et al., 2011; Wei et al., 2011). This allows adolescents to form both healthy social relationships and wholesome self-perceptions.

**Conclusion**

As the prevalence of depression and anxiety increases among adolescents, self-compassion can pose a viable point of intervention for mediating these psychological symptoms. The relationship between self-compassion, depression, and anxiety is still not fully understood—further research is needed to understand whether a causal relationship exists between the two and, if so, in which direction the causality runs. Nevertheless, the power of self-compassion in mediating negative effects caused by insecure attachment, low self-esteem, and the personal fable can provide an important strategy for fighting depression and anxiety (Bluth & Blanton, 2015; Neff & McGehee, 2010). Future research may further expand the possibilities and use of self-compassion as an effective intervention strategy for adolescents.

**References**


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