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Joshua Doxey is a recent psychology graduate from BYU. Having a passion for mental and emotional health, he enjoyed his involvement in the major. He has found the arts to be a way to connect emotional feelings of the soul with physical sensations of the body. Many psychological topics are physically intangible or somewhat seemingly abstract, yet plenty of research would suggest that there is a reality experienced. Joshua plans to create countless oil paintings to express some of the complex realities that may appear invisible to the physical human eye. He does this by aiming to connect abstraction with realism.
Dear Readers,

When I was young, I loved reading about different people, cultures, and traditions so much that I constantly sought out literature that could teach me more about my fellow humans. As I grew older, I began to appreciate the sciences for similar reasons—knowledge about how the world around me works helped me make connections about things I, and others, experience. When I discovered that psychology is a science which joins diversity of personhood with scientific exploration, I was hooked. I think many of you who are reading this journal feel the same.

*Intuition* has gone through some changes. Over the past seven months, we had a complete staff turnover and combed through well over a hundred manuscript submissions. This volume is a product of research, discovery, and thousands of collective hours. We chose only the best of the best submissions to present to you, our readers. Each article in this publication is notable in its own way.

In these pages, you’ll find articles about depression, autism, eating disorders, trauma, religion, lying, bullying, holistic advancements, and professional areas such as school psychology. Our authors have worked tirelessly to present something novel, something hopeful, something helpful to each of you.

A journal like this relies on the hard work of many people. I would like to thank the many editors who have jumped into the editing process with optimism, resilience, and skill. Psychology faculty have been invaluable to our many content reviews. Megan Boswell, our typesetter, has helped us achieve a notable product. Joshua Doxey, our remarkable cover artist, has graciously shared his talents with us. Dr. Dawson Hedges, our faculty advisor, has guided us with flexibility and support. And most of all, Haylee E. Burnett has worked tirelessly as assistant editor-in-chief to boost the processes of this journal, tackling banal and arduous tasks with extraordinary aplomb.

You, our readers, are important. You make a difference as individuals and because you are willing to learn from your fellow scholars. I hope we
can continue to work toward love, inclusivity, and understanding our fellow humans. Learn something just for fun. Take a moment to listen to someone you don’t like. Appreciate the abilities you have. You—yes, you—have an important purpose. Thank you for being here with us.

Elise Johnson
Editor-in-Chief
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Advocating for the Advocates: School Psychologists Are Important in Addressing Mental Health Concerns Among Students

Brooke Curry
Brigham Young University

Abstract

For decades, there has been a severe shortage of school psychologists and a rising number of children and adolescents with untreated behavioral and mental disorders in the United States (Castillo et al., 2014). The current national ratio of school psychologists to students is estimated to be 1:1211, which is a concerning shift from the recommended ratio of 1:500-1:700, school psychologists to students (NASP, n.d.-a). This ongoing shortage may lead to issues both for the school psychologists themselves and for the students they help. For instance, Schilling et al. (2017) found that 90% of school psychologists have reported experiencing burnout at some point in their career. In addition, the large number of caseloads that contribute to burnout utilize a significant amount of time. Benson et al. (2019) explained that school psychologists spend an estimated 50% of their time performing assessments and services for special education (SPED). Although these SPED assessments are important, mental health interventions and meetings should also be prioritized, but have not been, due to lack of personnel (Centers for Disease Control and Prevention, 2020, as cited in Winsor & Mueller, 2020). The solution for this shortage is not simple. However, potential ideas include testing different recruitment methods, examining...
expansions on current graduate school programs for school psychology, and addressing the funding allocated to schools at a federal and state level. 

*Keywords*: shortage, school psychologist, mental health, special education, students, burnout, solutions.
Advocating for the Advocates: School Psychologists Are Important in Addressing Mental Health Concerns Among Students

Sometimes people must depend on the support of others when they cannot help themselves. Take one boy in an elementary school, as exemplified in a popular educational news source, Education North Carolina, in 2019. Although this boy was a capable student, most school faculty saw him as a troublemaker, due to his behavioral issues, and subsequently referred him to the school psychologist. Being familiar with these difficulties in students and having reviewed this boy’s file, the school psychologist recognized that the boy had an autism spectrum disorder and allergic rhinitis, struggles that were unknown to his teachers and other staff members. Leigh Kokenes, this boy’s school psychologist, observed, “There’s an educational impact for this medical diagnosis that he has.” The boy constantly missed school and lived in a state of discomfort while in class, resulting in behavior that his teachers interpreted as acting out (as cited in Fofaria, 2019, para. 24). Kokenes pushed for a diagnosis and, with the proper educational services, he rid this boy of his “troublemaker” status and placed him on the path to success (Fofaria, 2019). Unfortunately, not all students in his place are fortunate enough to have a school psychologist help them when they cannot help themselves.

This boy is just one student among millions in the United States who suffer from mental health challenges accompanied by behavioral issues that school psychologists can help to alleviate. School psychologists play an essential role in students’ mental health and education as they address the academic, social, emotional, and behavioral needs of students (National Association of School Psychologists [NASP], n.d.-b). Due to their extensive training and responsibilities, a school psychologist typically functions as the advocate for the student, dedicating their efforts to understanding the struggling students’ needs and relaying that information to parents, teachers, and other school administrators in order to create the ideal learning environment (NASP, n.d.-b). These experts are especially needed now, as mental health issues among adolescents are steadily increasing in the United States (Mental Health America, n.d.). However, a problematic shortage in qualified school psychologists has persisted for decades, and the shortage is projected to continue into 2025 (Castillo et al., 2014). The current national ratio of school psychologists to students is estimated to be 1:1211, with some areas in the country reaching 1:5000; this is a concerning shift from the recommended ratio of 1:500-1:700 school psychologists to students (NASP, n.d.-a). Furthermore,
an inverse relationship between the number of students diagnosed with mental health issues and the number of school psychologists to aid the students continues to develop and will likely lead to a variety of difficulties for both.

As a result of the ever-increasing workload, many school psychologists are experiencing burnout, often diminishing the quality of their services and hindering their availability to perform their duties. Burnout is defined as the state of mental, physical, and emotional exhaustion regarding one’s work environment. This is a prevalent issue shown by Schilling et al. (2017), who found that 90% of school psychologists have reported experiencing burnout at some point in their career (Mayo Clinic, 2012, as cited in Schilling et al., 2017). Additionally, the majority of school psychologists’ time is often placed on the important task of special education (SPED) services in order to uphold the Individuals with Disabilities Education Act (IDEA); furthermore, the imbalance of supply and demand between the growing number of students and relatively low number of school psychologists may limit the quality of additional mental health services and interventions that school psychologists can provide (American Psychological Association, n.d.). Potential solutions for the ongoing shortage of school psychologists are not simple. Nevertheless, the subsequent repercussions such as burnout, an overload of SPED assessments, and neglect of mental health interventions illuminate the growing need to combat the shortage, not only for the benefit of the students, but also for their advocates.

**Burnout Among School Psychologists**

Outnumbered and overwhelmed, school psychologists often experience job burnout. In order to standardize interpretations of burnout among researchers, Maslach and Jackson (1986) developed a model known as the Maslach Burnout Inventory (MBI) to rate and measure burnout according to a multifactor definition of burnout that consists of emotional exhaustion, depersonalization, and reduced personal accomplishment. Schilling and Randolph (2020) expanded on these three principles, explaining the following: how emotional exhaustion refers to the fatigue and overextension of being drained within a work environment, how depersonalization refers to detachment from one’s career and potential hostility towards others, and how reduced personal accomplishment refers to reduced feelings of motivation and subdued sense of accomplishment. These negative emotions can be attributed to different factors within the work environment; in addition,
a dwindling workforce in relation to demand may heighten the other stressors (Schilling & Randolph, 2020). These findings indicate that unrealistically high caseloads may contribute to burnout and likely affect not only the well-being of the school psychologist, but also their effectiveness.

Over the years, studies have attempted to measure the amount of burnout using the MBI. In 1992, Huebner employed the MBI and reported that 36% of a random sample of school psychologists had high levels of emotional exhaustion, 10% had high levels of depersonalization, and 28% had low levels of personal accomplishment (as cited in Schilling & Randolph, 2020). Compared with more recent assessments of burnout, Boccio et al. (2016) recorded that more than 33% of a sample of school psychologists across the country reported having high levels of emotional exhaustion, 5% reported having high levels of depersonalization, and 12% reported having low levels of personal accomplishment. Similarly, Schilling et al. (2017) observed that 46% of their sample had high levels of emotional exhaustion, 6% had high levels of depersonalization, and 26% had low levels of personal accomplishment. These findings indicate that burnout may be a consistent, ongoing issue, and emphasis needs to be placed on addressing emotional exhaustion and increasing personal accomplishment to reduce burnout.

Another type of empirical analysis that has been used to measure burnout involves surveys on job satisfaction. However, unlike the results of the MBI, these research findings tend to be polarized between the past and present. Worrell et al. (2006) reported that in 1982 and 1992, 86% of school psychologists claimed to be either satisfied or very satisfied with their job, with that percentage increasing to 91% in 2004. Recently, however, with a stronger emphasis on mental health services over the past several years and mental illness increasing steadily each year, the larger caseloads and demands that school psychologists face today have given rise to higher stress loads and less job satisfaction within the field of school psychology (Schilling et al., 2017). For these reasons, it is not surprising that current surveys have found slightly more than 90% of school psychologists have reported experiencing burnout at some point in their career and that subsequent focus has been placed on identifying the causes and finding solutions to these issues (Schilling et al., 2017). Surveys collected by Schilling and Randolph (2020) reported that school psychologists believed they would experience less burnout with more manageable caseloads and a stronger workforce. The emphasis should therefore be shifting attention to filling positions to combat shortages in order to relieve the stress that school psychologists currently are experiencing (Schilling &
Randolph, 2020). With a limited supply of trained personnel combatting the increasing demand for mental health issues, school psychologists are feeling the strain. Additionally, students cannot afford to have their advocates mentally overwhelmed and potentially leave the already understaffed field of school psychology. As feelings of burnout have increased over the years, research shows the need for an increase in professionals to protect school psychologists so they can continue to protect students.

**A High Demand for SPED Services**

Because of the ongoing shortage of school psychologists, the depth, breadth, and quality of services they are able to offer is reduced as they must often focus the large volume of intakes for SPED evaluations and programs (Boccio et al., 2016). School faculty members primarily focus on SPED services because they are important tasks mandated by law, and school psychologists in particular play an important role in helping students with disabilities (NASP, n.d.-a). The IDEA is a law protecting over 7.5 million children with disabilities’ rights to receive public education along with the appropriate SPED services (Individuals with Disabilities Education Act [IDEA], 2020). In order to provide these services, the IDEA provides federal funding to schools so long as they comply with certain principles outlined by the IDEA (American Psychological Association, n.d.). One of these principles includes ensuring that every student with a suspected learning or behavioral disability receives all the related evaluations. Additionally, the IDEA ensures that an Individualized Education Plan (IEP) is created if needed. An IEP outlines specific steps that the school faculty, the student’s family, and the student may follow in order to provide the best learning environment for the student (American Psychological Association, n.d.).

Therefore, school psychologists are valuable members of the school faculty because their work often carries out key requirements of the IDEA. Benson et al. (2019) explained that school psychologists spend an estimated 50% of their time performing SPED assessments and indicated that school psychologists’ top two areas of involvement included psychoeducational evaluations and creating IEPs for students requiring SPED services. The disproportionate ratio of school psychologists to students in turn leads to some school psychologists assessing an average of 204 students for their diagnosed needs as opposed to school psychologists assessing the recommended range, between 65-95 students.
These large numbers, along with pressure to comply with the IDEA so schools receive subsequent funding, may help explain why school psychologists often must prioritize testing and SPED services, leaving little time for anything else. Surveys from teachers and other school faculty report that they do not want a lack of emphasis or reduction in assessment services, but instead simply want school psychologists to perform more responsibilities on top of these testing duties (Watkins et al., 2001). School psychologists similarly wish they had more time to perform other duties, as opposed to spending the majority of their time performing only a portion of their capabilities as mental health providers. For these reasons, even if students are fortunate to have a local school psychologist, most students are not even aware of their presence or given the opportunity to meet with them because the school psychologist is often occupied with reports and tests and is therefore inaccessible to the students who may be silently struggling.

Reduced Quality of Mental Health Interventions

The lack of personnel can be especially damaging to the quality of services that seek to promote mental health, such as suicide awareness, prevention, and intervention, as these aspects of school psychology usually come after performing other duties such as assessments for SPED services (Clopton & Haselhuhn, 2009). Mental Health America (n.d.) reports that suicidal thoughts have been found to increase in individuals between 11–17 years old, and that towards the end of 2020, over 50% of adolescents had suicidal thoughts for more than half of the week for two weeks. Additionally, the Centers for Disease Control and Prevention (2020) discussed that suicide is the 10th highest cause of death overall in the United States, and unfortunately the ranking increases to the second highest cause of death among 10–24 year olds (as cited in Winsor & Mueller, 2020). Furthermore, although qualified professionals in school settings are there to address these needs, the problem continues to worsen, leading researchers to wonder about the quality of service that school psychologists provide with respect to suicide.

Research suggests that a majority of school psychologists may lack confidence and competency in suicidal postvention. O’Neill et al. (2020) surveyed 111 school psychologists in North Carolina, using a 4-point Likert scale, with the answers ranging from “not at all prepared” to “very prepared” on questions...
pertaining to the participants self-perceived training, experience, and confidence in preventing suicidal contagion as part of postvention. The data showed that approximately 75% of school psychologists reported feeling “slightly prepared” or “moderately prepared,” while 15% reported feeling “not at all prepared,” and only 10% of respondents reported feeling “very prepared” on their ability to provide postvention response (see Figure 1). This study additionally showed that the percentage of school psychologists who felt only slightly or moderately prepared to prevent suicide contagion effects increased to approximately 90%. Furthermore, O’Neill et al. (2020) concluded that if the psychologists are not prepared, they will be significantly less effective in preventing contagion effects of suicide. Ideally, a large portion of a school psychologist’s time and effort would be focused on preventing the problem of suicide before it even happens. Unfortunately, if school psychologists are too overwhelmed due to their lack of numbers in the workforce, then they may not feel prepared or able to perform prevention or postvention duties with the capacity that the task demands.

In addition to enhanced suicide protocols and services, there are several other duties that a limited number of school psychologists struggle to perform. It is estimated that every year one in five children in the United States demonstrates symptoms of a mental health disorder and, unfortunately, several of them are not getting the treatment that they need (Anderson & Cardoza, 2016). For instance, only 27% of youth with severe depression received consistent treatment in 2017–2018, and the problem has persisted since 2011 (Mental Health America, n.d.). The lack of mental health support has become so severe that it has become an official public health crisis (Committee on School Health, n.d., as cited in Eklund et al., 2017). Although there are qualified personnel to help, such as school psychologists, only half of them report being able to perform their duties in mental and behavioral services (Eklund et al., 2017).

**A Student’s Silent Struggles**

Anderson and Cardoza (2016) shared how a young student named Katie was one of the many students who did not receive any support from school-based intervention services or faculty members when she was demonstrating mental illness signs and symptoms. After moving to a new school, Katie felt isolated and quickly went from being an honor-roll student to failing her classes and missing several days of school. She also rapidly gained weight and was bullied by other
students, which led her to cut herself every day. Eventually Katie went to a therapist outside of school where she was diagnosed with bulimia and depression. She was also admitted to the hospital after explaining that she wanted to die. Katie shared her frustration about high school, saying, “I felt like every single day was a bad day... I felt like nobody wanted to help me... I was so invisible to them” (as cited in Anderson & Cardoza, 2016, paras. 13–14).

Looking back on this dark and confusing time in her life, one of Katie’s largest worries was how none of the faculty members asked her what was wrong (Anderson & Cardoza, 2016). School psychologists and other staff members’ goals are to help the students thrive and succeed, just as the school psychologist, Leigh Kokenes, was able to help the young boy with an autism spectrum disorder and allergic rhinitis (Fofaria, 2019). However, examples such as Katie’s demonstrate how, despite school psychologists’ best intentions, there are still students who are silently struggling and may desperately lack the attention they need from qualified individuals and quality mental health intervention services. Clopton and Haselhuhn (2009) explained that the way to prevent any child from being left behind was to have an adequate number of school psychologists to address the needs of the students, both on a systematic level as well as on a personal level. Unfortunately, Katie felt the consequences of the consistent lack of personnel, as the school psychologist was not accessible to her in her time of need.

Potential Solutions

There are several suggested solutions that may help combat the shortage of school psychologists. Some of them include the following: testing different recruitment methods with an emphasis on diversity, examining potential expansions on current graduate school programs for school psychology, and addressing the need for additional funding. These solutions are not simple, but they are important steps in benefitting both the school psychologists themselves and the hundreds of students that they provide service to.

Increasing both the number and the diversity of potential graduate school students through different recruitment methods is a needed change. This may be done through exposing more undergraduate students to a potential career in school psychology. Additionally, a particular focus in increasing the number of diverse applicants should be considered as approximately 87% of school psychologists are White and 86% only speak English (Walcott and Hyson, 2018).
as cited in Morrison, 2020). This is a striking contrast to the diversity found in public schools throughout the United States. In 2018, approximately 47% of students identified as White, 27% as Hispanic, 15% as African American, 5% as Asian, 4% as two or more races, less than 1% as Pacific Islander, and less than 1% as American Indian (U.S. Department of Education, 2021). Additionally, approximately 20% of students speak a language other than English in their homes (U.S. Census Bureau, 2020). Furthermore, several students would benefit from having someone they could better identify and communicate with should problems arise and they seek help.

Increasing the output of qualified school psychologists in graduate school programs is another necessity in combatting the lack of school psychologists. Morrison (2020) found that among eight universities, the median admission rate for graduate students entering an Education Specialist Program was only 23%. This is a significantly low number considering the need for more school psychologists. However, even if graduate programs wanted to admit more students, there is a limited number of faculty members within a graduate school to help train and mentor the students. For instance, a national survey revealed that 94 school psychology programs had 136 openings for faculty members (Clopton & Haselhuhn, 2009). Looking to expand current graduate school programs is a key factor in creating a solution to the shortage, since currently the field is about 35,000–63,000 school psychologists short in order to meet the national recommended ratio of school psychologists to students (Griffith, 2018). Different possibilities of increasing the output of graduate students include recruiting more professors and faculty members in order to realistically train a higher number of students at a faster rate. This could in turn lead to more positions being available for new applicants each year. This is not a simple solution, however, and would require more exposure to the field of school psychology as well as additional funds in order to further progress.

Furthermore, an increase in funding would help attain a stronger workforce in the field of school psychology. In 2019, the IDEA granted approximately $12.8 billion to schools across the country, which helped over 7 million children (Dragoo, 2019). However, these federal funds still fall about 15% short of the amount of money that is needed for individual student costs (Blad, 2021). This issue worsens knowing that the current budget is calculated with the existing small number of school psychologists. Therefore, if a school psychologist receives an average salary of $77,430, it would cost $2.7–4.9 billion annually if schools...
hired an additional 35,000–63,000 school psychologists as recommended by the NASP (Griffith, 2018). Currently, approximately 48% of public schools’ funding comes from state income taxes, 44% from local property taxes, and 8% from federal sources such as the IDEA (Chen, 2021). Each state is unique in how they collect and allot money as each state has different costs and funding needed per student (Chen, 2021). However, unpredictable economic recessions may lead to reduced state budgets, leading to a need for additional funding from other sources or a reduction in current school programs (Chen, 2021). Funding is not the only issue, however, as there are not enough people successfully entering the field of school psychology itself as previously articulated. There is not an easy solution to the shortage of school psychologists, but policymakers and educators should facilitate these steps to combat this problem and help students get the support they need.

**Conclusion**

Advocates such as school psychologists exist to help troubled students overcome the odds and thrive. A single person with proper training, quality testing, and enough time can take a struggling student labeled by others as a troublemaker and develop a plan to help the student succeed (Fofaria, 2019). However, given the emphasis on individualized support that school psychologists provide, serious consequences often arise when there is one only advocate assigned to several hundreds of students. For decades, there has been a severe shortage in school psychologists, which has led to a variety of difficulties for both the faculty involved and the students needing their services (Castillo et al., 2014). A proportional increase in school psychologists should be prioritized, as it is illogical to spend time and resources preparing school psychologists to help struggling students with their unique challenges, only to overwhelm the psychologists with unrealistically high numbers of students who need their time and attention.

School psychologists frequently experience job burnout, and Schilling and Randolph (2020) reported that school psychologists believe they would experience less burnout with more manageable caseloads and a stronger workforce. Given that burnout affects not only the well-being of the school psychologist, but also ensures a decrease in their effectiveness in helping students, there needs to be an increase in school psychologists to reduce the stress. Additionally,
in compliance with IDEA, the majority of attention is placed on assessments for SPED, which may be damaging to the quality of additional services that school psychologists are trained in and attempt to provide (Clopton & Haselhuhn, 2009). Negative impacts are especially prevalent in mental health interventions, such as suicide postvention, as O’Neill et al. (2020) asserted that a large majority of school psychologists are underprepared and underexperienced in the postvention of suicides. Given that children spend a large amount of time in school, school psychologists should be more engaged in working with all students, both those requiring SPED services and those who may be internally struggling with other stressors. Examples such as Katie’s demonstrate how, despite some school psychologist’s best efforts, there are still students who desperately lack the attention they need from qualified individuals who are on their side; Katie is not alone in feeling the consequences of the persistent lack of personnel.

One limitation of the extant research related to the topics discussed in this paper is a lack of geographical diversity within the survey samples of school psychologists; different states reflect different ratios of school psychologists to students. Additionally, the relatively low sample sizes in some surveys make it hard to effectively generalize their findings. However, moderate to severe shortages ranging all across the country and the subsequent feelings of burnout can reasonably be applied to the majority of school psychologists (NASP, n.d.-a). Future research should be conducted to further identify the factors that contribute to the lack of school psychologists and address how to quickly and effectively apply solutions for the shortage. The number of students diagnosed with mental health disorders in the United States may not change, but hopefully the number of school psychologists advocating for them will.

References


issues/shortage-of-school-psychologists#:~:text=Consequences%20of%20the%20shortages%20include,limited%20scope%20of%20service%20delivery


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Appendix

Figure 1
Preparedness Level to Provide Suicide Postvention Response

Note. Approximately 75% of school psychologists reported feeling “slightly prepared” or “moderately prepared,” while 15.3% reported feeling “not at all prepared,” and only 9.9% of respondents reported feeling “very prepared” on their ability to provide postvention response. Adapted from “Suicide Postvention Practices in Schools: School Psychologists’ Experiences, Training, and Knowledge,” (O’Neill et al., 2020).
The Double-Edged Sword: Unsuccessful versus Successful Religious Parenting and Transmission

Avanlee Peterson
Brigham Young University

Abstract

Religious participation can have many positive effects on children and adolescents, including improved health, academic, and social capabilities. Therefore, many parents are concerned by the decrease in religiosity in American society today. In response to this common concern, this literature review discusses how various types of religious parenting can improve parent-child religious transmission while maintaining good parent-child relationships and promoting healthy child development. Much of the research on parenting styles suggests that religious parenting is most successful when using an authoritative style of parenting (high structure, high warmth, high autonomy) rather than an authoritarian style (high structure, low warmth, low autonomy). Applications of authoritative religious parenting and their effects are also discussed.

Keywords: religious parenting, religious parent-child transmission, religious child development, authoritative parenting, religion
The Double-Edged Sword: Unsuccessful versus Successful

Religious Parenting and Transmission

Religiosity and spirituality are key aspects of a person’s identity. As children grow, they tend to develop their own religious and spiritual identities. According to Santrock et al. (2020), “adolescence and emerging adulthood can be especially important developmental periods in religious identity and behavior” (p. 375). As older children and adolescents develop cognitively and improve their ability to think abstractly, they are at a particularly sensitive time in their lives and, therefore, are increasingly moldable to their religious and spiritual environments. They begin to cultivate a greater awareness and ability to self-reflect, as well as an increased curiosity and motivation to wonder about the transcendent or divine meaning of life. In fact, research has shown that adolescents and emerging adults may be the most sensitive and responsive to spiritual and religious matters compared to any other age group (Good & Willoughby, 2008). Therefore, a child or adolescent’s time spent building his or her religious and spiritual identity plays a critical role in establishing personal religious values and shaping behaviors. But what forces predominately influence the establishment of these values and the shaping of these behaviors?

Historically, psychologists have often assumed that peers contributed more towards a child’s spiritual and religious development than parents; however, current research shows that parents share a greater—though different—role in their child’s spiritual and religious development than what was once presumed (Walker et al., 2003). Depending on the style of parenting, parents may influence their child’s religious or spiritual development in either positive or negative ways (Bartowski et al., 2019; Bornstein et al., 2017). While there is still limited research on the effects of parenting techniques on a child’s religious or spiritual development, studies on parenting in general offer some intriguing insights to parenting within the religious sphere. Coupled with research focused on religious parenting, these studies provide valuable information as to which parenting styles improve transmission of religion from parent to child, as well as foster healthy religious and spiritual development in the home. Learning more about the effect of parenting styles on a child’s religious and/or spiritual development may
help religious parents nurture their child’s religiosity and spirituality in healthy, successful ways.

But what constitutes healthy religious and spiritual development in the home? And how can religious parents disseminate religious and spiritual values to their children while maintaining a respect for personal autonomy, as well as creating a warm, but structured, environment? This review will attempt to answer each of these questions, as well as set the stage for religious and spiritual child development. It will also describe the healthiest form of religious parenting, which can be defined as “socializing… children into… religious identities, practices, and beliefs” by way of attending religious events, adherence to religious rituals, and teaching religious values (Smith et al., 2020, p. 2). While some parents may feel it is their moral or parental responsibility to apply an authoritarian (high structure, low warmth, low autonomy) approach to religious parenting, studies show that an authoritative (high structure, high warmth, high autonomy) approach to religious parenting seems to be the healthiest and most successful style of religious parenting. This is because authoritative parenting allows for the foundational structure—as well as the freedom and space—that a child needs to successfully develop his or her own religious and/or spiritual identity; furthermore, it improves the chances that parents will successfully transmit their religion to their offspring.

**Parent to Child Transmission: The Current Status of Religiosity**

Parents from a variety of religions are worried about the increasingly substantial influences of religious pluralism, relativism, and secularism on their children (Bengtson et al., 2013). While historical documentation on generational differences within the 20th century showed greater religious continuity and consistency within families, religious continuity and consistency seem to be on the decline within the 21st century. Over the last fifty years, American society has adopted many new cultural and social changes. These changes have led both younger and older generations to feel a putative “gap” between themselves regarding religious ideals and practices (Bengtson et al., 2013). Consequently, many adults feel that today’s youth are less religiously or
spiritually inclined, as well as less concerned with traditional, religious roles and moral values.

Indeed, these fears seem to be validated. Compared to 2007, there have been decreases in the percentages of religious identification within the United States, including an 8% decrease in Protestantism and a 3% decrease in Catholicism. On the other hand, there has been a 3% increase in agnosticism, 2% increase in atheism, and a 5% increase in ‘none-ness’ (not having a particular belief) (Pew Research Center, 2019). Similar decreases have occurred for Jewish Americans but, interestingly, not Muslim Americans (Mohamed, 2018; Pew Research Center, 2018). As a whole, the United States has seen a 12% decrease in Christianity and a 9% increase in religious non-affiliation (Pew Research Center, 2019). Furthermore, births out of wedlock and cohabitation are increasing, while marriage rates are declining (Daugherty & Copen, 2016).

Many parents feel that a decline in religious continuity is caused by a lack of interest in spiritual matters, but this does not seem to be the case. A widespread survey conducted by Lipka and Gecewicz (2017) found that, while Americans may be decreasing in religious affiliation, the same cannot be said about spiritual identification. In fact, compared to 16% in 2012, approximately 27% of Americans currently consider themselves to be spiritual but not religious. Therefore, there is evidence that the majority (approximately 81%) of the American population considers themselves either religious, spiritual, or both. Compared to 84% in 2012, 81% is a slight change that could be but a small dip in an ever-shifting continuum—it is not the major decline that many presume it to be. In other words, while it is commonly assumed that spirituality is on the decline, the data shows otherwise; while religiosity does seem to be declining, people are just as spiritual, if not more spiritual, than they were before. Therefore, perhaps the younger generations are not lacking in spiritual interest as much as their parents may have imagined, but rather are not motivated to pursue organized religion.

Researchers are beginning to wonder what is causing this decrease in religiosity or, in other words, a lack of religious transmission between parent and child. Is this trend rooted in social change, faulty religious parenting, or both? While there is evidence that both social change and lack of successful religious transmission are partly to blame for the decline in religiosity, this review will focus primarily on the impact of parenting styles (authoritative and authoritarian) on the successful—or unsuccessful—transference of religion from parent to child. Understanding what makes a successful or unsuccessful transference of
religion from parent to child will help parents encourage the continuation of religious family values through their offspring in healthy and successful ways. Or, in the case of religious difference, parents can learn to better foster positive parent-child relationships and help their child develop his or her religious and spiritual identities in a healthy way, no matter their child’s religious preferences.

Transmission of Religion from Parent to Child

While there is little research on religious parenting (parenting with the sole purpose of fostering religious development), there is a breadth of information on parenting styles in general which can be helpful in discerning good practices for parenting within the religious sphere. Given that religious values are comparable to other cultural or familial values, one can assume that such religious values can be transmitted from parent to child in a number of different ways. According to the widely respected Baumrind’s (1971) “parenting paradigm,” there are four styles of parenting, including (1) authoritarian parenting, (2) authoritative parenting, (3) neglectful parenting, and (4) indulgent parenting. Authoritative and authoritarian parenting will be the focus of this review since they are the most widely addressed in current academic research. Authoritarian parenting involves aggressive and forceful interactions between parent and child. It often includes fear mongering, weak parent-child communication, and excessive control. In other words, it is high in structure but low in warmth and autonomy. Authoritative parenting, on the other hand, encourages both structure and independence, often including healthy parental support, guidance, and cooperation. In simpler terms, it is high in structure, warmth, and autonomy.

Out of a desire or sense of moral obligation to pass their religion onto their children, parents may implement an authoritarian approach (high structure, low warmth, low autonomy) to religious parenting and teaching. In doing so, they may use excessive force to get their child or adolescent to participate in religious rituals and limit their religious autonomy. While there are differing opinions on whether authoritarian religious parenting is efficacious or not, there has been increasing evidence to suggest that an authoritative style (high structure, high warmth, and high autonomy) is better suited for successful religious transference between parent and child. Consequently, when parents apply an authoritative approach to parenting, the child is better able to harness the many benefits that come with religious and spiritual affiliation. Conversely, when parents apply an
authoritarian approach, they risk exploiting their child’s autonomy, often leading to religious embitterment later on (Bornstein et al., 2017).

**Benefits of Religiosity and Spirituality**

Before elaborating upon the elements of a successful or unsuccessful religious transference between parent and child, it is important to recognize why religiosity is largely beneficial for a child’s development. While some blame organized religion for creating “intolerance, hatred, and violence… [as well as] repress[ing] freedom of thought, and…fill[ing] people with guilt and anxiety” (Ward, 2008, p. 413), there is a multitude of evidence suggesting that participation within organized religion offers more benefits than harm (Aldwin et al., 2014; Koenig, 2015; Santrock et al., 2020). And though researchers recognize that negative religious coping mechanisms can lead to different forms of psychopathy, including paranoid ideation, anxiety, and obsessive-compulsiveness (McConnell et al., 2006), there is a greater amount of scientific evidence that supports the physical, emotional, mental, and social benefits of religiosity and spirituality when implemented in a healthy way (Aldwin et al., 2014; Koenig, 2015; Santrock et al., 2020).

In a review on the correlation between health, religion, and spirituality, Koenig (2015) synthesized evidence from more than 3,000 different studies. After analyzing these studies, Koenig discovered three essential benefits that were positively correlated with religiosity and spirituality: (1) increased mental wellness, including decreased depression, suicide, and substance abuse, (2) less risky behaviors, including less risky sexual behaviors, healthier diets, and increased physical activity, and (3) increased physical health, including fewer chronic illnesses and lower mortality rates. Aldwin et al. (2014) reached similar conclusions: They found that religiosity was linked to improved health habits while spirituality was linked to improved biomarkers including healthier blood pressure levels and increased immunity. Lastly, religiosity was also found to increase self-esteem, improve interpersonal relationships, and enhance prosocial behaviors (Santrock et al., 2020). Altogether, when incorporated in a healthy way, religion can be a great influence on a child’s overall mental, physical, social, and emotional
health. For this reason, it is recommended that parents encourage religiosity and spirituality in the home.

**When it Goes Wrong**

Given the benefits of religiosity and spirituality, parents often feel discouraged if their aims to persuade their children to adopt religious values and traditions are either unfruitful or frustrating. It is understandable that parents who are highly invested in their child’s religious and spiritual development and affiliation may struggle applying a parenting style that supports spiritual and religious autonomy. For this reason, parents may attempt to use authoritarian parenting to instill religious sentiments upon their children, especially since authoritarian parenting tends to enforce good behavior, emphasize safety, and incorporate clear, precise rules (Perry, 2019). Nevertheless, parents should keep in mind that an authoritarian approach to religious parenting can end up being more harmful than successful. Authoritarian parenting tends to evoke fear more than respect, resulting in weak parent-child communications and interactions. It also tends to limit the child’s freedom, undermining the need for children to explore and establish their own religious identities (Baumrind, 1971; Santrock et al., 2020). Furthermore, authoritarian parents frequently use fear mongering and excessive control to manage their children’s behaviors, often resulting in bitterness or lack of autonomy and self-sufficiency on the part of the child.

Additionally, when authoritarian parents are religious conservatists, they are more likely to endorse the use of corporal punishment, such as spanking and other types of physical discipline, in an effort to increase their control (Mahoney et al., 2001). Corporal punishment is especially common when the parents take a more fundamentalist, rather than liberal, approach to interpreting the Bible or other books of scripture (Bottoms et al., 2008). In other words, those who strictly conform to the exact letter of sacred texts are more likely to practice corporal punishment within the home. Studies have shown that corporal punishment can lead to “increased aggression, antisocial behavior, physical injury and mental health problems for children” (Smith, 2012, p. 60). The negative effects of corporal punishment can force children to accept their parents’ religion out of fear rather than faith, potentially leading to both religious and familial bitterness in adolescence or adulthood. In other words, the use of
corporal punishment can undermine a parent’s ability to influence their child’s religious and spiritual development for good.

Authoritarian religious parenting has also been linked to lower academic achievement. The negative effects of authoritarian religious parenting can be especially pervasive within a child’s academic success if the child identifies as being less religious while the parents identify as being highly religious (McKune & Hoffman, 2009). Additionally, in a study on the correlations between religion and educational success, Bartkowski et al. (2008) found that certain types of negative, religious parenting can lead to decreases in standardized test scores, more specifically in math, reading, and science. While it isn’t clear why children with authoritarian, religious parents tend to have lower standardized test scores, it can be hypothesized that—by nature of authoritarian parenting techniques—their frequent use of rage, comparisons, and intolerance to failure may apply excessive pressure on children to meet high expectations, potentially leading them to self-handicap themselves by decreasing academic effort in order to cope (Santrock et al., 2020). Fortunately, these negative influences may be mitigated through frequent, open parent-child religious discussions, which open conversations mark the technique of authoritative, rather than authoritarian, parenting.

Additionally, research has demonstrated a link between authoritarian religious parenting and increased tension within child-parent relationships. First, authoritarian, religious parenting is linked to increased conflict between the parent and child, as well as unnecessary tension between families and church authority. Furthermore, increased religious conflict and tension have been found to be positively correlated with decreased self-control and increased emotional issues in children (Bartowski et al., 2008). This is especially the case in mixed-faith households. Additionally, unnecessary religious conflict within the family may lead older children to parallelize religious incompatibility with familial relationships, resulting in feelings of rejection (Bornstein et al., 2017). Bornstein et al. also found that familial, religious conflict may decrease children’s self-esteem, increase their risk for depression, and minimize parental religious authority in the home.

But conflict isn’t the only way that authoritarian, religious parenting can increase tension between parent and child. When parents attempt to transfer religious beliefs to their child using an authoritarian style, they are more likely to disrespect or disregard their child’s religious agency. Furthermore, when adults
prioritize obedience over religious tolerance, their religious goals can be seen by adolescents as more restrictive than motivating (Bornstein et al., 2017). It is important to note that obedience and structure within the home are important elements of a healthy household; nevertheless, when parents undermine their child’s religious autonomy via complete lack of religious agency, children are more likely to develop problematic internalizing (harmful behaviors directed towards oneself) and externalizing behaviors (harmful behaviors directed towards others), as well as increased stress and anxiety (Bornstein et al., 2017).

Lastly, authoritarian, religious parenting runs the risk of crossing the threshold into abusive or manipulative behaviors, stagnating a child’s ability to develop a healthy relationship with God (Bottoms et al., 2008; Kvarfordt, 2010). And while this evidence shines light on problematic religious parenting, it does not imply that parents should neglect setting religious standards or priorities in the home; rather, excessive force and control can negatively impact a child’s religious experience and development.

When it Goes Right

If authoritarian parenting is not the best way to transmit religious values to children and encourage healthy religious and spiritual development, what is? Bornstein et al. (2017) discovered that religious parenting involving “communication, closeness, warmth, support, and monitoring” is key, along with less authoritarian parenting (p. 88). In other words, parents should develop an authoritative style (high structure, high warmth, high autonomy) of religious parenting. Additionally, Bornstein et al. encourage parents to practice what religious psychologists sometimes call sanctification, or the application of religious teachings that are embedded in everyday life. Sanctification is a critical aspect of religious authoritative parenting that prioritizes mutual respect, constructive discipline, and diminished conflict. In addition to sanctification, when authoritative parenting includes frequent attendance of religious services, families are more likely to experience a healthy religious transference between parent and child, as well as other benefits for the child: positive socialization, higher levels of parent-child cooperation, prosocial behaviors, increased social
capital, and greater psychological adjustment (Bartkowsi et al., 2019; Bartkowki et al., 2008; Ebstyne King & Furrow, 2004).

Authoritative styles of communication also impact the success of religious transference and development. If parents want to positively influence their child’s religiosity, they must prioritize two-way, respectful, religious conversations with their children. Bartkowski et al. (2008) found that when parents frequently participate in religious discussions with their children, their children tend to develop greater self-control and enjoy positive social interactions, improved cognitive processes, and enhanced learning capabilities. Good religious communication can also improve the bond between mother and child. Moreover, Bornstein et al. (2017) found that warm parent-child interactions (religiously centered or not) can lead to increased prosocial competence and academic performance, as well as fewer negative, externalizing behaviors by age 10. This is especially the case when both parent and child consider themselves to be highly religious or spiritual (McKune & Hoffmann, 2009). In other words, healthy religious interactions between parents and their children can augment a parent’s influence over his or her child and motivate prosocial behaviors and intellectual development.

Additionally, authoritative religious parenting, coupled with frequent church attendance, is associated with greater overall health, including psychological health (Chiswick & Mirtcheva, 2013). Both Chiswick & Mirtcheva (2013) and Shaver et al. (2020) discovered this association to be greatest when the child is between ages 12-15 and when the mother is educated and supported by co-religious adults. Furrow et al. (2010) reached similar conclusions, finding that authoritative, religious parenting that instills positive, religious sentiments helps children develop a greater psychological wellness and increases their sense of meaning and purpose. A greater sense of personal meaning and identity, coupled with positive ties to their religious community, boost children’s willingness to care for others, stay out of trouble, commit to the common good, participate within the community, and behave in a more altruistic manner. Furthermore, when religious parenting is done right, children are more motivated to participate in religious activities along with their parents and practice other prosocial, positive behaviors.

But what does authoritative, religious parenting look like? According to Barrow et al. (2020) and Owen (1984), parents can balance their desire for religious continuity and their child’s religious agency in a number of ways. First, parents should teach principles more than they should attempt to enforce religious practices. If a child does not want to pray or attend church, parents should patiently explain...
the principles behind prayer and worship. Forcing a child to participate without explanation often leads to rebellion, bitterness, or blind obedience rather than true faith and understanding. Second, parents should clearly communicate household expectations and standards for religious practice in the home; nevertheless, these expectations or rules should still allow for some personal exploration. For example, a household rule may enforce family church attendance, but children should also be allowed to visit other religious congregations if desired. Parents should respect their child’s views and be willing to listen to and support their religious beliefs. Additionally, parents should create an atmosphere of acceptance where children can learn from their mistakes rather than feel shame by using their child’s failures as teaching experiences and not being overly critical when disciplining. Lastly, authoritative parents should set an example by modeling the behaviors they want to see in their children. Doing so will decrease religious hypocrisy and conflict in the home, as well as encourage a spirit of religious harmony between parent and child.

**Conclusion**

While many parents may believe that an authoritarian style (high structure, low warmth, low autonomy) of religious parenting is the best way to transmit one’s religion to their child, research has indicated that an authoritative approach (high structure, high warmth, high autonomy) to religious parenting is more successful (Bornstein et al., 2017). Authoritative parenting applies a perfect mixture of restrictive and non-restrictive parenting techniques, allowing children the needed structure and space to develop their own religious identities. Rather than apply excessive force, it is recommended that parents set boundaries and religious expectations in their home, as well as encourage children to participate in religious rituals and activities. After all, healthy religious and spiritual practices can offer a multiplicity of benefits including increased mental, physical, social, and emotional health, as well as greater social capital, sense of meaning, and academic achievement (Aldwin et al., 2014; Bartkowski et al., 2008, Bornstein et al, 2017; Chiswick & Mirtcheva, 2013; Ebstyne King, & Furrow, 2004; Furrow et al., 2010; Koenig, 2015; McKune & Hoffmann, 2009; Santrock et al., 2020).

Further research is needed to better understand what makes a successful or unsuccessful religious transference between parent and child. Moreover, additional research is required to better comprehend the effects of religion on child.
development. Since much of the existing research is based on parenting in general rather than religious parenting, there must be more research directed specifically to parenting within the religious sphere, in addition to research on parent-child religious transmission. This research will help families understand how they can foster healthy, religious development in the home. As a result, families and individuals—as well as entire societies—will be strengthened. Only then will the psychology of religion and spirituality be “no longer… overlooked as an important developmental context” and facet of human understanding (Ebstone King & Furrow, 2004, p. 46).

References


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Exploring the Non-Malicious Influencers of Lying

Sienna Stroud  
Brigham Young University

Abstract

Although lying is often studied in relation to malicious factors like crime, delinquency, and lie-detection, there may be people who lie without any antagonistic intentions. In those cases, other factors like age, self-regulation, and impression management may be at play. Some studies suggest that teenagers and children may be more likely to lie than adults because of a lower maturity or because of desires for autonomy rather than malicious intent (Dykstra et al., 2020; Levine et al., 2013). Other researchers propose that some may lie because of low levels of self-control or ego depletion (Fan et al., 2016; Welsh et al., 2014). It is also suggested that both self-regulation and ego depletion may be influenced by certain mental illnesses, which may then indirectly influence lying (Barnett, 2019; Jarrett, 2016; Remster, 2014). Furthermore, some studies propose that impression management may be a motive for deceptive behavior, especially among people with low self-esteem or social anxiety (Cantarero et al., 2018; Myers, 2011; Walczyk et al., 2016). People may also attempt to use exaggeration to impress others and foster better relationships (DePaulo et al., 2004). Thus, lying may not always be influenced by an intent to harm, but by age, low levels of self-control, and the desire to impress people. Future research on the non-malicious influencers of lying could provide insight into better treatment options for those who lie without malicious intent.

Keywords: deceptive behavior, lifespan, self-regulation, impression management, mental illness
Exploring the Non-Malicious Influencers of Lying

Lying is often considered an unethical act that becomes a part of everyday life beginning at childhood (Evans & Lee, 2011). Motives behind various types of lies have been frequently contested, and differing opinions exist regarding the meanings and morality behind them. Generally, lying is defined as “intentionally [trying] to mislead someone” (DePaulo et al., 1996, p. 981). Through movies and storytelling, many children are taught early on that lying is wrong and that telling the truth is right (Talwar et al., 2018). Therefore, they may learn to perceive someone who lies as immoral or untrustworthy (Talwar et al., 2015). Additionally, children may learn through reinforcement to be honest by experiencing the rewards for truth-telling and punishments for lying (Schweitzer et al., 2006). Lying, therefore, is generally seen as a negative concept.

In psychology, lying is often studied in relation to various malicious factors, with maliciousness defined as “the intent to harm” (King et al., 2018, para. 1). Psychologists research deceptive behavior and its associations with crime, discipline, and lie detection, usually describing lying as an intentional decision that is morally wrong (Rutschmann & Weigmann, 2017). Research has also determined that sometimes lying may be influenced by personality, such as psychopathic personality traits which exhibit antagonism, disinhibition, and aggression (Dobrow, 2017). Moreover, studies focused on the less offensive underlying factors that may unintentionally influence deceptive behavior are less common, but perhaps equally significant.

Research has shown that while lying sometimes may be seen as malicious, people occasionally do lie without the intention to deceive (Rutschmann & Weigmann, 2017). Thus, in those cases where there are no antagonistic intentions to harm, other more innocent factors may be at play. Age, for instance, may influence one’s lying behavior as children grow and learn about honesty (Evans & Lee, 2011; Schweitzer et al., 2006). Furthermore, studies have shown that low self-control may lead to negative consequences, including health challenges, mental illnesses, and bad habits that may involve deceptive behavior (Jarrett, 2016; Jiang, 2016; Lo et al., 2021). Additionally, the people in one’s environment may influence their deceptive behavior. For example, the desire to impress people can also motivate lying and a loss of authenticity which may lead to anxiety and poor performance in the workplace (Gino et al., 2020). Through research on the additional factors that may influence deceptive behavior, new methods could be discovered for treating deceptive habits in those
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who mean no harm. Although deceptive behavior may sometimes be caused by an antagonistic intention to deceive, lying can be influenced by a variety of non-malicious factors, including age, self-regulation, and impression management.

Age as a Factor in Lying

Lie-telling may be influenced by the uncontrollable, non-antagonistic factor of one’s age. Several studies have examined which age groups lie more frequently and how lying changes across lifespan. Additionally, research has examined the motives behind why people of certain ages may lie more than others (Dykstra et al., 2020; Evans & Lee, 2011; Levine et al., 2013). Understanding which age groups lie more often may help psychologists better comprehend the origins of deception across all ages from a non-malicious perspective.

Lifespan of Deceptive Behavior

Some studies suggest that lying decreases with age. A study involving 58 high school students was performed by Levine et al. (2013) to determine the frequency of lies among 14- to 17-year-olds. Participants were asked to estimate their daily frequency of lie-telling and describe the types of lies they told. The results suggested that teenagers, on average, likely lie around 4.1 times per day, which was statistically greater than frequencies previously defined among college students and adults (Levine et al., 2013). In addition, other research proposes that lying begins in a child’s preschool years and decreases as they grow (Evans & Lee, 2011). Glätzle-Rützler and Lergetporer (2015) supported this assessment in their study determining that fifth graders are likely more involved in deceptive behavior than eleventh graders. It is suggested, therefore, that lying begins in the early years of life and then decreases in frequency as one ages.

On the other hand, some researchers propose that lying peaks in the adolescent years. Debey et al. (2015) performed an experiment which examined lie-telling across lifespan, including participants from ages 6 to 77. Upon reviewing the participants’ responses about their lying frequency, the researchers concluded that lying increases throughout childhood, peaks in adolescence, and then decreases in the adult years. Some propose that the contradicting results of these studies could be settled through further research differentiating the type of lie told (Dykstra et al., 2020). For example, researchers suggest that teenage lie-telling may be related to
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secret-keeping and lies of omission, but less frequently lies of commission. Future research differentiating the two may show more clearly which age group most frequently lies and whether or not their motives are led by a desire to harm others. Although the reason for the contradicting results is unclear, most research on the subject accepts that teenagers likely lie more frequently than older adults (Levine et al., 2013). Thus, lying may be connected to one’s age. Instead of accrediting the frequency of lying among teenagers to malicious intent, it may be helpful to examine the more innocent motives behind their deceptive behavior.

Possible Explanations for Teenage Lie-Telling

Some studies suggest that teenage lie-telling may be related to maturity. For instance, Levine et al. (2013) proposes that the increase in lying among young people may be based on lower levels of cognitive, emotional, and moral maturity. Additional research supports that once a person has more knowledge about lying, they are less likely to lie (Evans & Lee, 2011). In other words, as a person grows and learns more about the consequences of lying, they may lie less often. If this idea is correct, then lying may be a natural habit that one grows out of as they mature.

Furthermore, significant research suggests that desires for autonomy may be related to the frequency of deceptive behavior among teenagers. Dykstra et al. (2020) propose, through studying the correlation between lying among adolescents and the quality of parent-child relationships, that teenage lie-telling may be related to desires for freedom and independence. Similarly, other research suggests that teenagers with autonomy-supportive parents are often more honest than those with controlling ones (Bureau & Mageau, 2014). It is hypothesized that this is because they trust their parents to listen to them without punishing them severely when they confess their wrongdoings. In this case, negative parent-child relationships may lead to more dishonesty, and teenagers may lie at greater frequencies because of a desire for more freedom and less parental limitation.

Self-Regulation

In addition to age, another non-antagonistic factor that may influence lying is self-regulation. A deficit in self-regulation may lead to less control over impulses and emotions (Welsh et al., 2014). Similarly, when a person exercises a lot of
self-control, they may deplete their capability for self-regulation and experience “ego depletion” (Baumeister et al., 1998). This concept is based on the theory that everyone has a pool of self-control that can be drained out, making natural impulses harder to resist. Using this theory, researchers have proposed that ego depletion often leads to unethical behavior (Jiang, 2016). Both self-regulation and ego depletion have been studied in relation to lying. In addition, different mental illnesses have been studied as factors that may affect low self-control and ego depletion, which may indirectly influence deceptive behavior. In the case that lying is correlated to these deficits in self-regulation capabilities, lying may not always be influenced by the intention to harm someone, but may at times be related to a lack of control over emotions and impulses.

Deceptive behavior may be correlated with general deficits in self-regulation. One study determined through a series of experiments examining the role of self-control in deception that those with lower self-control had more tendency to deceive (Fan et al., 2016). Furthermore, Cantarero et al. (2018) performed a study in which participants kept a journal of their social interactions, recording each time they lied for one week. Following this journaling, questionnaires were given to assess self-control. Results found that lying frequency may be related to a deficit in self-control (Cantarero et al., 2018). Deception, therefore, could be correlated with lower levels of control over emotions and impulses rather than malicious intent.

Likewise, many studies support that ego depletion may influence deceptive behavior. Welsh et al. (2014) determined, using the State Ego Depletion Scale, that a sleep-deprived group of participants had higher levels of ego depletion than another group. They then performed an experiment in which each participant had to choose whether to tell the truth or to lie to another participant with money as an incentive. The results suggested that those who were sleep-deprived and ego depleted were more likely to lie, supporting that ego depletion could be a predictor of lying behavior (Welsh et al., 2014). Additionally, Jiang (2016) tested whether or not a group of students would lie about their percentage on a word processing test if they were ego-depleted and knew the average percentage was higher than their own. He confirmed that those in the ego depletion group were more likely to lie than those in the non-ego-depletion group. Research, therefore, suggests a positive relationship between deceptive behavior and ego depletion in
addition to self-regulation. Thus, lying may sometimes be more related to limited self-regulation capabilities than an antagonistic intention to deceive.

Research on what leads to self-regulation deficits may help clarify what other non-malicious factors may indirectly influence deceptive behavior. Studies show that these deficits, for example, are possibly related to certain mental illnesses. Specifically, researchers have supported that those with anxiety and attention-deficit/hyperactivity disorder may have difficulty regulating their emotions (Jarrett, 2016). Likewise, some adults with hyperactivity struggle to control their impulses in the workplace, also supporting a correlation between attention-deficit/hyperactivity disorder and low self-control (Barnett, 2019). Depression may also be significantly correlated to low levels of self-control, which may explain some delinquency among teenagers with mental illness (Remster, 2014). Thus, anxiety, attention-deficit/hyperactivity disorder, and depression may be related to deficits in self-regulation, deficits which are sometimes associated with a high frequency of lying behavior. Because of this relation to self-regulation, some researchers may consider mental illness a non-malicious influencer of lying as well. For example, some researchers propose that those with high levels of anxiety may tell more self-promoting lies (Cantarero et al., 2018). Additional research may be needed to fully determine if there is an association between mental health and frequency of lie-telling through the mediation of self-regulation.

**Impression Management**

Just as the ability to control one’s impulses may correlate to lying behavior, the desire to control one’s impressions is another non-antagonistic factor that may influence lying. Impression management is what occurs when one tries to control the way they are perceived by others, thus “managing” the impression they make (Leary, 2001). Some of this management can be positive, like when someone emphasizes their talents during a job interview. Other times, impression management can be a motive for deceptive behavior.

Several studies have examined the relationship between impression management and lying. For example, a study was performed by Walczyk et al. (2016) involving a mock job interview in which participants were asked questions that may have embarrassed them by highlighting their less-desirable traits. Following the interview, participants were asked in a questionnaire to identify the questions to which they had lied and to explain their motives for doing so.
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The results showed concerns for impression management among both truth-tellers and liars, but liars were twice as likely to consider what was needed to make a positive impression than truth-tellers (Walczyk et al., 2016). Additionally, Phillips et al. (2011) issued a series of questionnaires to undergraduate students and found correlations between impression management and lying across several different studies. DePaulo et al. (1996) also support that higher scores of impression management may be related to a greater frequency of deceptive behavior, explaining that some people may create entirely new personas in order to impress people. Deceptive behavior and impression management, therefore, are likely related. Those who lie frequently may not do it out of malice, but in order to gain the approval of others. Considering additional factors could help determine what elements of impression management might lead people to lie.

Social Anxiety

Correlations between impression management and social anxiety may provide insight into what can provoke deceptive behavior. Research shows that social anxiety is sometimes correlated with a difficulty in making good impressions, which may cause people to struggle to form new relationships (Tissera et al., 2020). This struggle to make friends may be a motive for lying behavior. Those with high levels of anxiety may have more tendency to lie in order to benefit themselves, which may be due to a desire to appear more impressive (Cantarero et al., 2018). This research further supports that mental illnesses like social anxiety may indirectly influence deceptive behavior. Recognizing correlations between anxiety and impression management could open the door to understanding more profoundly why people with anxiety may lie without meaning any harm, and if this deceptive behavior could be eliminated by treating social anxiety.

Self-Esteem

Likewise, connections between lying, impression management, and self-esteem could help explain what influences deceptive behavior. For instance, Myers (2011) performed a study in which participants were asked to respond to several questions about their own feelings of self-worth. These assessments were followed by additional, similarly-worded questions, this time using machinery that would convince participants that their lies would be detected. As a result,
Myers proposed that those with low self-esteem are more likely to lie about their self-esteem in order to appear more confident in themselves. In this study, the purpose for deceptive behavior was not to cause harm, but to appear more confident than they truly felt (Myers, 2011).Similarly, according to Cantarero et al. (2018), low self-esteem may be ascribed to a greater use of beneficial lies, or lies that are promotion-focused. These promotion-focused lies are described as being motivated by desires for accomplishment, fulfillment, and other positive outcomes (Cantarero et al., 2018). This further supports that people with low self-esteem may not have malicious intent in lying, but sometimes use it to promote their image and make a good impression, which could lead to future accomplishment or fulfillment.

**Exaggeration**

Finally, some people may attempt to manage their impressions through exaggeration. At times, exaggeration can lead to negative impressions when a person’s expectations for truthfulness are violated (Rycyna et al., 2009). On the other hand, Cole and Beike (2019) suggest that exaggerating stories may promote closeness among the listener and storyteller, and that it is not always considered harmful or offensive. They also support that this form of exaggeration may be done with no intention to harm (Cole & Beike, 2019). Furthermore, exaggeration may be implemented when one wishes to appear more desirable or exciting to the people around them (DePaulo et al., 2004). In this case, people may use deceptive behavior in order to form friendships and create positive relationships, which supports that not all deception is malicious or led by antagonistic intentions.

**Conclusion**

In conclusion, lying does not always imply malicious intent, but may be influenced by age, self-regulation, and impression management, factors that are often hard to control or unintentional. One’s age, for example, likely influences the amount of lies told. Teenagers are shown to have high frequencies of lie-telling, which may be related to desires for autonomy or to lower levels of emotional, moral, and cognitive maturity (Levine et al., 2013). Furthermore, self-control varies widely among individuals, and research suggests that those with less self-control are more likely to be involved in deceptive behavior (Welsh et al.,
Impression management may lead to deceptive behavior when one tries to appear more desirable by exaggerating or lying about their attributes (DePaulo et al., 2004). Thus, many of the factors behind deceptive behavior may have no antagonistic intentions. Lying, instead, may be influenced by the circumstances involving one’s age, by the struggle for self-control, or by a desire for positive relationships and impressions.

Many psychological studies examine the antagonistic causes of lying, but the research cited in this review focuses on the more natural or innocent influencers of deceptive behavior. Some of these non-malicious influencers of deceptive behavior have connections to mental illness, including anxiety, attention-deficit/hyperactivity disorder, and depression. For instance, those who have deficits in self-regulation often struggle with attention-deficit/hyperactivity disorder as well (Barnett, 2019). Additional associations are examined between self-regulation and anxiety, impression management and low self-esteem, etc. in relation to deceptive behavior. These connections could open the door to future studies determining the relationship between lying and other non-malicious factors, including mental illness.

The research presented is limited because it does not fully explain all of the motives for lying, nor the negative consequences of deception. Additionally, limitations include a need for more information on the correlation between mental illness and deceptive behavior. More research could reveal new ways to promote honesty by determining how much of the decision to lie is conscious and how much is influenced by uncontrollable factors. Furthermore, a better understanding of deception’s connection to age, self-regulation, or impression management could lead to more sympathy and better treatment possibilities for those who lie without malice. Society’s view on those who lie could be shifted as more people come to understand how other factors influence their deceptive behavior. In summary, lying could be better understood and better treated if specifically studied for the benefit of the non-malicious liar.

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Exploring the Non-Malicious Influencers of Lying


Society’s Responsibility to Prevent Rising Mental Illness in Youth

Spencer Smith
Brigham Young University

Abstract

The increasing rates of mental illness in the world is becoming an issue that has been ignored for too long. Stigma and ableism, “discrimination against individuals with disabilities or the tendency to be prejudiced against and to stereotype them negatively,” are contributing factors to the delay of seeking mental health treatment and worse prognosis (VandenBos & American Psychological Association, 2007). Preventing mental illness in youth requires changes in education. By increasing education at school, from parents, and understanding personal responsibility, it may be possible to prevent or mitigate mental illness development. Though there seems to be no one best practice for prevention, this multi-faceted approach can be adaptable to each individual circumstance to greatly increase the efficacy of early intervention and prevention therapies.

Keywords: adolescents, mental health, early intervention, mental health education, stigma
Society’s Responsibility to Prevent Rising Mental Illness in Youth

An 8-year-old child cries as he is driven away from the place where he grew up, and on to a new town and new life. He is utterly devastated, lost, and confused with where he stands among his peers. The differences in culture that are evident in just a few hundred miles makes him a social outcast, incompatible with the other children around him. This bright, extroverted child quickly retreats within himself as he is tormented and bullied by people he thought could be his new friends. Quickly, he becomes an introverted, shy, anxious, and completely depressed child. In a perfect world, immediate action would be taken by either teachers or parents to help this child get the support he needed to adjust and understand what he was going through. Fast forward, and the child is now an adult in his early 20s, and for the first time is told that constantly thinking about taking his own life is not a normal state of being. This man now realizes that he has a mental illness, a word that seems almost foreign in his own mouth. The tragedy of this story does not lie in the illness, but in the simple realization that earlier understanding and recognition could very well have changed the course of this person’s life.

Though this may be a fictional representation, the circumstances described could become the norm for many young people. Around the world, the rate at which children and adolescents have submitted to psychological care has increased dramatically over the past few years (Appleyard et al., 2007). However, there are many students that choose not to disclose when they are struggling either because of stigma or ignorance. For example, in a study on the effects of a suicide prevention program, it was found that just under half of the participants in the study that were in the at-risk population, had yet to seek any outside help (Bailey et al., 2017). This trend is made all the more impactful when added with the fact that many major depressive symptoms peak during adolescent years. Not only do these symptoms peak during the formative years of puberty, but they also carry on into early adulthood and beyond (Kwong et al., 2019). If these patterns continue, the ramifications could be catastrophic. Unless something is done to reverse this upward trend of the downward spiral, the next generation will likely face a similar reality.

There is a stigma of ableism that surrounds the mentally ill. Ableism, which is defined as “discrimination against individuals with disabilities or the tendency...
to be prejudiced against and to stereotype them negatively,” is unfortunately very prevalent against those with mental illnesses (VandenBos & American Psychological Association, 2007; Young et al., 2019). This is likely because, unlike other handicaps or disabilities, mental illness can be invisible. Many people with these disabilities refuse to allow it to come to light due to the stigma of ableism that can accompany a disease that cannot be seen (Young et al., 2019). This associated stigma is an additional struggle that someone experiencing a mental crisis should not have to endure. Yet, if people can overcome the stigma that surrounds mental illness, the road to recovery may become much clearer. As the largest stumbling block when first beginning treatment for mental illness, stigma often impedes progress toward recovery; when it is overcome the number of people that seek help grows. When an individual starts the help-seeking process for the first time, the likelihood of later help-seeking behaviors also increases (Schomerus et al., 2019). Though there is stigma surrounding mental illness (with the topic itself generally shunned or avoided for fear of triggering those who suffer), a more in-depth and multi-faceted approach to mental health education for adolescents should be adopted. Heightening awareness in an academic environment, learning about mental health at home, and enhancing active awareness of one’s own psychological well-being can dissipate feelings of shame and increase young people’s willingness to seek help when needed.

**Heightening Awareness at School**

In a multifaceted approach to mental illness, it makes sense to ensure that measures are taken in the places that adolescents spend a large amount of time. With many high schools running on a schedule of eight hours per weekday, creating an environment there that promotes heightened awareness for students would be a good place to start. This does not mean that school-based intervention programs are a sure way to prevent mental illness, there have been many studies that have found that intervention programs in schools have had a limited effect in combating disease (Gaete et al., 2016; Singh et al., 2019). However, while there did not seem to be direct positive effects to the mental health of the participants, there are longitudinal benefits to school-based interventions that may indirectly contribute to the increase of good mental health in the students (Singh et al., 2019). Even without direct effects, creating an environment in schools where mental illness can be discussed freely should not be abandoned. The task becomes
finding a way to best capitalize on the indirect benefits that a school centered intervention may bring.

Introducing mental health in school can bring awareness of these diseases to the students and to those in a position to promote changes in these students’ lives, as well as help normalize the discussion of mental illnesses. There have been many studies on programs in schools focusing on mental health and related concerns, like suicide, depression, anxiety, etc. In their study about suicide prevention in schools, Bailey et al. (2017) found that almost half of the students participating, who had no prior outcries or reporting of mental illness, had mental states that made them at-risk for suicide. This drastic increase in the rates of suicidal risk is concerning, but it may be combatted. Society can provide the support to prevent future illness through preventative measures like school programs focusing on mental illness (Jonge-Heesen et al., 2016; Silk et al., 2019). Mental illness is clearly not completely unavoidable, however, with the proper care and watchfulness for the warning signs, it may be avoided in a significant number of cases.

Although school-based interventions are not always greatly impactful in the short term and the longevity of the positive effects of these therapies leaves much to be desired, there may be indirect longitudinal benefits. Singh et al. (2019) conducted a study on others involved with the students, i.e., teachers and parents, and found that there were longitudinal benefits that came indirectly in the form of a reduction in depressive symptoms. This long-term benefit should be a focus of intervention and shows how important it is to highlight the important issue of mental illness. Within a support structure of teachers and parents, it may be much easier to target those within the adolescent population with a greater need for additional support, and that support may prove to be a long-term benefit that is worth the investment.

Learning At Home

As the main point of reference for how life should be lived, parents should be charged with the task of being a source of education regarding living a happy life. However, stigma seems to be thickest within the walls of the home. Knight and Winterbotham (2019) found that adults are less likely to perceive mild symptoms of mental illness as important enough to seek treatment, though they are more likely to identify major psychological issues than others. As mental
illness is often progressive, it is important to identify symptoms before the sickness interferes severely with daily life. A possible remedy for this could be to educate parents on their own influence and on effective methods of supporting their children.

Perhaps a parent’s largest influence in their children is the ability to affect how a child perceives themselves. As children hold their parents as their main role model, it follows that how they see themselves stems directly from what they have been told by that model. However, it is not just important to avoid demeaning a child, lack of positive encouragement also creates a void which may be filled with outside negative influences whether that be peers or other unrealistic standards set by the media. Positive reinforcement from parents is a necessity. When added to other methods of mental illness prevention, parents focusing on their children’s strengths significantly increases mental health (Shochet et al., 2019). If the role of a parent as an influencer can be emphasized, children’s mental health can be bolstered by having that type of positive influence to help maintain their wellbeing.

Another important factor of a parent’s influence comes from their own personal experience. If a parent understands their own mental health and can understand what it means to suffer from mental illness, they can pass on that knowledge. However, parents can be reluctant to disclose those challenges to their children, often to protect their child from that stressful topic. Claus et al. (2019) found that when placed in an open dialogue and a safe space, children were able to understand much more about depression with their parents and cope with stress. Additionally, the increased clarity in the parent/child relationship may have also had a positive effect on communication between parent and child. Thus, if parents are able to learn more about mental illness themselves and start opening a dialogue with their children about this sometimes touchy subject, both will reap the rewards of having a better understanding of the other. This increase in understanding may be instrumental in helping prevent further mental illnesses.

Providing support to a child in crisis is also a major role that parents can play. When faced with mental illness, it can be hard to know just what to do, especially if understanding of the symptoms and effects is limited. For many who have not experienced mental illness, it can be a scary and daunting thing. Parents often send their child to therapy and then hope for the best. However, a more effective approach to support may include attending counseling with
their child. The ability to actively support a child in their treatment may be a more accessible alternative to hospitalization for many parents and can be just as effective (Esposito-Smythers et al., 2019). Taking an active role in a child’s recovery may be an effective deterrent to further mental illness and ought to be considered by parents as a way to actively support a struggling child.

**Personal Responsibility**

Without personally understanding the need for change or help, it is almost impossible to successfully combat or overcome mental illness. This brings into play the need to teach adolescents about their personal responsibilities regarding living a mentally healthy life. Not only does understanding instigate changes in one’s mental state, but it can also prevent worsening mental illness from occurring. Some people find that understanding, in context to mental health, prevents much of the extra stress from interactions with others (Claus et al., 2019). It is therefore prudent to bring responsibility full circle and help the adolescent generation to understand, though they are not alone in their struggle towards recovery, they are responsible for their own wellbeing.

With personal uniqueness being a significant factor in all parts of life, it is important to understand oneself. By understanding how mental illness affects oneself, the options to combat failing health become clearer. This makes it essential to teach children to self-reflect in a more meaningful way. Hankin et al. (2018) found that testing to measure cognitive and interpersonal risks of depression makes it possible to predict what will cause the onset of depressive episodes. Early testing of youth could allow for the creation of personalized prevention plans for adolescents. With these new strategies, understanding one’s mental state may become easier and more straightforward. As further understanding is developed, adolescents may become more motivated to seek out changes, and that motivation may be key. Merrill et al. (2017) found that those with higher levels of motivation reaped more benefit from psychotherapy intervention than those with less motivation. Conversely, it was also found that the symptoms of mental illness greatly decreased youth motivation. This makes it imperative to teach youth to understand their mental states early. If it is possible to keep
adolescents motivated to stay mentally healthy, it will be much easier for them to prevent severe mental illness from ever occurring.

After understanding what mental illness means to them, society can then teach the youth how to self-manage these diseases. Successfully self-managing symptoms could lead to a positive effect on wellbeing, and may also lead to an increase in confidence in one’s ability to overcome these significant obstacles. There are numerous ways to self-manage. One study explored 50 different strategies to see which were most effective and found that of the 50, 45 were used by at least half of participants (van Grieken et al., 2018). With such a variety of techniques available, if society were to combine teaching the youth what types of things lead to their own personal illness episodes along with useful techniques in managing during those times, there may be a way to drastically reduce the rising rates of mental illness that is currently plaguing the world.

**Conclusion**

Through all the research that has been done about mental illness, it is clear that one single perfect treatment may not exist, as mental illness is not one single homogenous disease. There are many types, subtypes, and spectrums within mental illness. It seems many treatments may have similar effects, dependent on a variety of factors: the patient, the culture, the environment, the course of illness, etc. (Esposito-Smythers et al., 2019; Gaete et al., 2016; Singh et al., 2019). Despite the tenacity of mental illness and the struggles that society has faced in counteracting this pandemic, there is likely effective treatment options that can be applied to individuals in their unique situations/circumstances. The pattern of misunderstanding and stigmatization may be the reason that it becomes so hard to see when people are struggling with their mental wellbeing. To live in a world where being able to discern major mental illness is common, yet understanding mild symptoms is often overlooked is no longer a viable option (Knight & Winterbotham, 2019). Rejecting milder symptoms opens the door for more severe symptoms to emerge in the future. To prevent those harsher symptoms from ever becoming more prevalent, it is important to incorporate interventions into the core of an adolescent’s life.

In reducing the stigma around mental illness via a multi-faceted approach, the school system should become an environment where mental illness can be discussed openly. Though the benefits of increasing psychological education
may not directly influence the main student audience, the indirect benefit of having positive role models with a better understanding of mental health can be life changing (Singh et al., 2019). At the very least, being better able to identify adolescents that struggle with their mental health could provide an advantage in combating mental illness (Bailey et al., 2017). Ensuring that mental health is watched at school, a place where youth spend a majority of time, may enable positive changes to be made by those in a position to evoke that response.

As the primary role model, youth most often look to their parents for a baseline on how to live. This makes it important that parents share their experiences with mental health with their children. By doing so, parents can help to lift the stigma of mental illness and help reduce the stress of mental illness faced by their children (Claus et al., 2019). In addition to sharing experience, a parent can have a great effect on mental wellbeing by supporting their children. Focusing on their child’s strengths in combination with other therapeutic interventions can increase these positive effects (Shochet et al., 2019). Parents who are taught these skills can be better prepared to implement them into the lives of their children and help defend them against the rising rates of mental illness.

Perhaps most importantly, there must be a method by which the youth are taught to take responsibility for their own mental wellbeing. By becoming self-reliant and by self-managing symptoms, youth tend to have a more positive outlook and are more motivated to make changes for themselves (Merrill et al., 2017). With so many different forms of self-managing to incorporate, there are bound to be a few that are effective for each unique person (van Grieken et al., 2018). If society can raise awareness through educating the youth on these topics, the tide of rising mental illness may be stemmed.

Although there are limitations that have been found in the research that has been done so far, it shows a clear avenue for further research. The short-term failings of school- and home-based interventions, though concerning, should not hinder their uses. It may be possible that combining school and home interventions may have an additional positive effect in the short-term on mental health that each intervention is lacking separately. This is an area in which more research could and should be done.

The steps to ensure that mental illness does not impede the limitless potential of the younger generations are within reach. It is the duty of the schools, parents, and the individual to help combat this pandemic of mental illness. If society can work together to fight, the prognosis of the future may be much brighter, but
we need to begin the process now. Hopefully, it may be possible to reverse the current upward trend of mental illness and have a better hope for tomorrow.

References


Anxious for Answers: A Behavioral Approach to Anxiety in the Home

Kassidy Bowen
Brigham Young University

Abstract

Children who have one or more parents with anxiety disorders are 76% more likely to develop anxiety disorders themselves (Hudson et al., 2014). With this correlation in mind, many studies aim to improve the treatment outcomes of children in such circumstances. However, the involvement of caregivers with anxiety disorders in the treatment of their children, specifically with cognitive behavioral therapy (CBT), does not always decrease the effects of anxiety on their children (Breinholst et al., 2012). Additionally, child CBT may not reduce stress-inducing factors originating from parental responses in the home (Metz et al., 2018). Parental tendencies that are common to those with anxiety disorders, such as accommodation, anxiety sensitivity (AS), and other anxiety-enabling responses, may negatively impact the treatment of anxious children (Francis, 2014). Research also indicates that attachment and perceived relationship factors of parents with anxiety disorders significantly impact child anxiety (Breinholst et al., 2018). Overall, patterns of parenting seem to have more impact on children with anxiety disorders than parental anxiety itself (Apetroaia et al., 2015). Increased perceived warmth has been shown to decrease stress levels, and strengthening parent–child relationships may be impactful in the reduction of anxiety (Wei & Kendall, 2014). Targeting specific behaviors of anxious parents may also be effective in reducing anxiety in both the parent and the child. More research is needed to determine which method of behavioral control and regulation is most effective in stress reduction.

Keywords: anxiety, cognitive behavioral therapy, anxiety sensitivity, accommodation, attachment
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Anne brings her young child, Ben, to run errands. Anne suffers from an anxiety disorder. Before leaving the house, she realizes she has incorrectly completed her work expense report and must redo it the following day. As they climb into the car, she is on edge. While Ben plays and engages with her, she is distracted and tense. On the way to the store, traffic moves along slowly, causing Anne’s stress levels to rise. She begins to exhibit frustration with the cars around her, and when Ben distracts her from the road, she responds with impatience. Taking his cues from his mother, Ben begins to feel the stress of the environment. Because he cannot understand Anne’s reasons for being anxious, he attributes her reactions to what he can observe. This may lead Ben to perceive driving as dangerous, negative, and something to be feared. Additionally, he might misunderstand her behavior toward him and instead internalize her coldness. Anne’s impatience and negativity might dissuade Ben from interacting with her, contributing to a disconnect in their relationship. This example illustrates how parenting behaviors, influenced by anxiety, may foster anxious behaviors in children.

Children are 76% more likely to exhibit anxiety when they have a parent who suffers from an anxiety disorder, so when treating anxiety in children, it may be imperative to treat parental anxiety as well (Hudson et al., 2014). As such a reliable predictor, parental anxiety could be the key to addressing this disorder, which affects one in eight children (Apetroaia et al., 2015). This influence, which Escovar et al. (2019) called “the maladaptive cycle between parent and child anxiety,” cannot effectively be combated by addressing just one of the involved parties (p. 26). Lasting reduction in child anxiety levels typically occurs with a reduction in the anxiety levels of a parent. Additionally, change in parental factors tends to alleviate stress factors that contribute to child anxiety, which in turn may reduce parental anxiety relating to the child (Escovar et al., 2019). However, parental anxiety is rarely treated in cases of child anxiety disorders, as pointed out by Breinholst and colleagues (2012). When approaching treatment options, parental anxiety is not given sufficient focus and should be more intentionally addressed.

Anxiety-producing stress in the home can be linked to attachment insecurity, causing children to view caregivers as unresponsive, uncaring, or
inconsistent (Breinholst et al., 2018; Breinholst et al., 2015). Displays of rejection and controlling or protective behaviors are common results of anxiety, and receiving these from a parent may cause a child to develop insecure attachment (Breinholst et al., 2018). In addition to negative parental relations, these behaviors may lead children to develop a fearful or negative view of the world, as children tend to form paradigms based on parental influences. Furthermore, much of a child’s fear response appears to be related to the emotional sensitivity and warmth of the caregiver (Breinholst et al., 2018). Since anxiety disorders are characterized by overactive fear responses, attachment may be a significant factor in these cases, demonstrating that it is imperative to address parental influence when treating children with anxiety. Still, parental influence is rarely addressed as treatment is approached.

Cognitive behavioral therapy (CBT) is a frequently utilized treatment for anxiety disorders that addresses thought patterns and maladaptive behaviors in children, although this might not be the best option for children with anxious caregivers. According to Bubrick (2019), CBT has been considered the most effective anxiety treatment method for over 20 years. However, there are negative factors associated with CBT in cases of child and caregiver anxiety. For instance, Breinholst et al. (2012) found that when anxious parents put their children through therapy, many children experienced intrusiveness, negativity, and controlling pushes toward recovery. Although this treatment for child anxiety disorders was recommended and typically effective for children of mentally healthy parents, CBT was not always effective for children whose parents also experienced anxiety (Breinholst et al., 2012). Parents experienced similar stress factors through the CBT treatment measures of their children. Apetroaia et al. (2015) found that caregivers felt a greater sense of responsibility and self-blame for their children’s anxiety, which led to poor treatment outcomes for their children. This suggests that CBT, although helpful in many cases, may also be linked to additional anxiety.

While treatment of anxiety should be pursued, addressing such issues solely through CBT and similar methods may be insufficient to combat parent–child anxiety disorders. Instead, greater reduction in familial anxiety can be achieved through targeting parental behaviors. Changing negatively perceived behaviors to display acceptance has been shown to lower stress and anxiety levels in familial settings (Wei & Kendall, 2014). Although CBT and other treatment methods for child anxiety disorders acknowledge and target parental anxiety as a factor,
simply addressing anxiety may not be effective. A specific focus on altering parental behaviors to improve attachment and decrease stress responses may significantly decrease the anxiety levels of both the caregiver and the child due to the benefits of reducing treatment-related stress factors, the advantages of minimizing anxiety-inducing stress factors in the home, and the effectiveness of improving stability in parent–child relationships.

**Reduction of Treatment-Related Stress Factors**

Treating anxiety disorders through CBT can cause stress in the lives of both the parent and the child. Although many factors contribute to the stress levels and anxiety of parents and their children, it is important to note that CBT may be responsible for certain stress factors in parent–child relationships (Breinholst et al., 2012). Parents may feel responsible for and anxious about the recovery of their children. However, positive treatment outcomes in children may be difficult to facilitate under certain circumstances, such as the conditions that occur under the influence of an anxious parent (Creswell et al., 2011). Additionally, parents may be affected vicariously through the treatment of their child (Apetroaia et al., 2015). Thus, focusing on parental behaviors may reduce some of the stress factors related to treatment of the child.

**Parental Response to Treatment of a Child**

Involvement of parents with anxiety disorders may be linked to poor CBT treatment results in their children. As observed by Creswell et al. (2011), poor treatment outcomes were thought to be the result of over-investment, control, and pressure displayed by the caregiver. This over-involvement in treatment may negatively affect the parent, as well as the child, by increasing worries in the parent. According to a study conducted by Apetroaia et al. (2015), parents with an anxiety disorder experienced an average of 12% higher feelings of responsibility for their child’s well-being than did parents with no anxiety disorder. Anxious parents tend to feel they should have more control over their child’s well-being and feelings (Apetroaia et al., 2015). These feelings
of responsibility led to heightened feelings of anxiety when their child was not improving as much as the parents expected or hoped.

Additionally, researchers have found that increased anxiety in the caregivers may lead to more frequent displays of intrusive, controlling, and other negative behaviors, which in turn can negatively impact the child (Apetroaia et al., 2015). Such behaviors can cause children to develop insecurity and anxiety, as they are not allowed to develop autonomy. Another study, conducted by Breinholst et al. (2012), asserted that assumptions made by anxious parents led them to view the treatment of their child with heightened degrees of negativity, which may cause increased controlling and overprotective behaviors. These attitudes can be driven by defensiveness, stigmas around mental health, and mistrust of therapists, creating challenges for both the parent and the child. Due to this, Breinholst and colleagues stated that parent–child anxiety disorders were not benefited by CBT (Breinholst et al., 2012). Their research indicates that because of anxious parents tend to view treatment methods negatively, treating children using CBT may increase the anxiety levels of their parents and in turn decrease the effectiveness of treatment for the child.

**Child Response to Treatment**

In addition to the strain it may put on parental figures, CBT may cause added stress for children with anxiety disorders. For instance, Apetroaia et al. (2015) found that children whose parents had anxiety disorders were exposed to more negative parental behaviors when completing treatment-related tasks than those whose parents did not have anxiety disorders. Anxious parents tend to feel increased responsibility and in turn, their children tend to feel increased pressure to improve with treatment. Another study, conducted by Walczak et al. (2017), found that while CBT did improve the longevity of reduction in child anxiety disorders, this was only true in the cases where the treatment also addressed stress-causing behaviors displayed by the parents. Children experienced greater stress, and parental involvement thus played a negative role in the overall treatment of the child. The study further stated that parental anxiety may have led the CBT to reinforce habits of avoidance and other negative coping mechanisms (Walczak et al., 2017). Anxious parents were more likely to shield their children or treat issues as irresolvable, encouraging avoidance and reluctance to address issues.
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According to these findings, CBT seems to be less effective and more stressful for children whose parents suffer from anxiety disorders.

**Minimizing Anxiety-Inducing Factors in the Home**

While CBT addresses stress factors and coping mechanisms, it may not directly address anxiety-inducing aspects of home life. Children learn behaviors from their parents, and simple stressors in the home may invoke a disproportionate response from parents with anxiety disorders. Parents with anxiety disorders may also foster enabling behaviors in their children, such as accommodation for fears or avoidance of stressors (Meyer et al., 2018). Directing attention to and reducing these responses can minimize the effect of anxiety-inducing factors on the child (Metz et al., 2018). Additionally, targeting responses to everyday stressors, such as work, household chores, and personal dilemmas, in parental behavior may reduce parental anxiety levels (Wei & Kendall, 2014). Taking a therapeutic approach with an emphasis on these behaviors, or simply coaching parents through such behaviors, could provide a solution. Such focus on parental behaviors may create a safer home environment for both the child and the caregiver.

**Reducing Enabling Behaviors**

Parents with anxiety disorders often exhibit behaviors that enable and enhance anxiety disorders in their children, and these behaviors should be addressed. Anxious parents are more likely to produce offspring with anxiety disorders, and parent perception of child behaviors may contribute to that likelihood. One study discussed this tendency, known as anxiety sensitivity (AS), explaining how parents with anxiety are up to 44% more likely to perceive anxiety in their own children than parents without anxiety (Francis, 2014). Parents in the study were not only more likely to report symptoms of anxiety in their children, but they also were much more afraid that their children would develop an anxiety disorder. Francis (2014) suggested that higher AS may be related to child panic and anxiety. Parents’ fear that their children may develop a disorder often creates stress in the home, leading to a higher possibility of this fear becoming a reality.

In addition to this predictive behavior, anxious parents tend to coddle their children, perpetuating avoidant responses in their children. Anxious parents...
are more likely to encourage children to view stressors as catastrophic, which leads to avoidance of issues (Apetroaia et al., 2015). Meyer et al. (2018) observed that parents who have anxiety disorders tend to accommodate their children. Accommodation, or parental action taken to reduce the anxiety of the children, was much more common among parents who also experienced anxiety (Meyer et al., 2018). Anxious parents tend to feel a higher responsibility for the feelings and well-being of others and therefore seek to shield their children from negativity. Although intended to alleviate stress, accommodation tended to increase the likelihood of the development of anxiety disorders (Meyer et al., 2018). Children who have experienced accommodation lack confidence in their ability to overcome problems and therefore do not know how to deal with issues without avoiding them altogether. Such enabling beliefs and behaviors in the home tend to continue the cycle of familial stress and should be addressed to prevent the continuation of anxiety disorders.

Reducing Stress-Signal Behaviors and Fear Response

In addition to altering the treatment of their children, parents should seek to reduce their own reactions to stress and the world around them. Wei and Kendall (2014) discussed how parental displays of anxiety may influence children to internalize negative worldviews. When parents displayed fear responses to situations in the home or everyday life, children accepted this as a natural response and became more likely to exhibit similar responses. Children tend to mirror the behaviors they observe, so when parents do not control their fear responses, they may be unintentionally teaching children to view the world with apprehension and anxiety (Wei & Kendall, 2014). Furthermore, Metz et al. (2018) found that parental anxiety and stress signals led to more fearful temperaments in children. These fearful dispositions were observed even in the child’s infancy. The researchers emphasized that parents should focus on assuring their children that they are emotionally safe by controlling the responses parents have to their environments (Metz et al., 2018). These studies suggest that in order to reduce anxiety and teach children a healthy worldview, parents should focus on controlling their own fear responses. Learning to handle such responses may take
time and training. More research is needed to understand how to best address such parental behaviors.

**Improved Stability in Parent–Child Relationships**

Children may not only learn from their parents’ reactions to the world, but they are also influenced by how a parent reacts to them (Chorot et al., 2017). To understand these learned reactions, it is necessary to know how children view their relationships with their caregivers. For instance, attachment insecurity has been linked to several influencing factors, including anxiety (Chorot et al., 2017). Increasing warmth, on the other hand, may reduce stress within parent–child relationships (Wei & Kendall, 2014). Addressing attachment and perceived warmth between parent and child may, therefore, play a significant role in reducing anxiety within the family.

**Attachment and Anxiety**

Many behaviors associated with anxiety disorders may contribute to attachment insecurity. For example, Chorot et al. (2017) found that children who had fearful/preoccupied attachments to their parents had significantly higher rates of anxiety than those with secure attachments, accounting for 36% of variance in symptoms. The attachment insecurity of these relationships was influenced by three factors: over-control, aversiveness, and neglect by the parent. As illustrated in Figure 1, children tend to perceive such displays of anxiety as signs of detachment, which may lead to heightened child anxiety. When these child-rearing behaviors were decreased, attachment was observed to be more secure and anxiety levels were reduced (Chorot et al., 2017). A similar study conducted by Breinholst et al. (2015) also indicated that attachment insecurity may be a predictor of child anxiety. Anxiety-induced parental behaviors, such as perceived rejection, distraction, and control, tended to foster insecure attachment. Because many symptoms of anxiety manifest in ways that may lead to insecure attachment, these children may be at a greater risk of developing an anxiety disorder (Breinholst et al., 2015). Focusing on improving attachment through family therapy and knowledge of attachment theory may improve relationships.
between parents and their children, subsequently lowering anxiety levels in the home.

**Perceived Parental Warmth**

Improving perceived parental warmth may improve parent–child relationships and, in turn, reduce anxiety of parents and children with anxiety disorders. Wei and Kendall (2014) found that parenting style influenced child perception of warmth. Parents in the study who focused on reducing control and increasing acceptance of their children were perceived by their children as warmer and more affectionate. Furthermore, an increase in warmth and affection was linked to a decrease in symptoms of anxiety (Wei & Kendall, 2014). This suggests that perceived warmth between children and their caregivers may be key to understanding stress levels in familial settings. Additionally, Festen et al. (2013) found that, even after CBT, children who perceived lower levels of warmth and affection from their caregivers tended to display more symptoms of anxiety and distress. The researchers recommended that future efforts and studies should explore potential methods of increasing perceived parental warmth (Festen et al., 2013). These researchers agree that focusing on altering parental behaviors to increase perceived warmth may improve parent–child relationships and decrease levels of anxiety.

**Conclusion**

Although many factors contribute to anxiety disorders, particularly in cases where both the parent and the child are affected, these factors should not be addressed by treating the child alone. In order to disrupt the “maladaptive cycle between parent and child anxiety,” parental behaviors that perpetuate anxiety should also be altered (Escovar et al., 2019, p. 26). As Walczak et al. (2017) stated, when approaching child anxiety, it is necessary to target the parental behaviors that preserve it. For this reason, although CBT may be helpful in treating some cases of anxiety, that treatment alone may not be sufficient to address stress-inducing behaviors in the home. In addition, CBT may introduce a certain amount of stress into the family. This stress, along with the many factors in the home that foster anxiety disorders, could be reduced through the correction of parental behaviors and response (Metz et al., 2018). The correction of these behaviors, along with the improvement of attachment and parental warmth, may significantly lower
Anxious for Answers: A Behavioral Approach to Anxiety in the Home

Anxiety in parent–child relationships (Wei & Kendall, 2014). Improving the conditions of the home could be the key to breaking the cycle of parent–child anxiety by reducing stress factors on both parties, and creating a safer, less fear-inducing environment for families.

Although evidence of a correlation between parental behavior and child anxiety has been observed for some time, little research has been conducted to determine how to most effectively alter parenting practices to reduce familial stress. While multiple studies have established the link between parent–child relationships, parental worldviews, and child anxiety disorders, there is a lack of commentary on how such behaviors are best reduced. In future research, it may be beneficial to study what parenting behaviors most efficiently reduce negative perceptions and impacts on children. Additionally, future research might address the treatment of parents to reduce enabling behaviors such as AS and accommodation. Targeting these behaviors during or in place of CBT may yield positive results. If observable responses to anxiety can be reduced by targeting anxiety-inducing behaviors (such as fear response, enabling behaviors, and perceived coldness), then it may be possible to interrupt the feedback loop between children and their caregivers. Improving parental behaviors has the potential to reduce stress in the home and to create a more positive environment for parents and their children.

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**Appendix**

**Figure 1**

![Diagram of the association between anxiety-induced parental behaviors, fearful/preoccupied attachment, and child anxiety. Adapted from “Perceived Parental Child Rearing and Attachment as Predictors of Anxiety and Depressive Disorder Symptoms in Children: The Mediational Role of Attachment,” (Chorot et al., 2017).](image)

**Note.** Diagram of the association between anxiety-induced parental behaviors, fearful/preoccupied attachment, and child anxiety. Adapted from “Perceived Parental Child Rearing and Attachment as Predictors of Anxiety and Depressive Disorder Symptoms in Children: The Mediational Role of Attachment,” (Chorot et al., 2017).
Sexual Intimacy After the Transition to Parenthood: Using Emotionally Focused Therapy

Mallory Kindt
Brigham Young University

Abstract

The transition to parenthood requires a significant amount of adjustment and often leads to a decrease in a couple’s relationship satisfaction. Specifically, new parents often experience attachment distress that can negatively affect their sexual relationship. Attachment distress may stem from the over prioritization of the parent role, postpartum fatigue and overall toll on new mothers, and unreasonable sexual expectations. One specific treatment that may help couples to overcome the negative repercussions that the transition to parenthood may have on their sexual relationship is Emotionally Focused Therapy (EFT). EFT uses three stages, cycle de-escalation, changing interactional patterns, and consolidation/integration. These stages are broken into nine steps that aid parents in learning how to acknowledge their emotions and unmet attachment needs, as well as how to change their interaction patterns to have an increase in positive interactions and thereby develop a more secure attachment. Overall, through EFT, couples may learn how to cope with the changes in their sexual relationship during the postpartum period, leading to more positive relationship outcomes.
Sexual Intimacy After the Transition to Parenthood: Using Emotionally Focused Therapy

The arrival of a new baby is usually met with feelings of great excitement. However, the transition to parenthood is also a time of adjustment. A majority of research discussing the transition to parenthood and related stressors indicates that there are often deteriorations in relationship satisfaction (Don & Mickelson, 2014; Doss et al., 2014; Ferriby et al., 2015; Holmes et al., 2013). A decline in relationship satisfaction may be related to couples struggling to make necessary adjustments in their sexual relationship. Girard and Woolley (2017) suggest that when sex is causing distress in a relationship, “it is responsible for 50% to 75% of the relationship satisfaction” (p. 720). Therefore, ensuring that couples can adjust to a new normal regarding their sexual intimacy is integral in promoting positive relationship outcomes.

First-time parents may be especially vulnerable to experiencing attachment distress due to new stressors that affect their sexual intimacy. In this context, attachment refers to the enduring bond between two individuals. An increase of negative attachment experiences (e.g., feeling unloved, being worried about the state of the relationship, etc.) may lead to a deterioration of the attachment bond (Birnbaum & Reis, 2019), that when coupled with feelings of disconnection, may contribute to decreases in commitment, as each individual may become more preoccupied with self-soothing and neglect the relationship (Ferriby et al., 2015). Couples may experience increases in conflict frequency that infiltrate all aspects of their life, including career, finances, social life, parenting ability, and sex (Doss et al., 2014; Holmes et al., 2013; Simpson & Rholes, 2019). As such, finding an effective way to soothe new parents’ attachment distress and finding solutions to their sexual distress is essential to ensure more positive outcomes regarding the couple’s relationship.

While the majority of this article uses research that focused on or had samples that were exclusively heterosexual couples, occasionally, the cited research does include both heterosexual and homosexual couples. As such, this article will attempt to specify when the research includes heterosexual and homosexual couples through the use of the word “partner.” In other words, when the term “partner” is used, it is referring to research that included individuals who may
identify as homosexual. Otherwise, it can be assumed, in this article, the research exclusively focused on heterosexual couples.

A specific intervention that is used to soothe attachment distress is Emotionally Focused Therapy (EFT). As EFT is an empirically supported treatment and focuses on the acknowledgment of primary emotions, unmet attachment needs, and the cycle of interaction, it may be beneficial for couples who are suffering from attachment stress during the transition to parenthood (Greenman & Johnson, 2013). Sexual intimacy issues that can be addressed using Emotionally Focused Therapy (EFT) include the new prioritization of the parent role, postpartum fatigue and overall toll on new mothers, and unrealistic sexual expectations. Going through the EFT stages of cycle de-escalation, changing interactional positions, and consolidation/integration may be an effective way to help couples recognize unmet attachment needs and create new emotional patterns that allow them to improve their expectations of, feelings toward, and communication about sexual intimacy during the transition to parenthood.

**Issues Regarding Sexual Intimacy and Attachment In Couples Postpartum**

After the birth of a child, it is common for new parents to experience significant changes in their sexual intimacy patterns. For instance, it is typical for regular patterns of sexuality to not resume until approximately a year after birth (Lévesque et al., 2019). Significant changes in a couple’s sexual intimacy patterns may be due to a new focus on the baby, which could result in feelings of ambivalence from both partners toward their sexual relationship (Olsson et al., 2010; Woodhouse et al., 2012). Pattern changes in the couple’s sexual relationship may lead to an increase of negative feelings toward sexual relations, thus leading to a decrease in sexual frequency (Lévesque et al., 2019). As such, it is necessary to understand how a couple’s sexual relationship is highly affected by the new prioritization of the parent role, fatigue and the overall toll, and unrealistic postpartum sexual
expectations and how these factors may lead to a perpetuating cycle regarding sex and attachment distress.

**New Prioritization of Parent Role**

New parents, especially mothers, prioritize their parental roles and responsibilities after the birth of a baby. Having a baby requires the couple to restructure and gain a new focus that changes the fundamentals of daily life (Don & Mickelson, 2014; Olsson et al., 2010). For example, Lévesque et al. (2019) and Vannier et al. (2018) found that parents not only gave priority to the baby in terms of meeting needs and time but also gave more priority to the role of being a parent than any other role in their life. These findings suggest that when a baby is born, couples might no longer prioritize or have time for their sexual relationship, which could create feelings of disconnection and loneliness. Additionally, even if couples do find time to be sexually intimate, the presence of a baby may make it difficult for both partners to focus on and enjoy the sexual experience, as they might be preoccupied and worried about the baby (Lévesque et al., 2019). As such, evidence suggests that when a baby is born, being a parent becomes the priority and the focus is not on being a sexual and romantic partner.

Fathers, depending on their attachment style, may be particularly susceptible to experiencing feelings of attachment distress and decreases in sexual satisfaction during the postpartum period. The studies in this paragraph utilize attachment styles as defined by Bowlby, instead of the more general definition above (Fletcher & Gallichan, 2016). Olsson et al. (2010) and Kohn et al. (2012), suggest that first-time fathers who have an anxious attachment could feel that they have to compete with the baby for the mother’s attention and subsequently feel uninvolved and distant, both as a partner and as a parent. For fathers that have an avoidant attachment, feelings of distance are amplified if the father feels overly relied upon and that their independence is being stifled as a result (Kohn et al., 2012; Simpson & Rholes, 2019). Whether a father has an insecure attachment or not, if attachment needs are not met, the father may withdraw and express feelings of ambivalence, which could be detrimental to the romantic and sexual relationship (Ferriby et al., 2015). When new fathers feel that they are no longer the priority to their partner, fathers may experience increased attachment distress and withhold
love and affection from their partner in attempts to be noticed, thereby creating negative patterns of interaction.

### Postpartum Fatigue and Toll on New Mothers

One certainty that comes with being a new parent is experiencing fatigue, which may be due to the difficult physical and emotional tolls that come with pregnancy, birth, and the postpartum period. Increases in fatigue due to new parenting responsibilities have specifically been linked to a decrease in a woman’s sexual desire in the postnatal period, as women usually carry the burden of parenting responsibilities (Lévesque et al., 2019; Woodhouse et al., 2012). Additionally, the lack of energy may cause both parents to not desire or prioritize a sexual relationship. Olsson et al. (2010) found that even if both couples wanted to engage sexually, due to fatigue, the opportunity to sleep became more important than their sexual desire. Long-term fatigue may hurt a couple’s ability to maintain a sexual relationship if sleep continues to be prioritized over sex (Olsson et al., 2005), which might lead to increased feelings of disconnection. Therefore, women may be particularly susceptible to feelings of disconnection as they experience the majority of the physical and emotional toll of carrying and delivering the baby and recovering from childbirth.

### Physical Toll on Mothers

Another certainty that comes with having a baby is the physical toll on the mother’s body. The physical toll begins in the early stages of pregnancy and carries on through birth and postpartum. Physical changes that women experience during pregnancy, childbirth, and postpartum that might affect a woman’s interest in sex include bleeding, early contractions, weight gain, tears of vaginal tissue that occur during birth, vaginal dryness, and pain during intercourse (Don & Mickelson, 2014; Hartley et al., 2018). Woodhouse et al. (2012) suggest that around 80% of new mothers will experience sexual difficulties in the postnatal period due to these physical changes and stress on the body. Additionally, Woodhouse et al. suggested that women may also experience a loss of sexual desire which may lead to a lack of intimacy and feelings of disconnection as sexual and emotional intimacy are inevitably connected. First-time fathers may struggle to understand their mate’s lack of desire for sex as their bodies have not gone through the same strain and
physical changes. Fathers with an anxious attachment may particularly feel they have lost access to their mate (Ferriby et al., 2015). Overall, if the mother and father have different perceptions of the impacts pregnancy and birth has on the woman’s body, it may lead to conflict in the relationship.

Emotional Toll on Mothers

Relatedly, pregnancy, birth, and breastfeeding contribute to an emotional toll on the mother’s psychological well-being. To illustrate, the drastic physical changes that occur in a woman’s body both during and after pregnancy may lead to feelings of insecurity and negative body image (Hartley et al., 2018; Woodhouse et al., 2012). Rallis et al. (2007) found that in the first year postpartum, new mothers were struggling with feelings of being fatter and felt a discrepancy between their body’s current size and their ideal size. Additionally, women may feel that their body is more for the baby, especially if a mother is breastfeeding, rather than her body being for her husband and sexual relations (Olsson et al., 2010). Feelings of body insecurity may lead to a woman having negative perceptions of herself and a lack of confidence, which may contribute to feelings of postpartum depression (Hartley et al., 2018). Kalbach et al. (2015) suggests that anhedonia (defined as “blunted positive affect and diminished appetite drive” p. 1636), which is specific to depression, is related to lower sexual desire and other related sexual difficulties. Overall, with less interest in sexual intimacy or greater struggle in sexual discrepancy, couples may experience an increase in tension if partners are not able to express their needs and emotions concerning their sexual relationship.

Unrealistic Sexual Expectations

As it is impossible to fully comprehend how becoming a parent may affect one’s life, it is common for both men and women to have unrealistic expectations after the birth of a child, especially concerning their sex life. For example, men are especially vulnerable to having unrealistic expectations towards their sex life and may struggle to redefine what sexual intimacy means to the relationship during the postpartum period (Olsson et al., 2010). Unrealistic sexual expectations may be further exacerbated as around 60% of men experience no change in sexual desire during the period of pregnancy (Radoš et al., 2015). Little to no change in a man’s sexual desire may make it difficult for a male partner to understand why his sexual relationship changes. New fathers may be frustrated when the frequency
of sexual interaction declines or when it is necessary to adjust to the mother’s physical changes, and this may push men to rush the mother into returning to their pre-birth sexual patterns (Olsson et al., 2010). The man’s pressure to return to normal sexual patterns may have an unintended conflict and the female partner may feel misunderstood and hurt. Overall, having unrealistic sexual expectations may perpetuate issues around the couple’s sexual relationship.

Women, likewise, may have unrealistic sexual expectations during the postpartum period. To illustrate, women could struggle with “socially constructed images of being a mother who ‘has it all’ – perfect body, passionate relationship with partner, loving relationships with children…” (Woodhouse et al., 2012, p. 185). Due to perceived societal expectations of what motherhood is supposed to be like, it is not uncommon for a woman to fail to anticipate sexual difficulties, especially if it is her first child (Vannier et al., 2018). Also, women may hold themselves to high standards and assume that they will be able to maintain their sexual activity in the postpartum period. If they are not able to maintain their sexual activity and desire for sex, they may feel like a failure or feel guilty about declining sex (Tavares et al., 2019; Woodhouse et al., 2012). Indeed, if a woman feels she is unable to meet her own expectations regarding her sex life, she may feel guilty and inadequate (Woodhouse et al., 2012), possibly making it difficult for her to connect sexually.

The Relationship Between Postpartum Sexual Issues and Attachment

Overall, with the birth of a baby, couples are likely to experience significant changes in their sexual relationship that may lead to attachment distress in the relationship. As mentioned above, the new priority placed on parenthood rather on the couple relationship may lead to a decrease in frequency of sexual relations. Discrepancies in desire for sex or other negative emotional experiences associated with sex can cause anxiety in the relationship, as sex is important for couple intimacy and overall relationship satisfaction (Girard & Woolley, 2017). Additionally, postpartum fatigue and the overall toll on new parents, may make it difficult for parents to align their sexual desires and needs. Mothers may be in pain from delivery and struggle to see themselves as physically attractive (Woodhouse et al., 2012) and fathers may not understand or be educated in how sex may change after birth (Olsson et al., 2010). Additionally, both men and
women are susceptible to having unrealistic expectations after birth (Olsson et al., 2010). As such, parents could experience feelings of disconnection if they are not able to communicate about their sexual desires as constructive communication and feelings of accessibility, responsiveness, and engagement are vital to promoting secure attachment and understanding (Brimhall et al., 2018). In sum, the increases in miscommunication and feelings of disconnection could lead to a decline in partner attachment if neither partner feels that their partner is accessible, responsive, and engaged during the postpartum period.

**Using Emotionally Focused Therapy**

Significant adjustment in the transition to parenthood is necessary due to stressors that occur during the postpartum period, including the new prioritization of the parent role, lower sex drive, or unrealistic sexual expectations. Such stressors may contribute to couples experiencing lower couple satisfaction due to a cycle of conflict, disconnection, and stress. The EFT model could help couples cope with the transition to parenthood by identifying negative interaction cycles, validating attachment needs, and creating new emotional experiences. Furthermore, as couples come to understand their emotions in response to the stress of the postpartum period, they might be able to make their relationship a place of refuge and security (Greenman & Johnson, 2011). EFT promotes a positive marital relationship by following three stages, cycle de-escalation, changing interactional patterns, and consolidation/integration.

**Stage One: Cycle De-escalation**

Stage One of EFT guides the therapist to develop a relationship of trust with both individuals in the relationship and to assess presenting issues. The therapist may establish reliability with the couple by listening to the couple’s stressors and validating their emotions and thoughts. For example, the therapist could validate the couple by acknowledging how difficult the transition to parenthood can be and reminding the couple that it is normal to have to renegotiate their relationship as they are learning to fulfill their new parental role. While validating the couple’s experience, the therapist may start to explain that as postpartum is a stressful period, the couple’s attachment injuries may be activated (Alves et al., 2019; Simpson & Rholes, 2019). An attachment injury can be defined as an experience when “one partner violates the expectation that the other will offer comfort and caring in times of danger or distress” (Johnson et al., 2001, p. 145). It is through
this process the therapist builds a relationship of trust, allowing the couple to talk about sensitive things like postpartum sexual dysfunction. Furthermore, as a therapeutic alliance is created, the therapist may be able to fully assess attachment styles, again referring to Bowlby’s attachment styles. The therapist could pinpoint anxious or avoidant attachment, which may cause one or both individuals to worry about disconnection and either pursue or withdraw from the relationship (Alves et al., 2019). With a therapeutic alliance established and an initial assessment completed, the therapist can help the couple understand how their sexual dysfunction is related to unmet attachment needs that might have been triggered by the onset of parenthood and the new prioritization of their parental role.

As a second step, the therapist would identify the present negative interaction cycles surrounding the couple’s sex life. By doing this, the therapist helps the couple understand that their relationship stress may be due to negative interaction cycles (Greenman & Johnson, 2013) and with new awareness, couples may begin to make connections between their current circumstances, feelings, thoughts, and behaviors with their patterns of interaction. The therapist then explains that people are born with the need to securely connect with others and if stress, like the transition to parenthood, is placed on that connection, negative interaction cycles may begin (Girard & Woolley, 2017). If a couple is struggling with their sex life postpartum, a therapist may help the couple make connections between their new circumstances and stressors as parents, their emotions, and the couple’s negative interaction cycles. The couple may begin to realize that negative interaction cycles are not occurring due to the lack of typical sexual experiences, but due to feelings of disconnection in the couple relationship that are amplified by new stressors such as lower sexual desire from the physical and emotional toll of pregnancy and birth.

Once the couple recognizes their negative interaction cycles regarding their sexual intimacy, in step three, the objective is to begin to access the unmet attachment needs that are causing secondary and primary emotions that lead to negative interaction cycles (Girard & Woolley, 2017). Both individuals in the relationship need to gain the ability to recognize and express their attachment needs to their partner. Recognizing and understanding unmet attachment needs is important for a couple who is attempting to reconnect sexually, since couples who have higher levels of sexual intimacy and sexual satisfaction also feel more secure in their relationships (A. Hughes, personal communication, March 9,
2020). Therefore, a couple’s recognition of their primary emotions and unmet attachment needs may have a positive impact on the couple’s sexual satisfaction (Lévesque et al., 2019). When couples have an increased ability to recognize their unmet attachment needs and negative interaction cycles, they may be better equipped to understand how the stressors of becoming a parent affect their sexual relationship.

In step four, the therapist focuses on reframing the couple’s issues with sexual intimacy as actually being about their communication process and their underlying attachment needs, rather than focusing on the more surface-level sexual issues. For instance, the therapist could suggest that with the stress of postpartum, the couple has begun to miss each other’s cues and desire for sexual connection (Girard & Woolley, 2017). Such stressors could include the physical and emotional toll that pregnancy takes on the mother. The toll from pregnancy may make it more difficult for the mother to be in tune with her mate’s needs. If the couple has been missing each other’s bids for connection, both individuals might be more likely to express secondary emotions such as anger, frustration, and sadness in an attempt to reconnect. However, as one individual expresses these emotions and verbalizes discontent with the sexual relationship, the other individual may respond similarly defensive manner, leaving both individuals with negative feelings and thoughts, such as believing that they are unlovable. Fortunately, if the couple can recognize negative interaction cycles, they may have more empathy for one another and have less conflict centered around their sex life (Lévesque et al., 2019). Therefore, reframing the couple’s sexual stress as actually being about their desire for connection instead of their sexual issues is an important step in healing attachment injuries. Additionally, with the need for connection identified, couples may more readily emotionally support one another as they cope with the strains of being new parents.

**Stage Two: Changing Interactional Positions**

Stage Two begins with step five, in which the therapist aims to help couples begin to identify and express their own attachment needs. Step six is closely related in which the therapist teaches the couple how to listen to and validate one another’s primary emotions and attachment needs. In a postpartum context, a therapist could start by explaining that each individual may have different needs that manifest in disparate approaches to sexuality, but both individuals have the same aim of feeling loved, valued, and seen (Girard & Woolley, 2017). Conversations about primary emotions and attachment needs may
be unfamiliar for couples, if both individuals have increased self-awareness of their own primary emotions and attachment needs, they may be able to express those needs and feel more connected to one another. Furthermore, with increased communication regarding one another’s attachment needs, couples could plausibly gain a clearer perspective that they are transitioning into parenthood together, further promoting empathy and connection (Alves et al., 2019). Feelings of connection could lead to greater sexual desire as each individual begins to recognize and attend to their partner’s attachment needs (Girard & Woolley, 2017). Therefore, as the couple expresses their attachment needs, they may recognize that their sexual dysfunction is not about sex, but about the need for connection and emotional security. Additionally, couples may be able to let go of unrealistic expectations for sexual intimacy and work together to form joint desires regarding sexual relations during this time period.

The objective of step seven is to instruct the couple on how to build a new interaction cycle that can create an environment for emotional connection. Step seven can be particularly powerful for a couple who is experiencing sexual distress during the transition to parenthood if the couple is vulnerable and explicitly asks for connection. Asking for connection can then lead to the promotion of emotionally and sexually satisfying experiences (Girard & Woolley, 2017; Olsson et al., 2013). A therapist may use specific tactics, such as blamer softening (i.e., not blaming a partner for declining sex) and withdrawer re-engagement (i.e., a partner is stressed and refuses to have a conversation, but then recognizes attachment fears and chooses to actively respond) which may lead to more positive interaction cycles (Greenman & Johnson, 2013). At this point, couples may be able to share their sexual needs and concerns with one another and understand how those things impact their relationship satisfaction. A couple may recognize that if they consistently tune in to one another’s attachment needs, the desire for sex may increase (Woodhouse et al., 2012). At the end of this step, couples may experience relief as they practice awareness of their own needs, express their needs, and actively listen to their partner, all of which promote a more secure attachment and greater sexual satisfaction.

**Stage Three: Consolidation/Integration**

In the last steps of EFT, steps eight and nine, the therapist will assist the postpartum couple in finding new solutions to their sexual dysfunction followed by consolidating the information covered in therapy. A variety of solutions may
be discussed. Some couples may decide to emphasize emotional intimacy until some of the postnatal stressors have subsided, like giving time for the mother to physically heal properly. Postpartum could also be a time for the father to increase positive affect, showing affection toward the mother and being empathetic, which has been correlated with increases in sexual satisfaction (Tavares et al., 2019). Partners may also change the focus of their sexual interests, which may have previously focused on sexual genitalia and certain sexual behaviors but may now be focused on creating a safe space for the couple to intimately connect and recognize their romantic partnership in conjunction with their parental role (Lévesque et al., 2019; Woodhouse et al., 2012). Putting such strategies into practice could promote a teamwork mentality, in which the couple deals with the stressors of the postpartum period together. A teamwork mentality has been associated with positive outcomes regarding couple relationship satisfaction (Don & Mickelson, 2014; Woodhouse et al., 2012). Hopefully, couples leave therapy with a secure attachment, more positive interaction cycles, and the ability to effectively cope with the stress of being a new parent.

**Conclusion**

The time after the birth of a child is often a time of significant adjustment, especially regarding the couple’s sexual intimacy patterns. As mentioned above, new stressors may disrupt a couple’s sex life as they may prioritize their parental role, deal with postpartum fatigue and the toll of pregnancy and childbirth, and have unrealistic expectations of their postpartum sex life. The combination of these factors may lead to negative cycles of interactions, especially concerning the couple’s sexual intimacy, leading to feelings of disconnection in the relationship. EFT can be an effective treatment for couples who are struggling with postpartum sexual dysfunction, as it focuses on the emotions underlying the negative patterns of interaction and unmet attachment needs. As couples go through the stages and steps of EFT, they may be able to express and attend to one another’s needs and thus build positive patterns of interaction that allow them to successfully cope with the stressors of newfound parenthood and promote a positive and connecting sexual relationship. Overall, the aim of this paper was to gain a better understanding of the issues couples face during the postpartum period, how those issues are related to couples’ sex lives, and offer a viable option for
couples to explore in therapy. EFT is a viable solution and has the potential to help couples successfully navigate their sex lives during the postpartum period.

References


Sexual Intimacy After the Transition to Parenthood: Using Emotionally Focused Therapy


Infant Language Development: The Consequences of Trauma

Janna Pickett
Brigham Young University

Infant Language Development: The Consequences of Trauma

Infants between 0 and 36 months who experience physical and emotional trauma are at risk for severe social, emotional, cognitive, and physiological developmental deficits (Carpenter & Stacks, 2009; Jacobsen et al., 2013). As researchers search for protective factors against these deficits, productive language acquisition (the words an infant can verbally produce) has emerged as a potential predictor of resilience (Bellagamba et al., 2014; McCabe & Meller, 2004). This review proposes that infants who have acquired more advanced language, such as emotion descriptors, are able to define their experiences, learn how to respond to those experiences, and feel in control of their environments. This feeling of control provides resilience against external factors such as those brought on by trauma. However, trauma increases an infant’s susceptibility to cognitive deficits such as delayed language (Carpenter & Stacks, 2009; Jacobsen et al., 2013). Furthermore, infancy is a sensitive period for language development (d’Souza et al., 2017). When infants are traumatized, they may miss a critical period to develop language and then suffer long-term language deficits. Language provides resilience, but infants undergoing trauma risk language development deficits, so these infants are forced to confront the challenges of trauma with an underdeveloped language coping system. Infants are also at higher risk, in comparison to other age groups, of being exposed to traumatic events (Lieberman & Van Horn, 2009). Thus, it is vital to understand how—and in what contexts—trauma is related to lower productive language acquisition in order to protect this vulnerable population.

Through a review of the current literature, this paper will explore the patterns found between physical and emotional trauma and productive language. In addition, this paper will present ideas for promoting resilience to guide researchers, pediatricians, teachers, parents, and other professionals working with
infants in their practices. Suggested avenues to protect this vulnerable population include responsiveness to infant cognitive development, careful attention to medical direction, early intervention, and providing stimulating environments.

### Defining Trauma

To understand the literature on trauma and language development, clarification is needed on what is being measured. Conceptually, trauma is difficult to define because it is a broad term for a number of experiences, including physical abuse, sexual abuse, medical trauma, natural disasters, neglect, maltreatment, community violence, and grief (National Child Traumatic Stress Network, n.d.). Furthermore, defining trauma is complex because every infant’s experience with trauma is distinctly dependent on age, contextual factors, and severity (De Young et al., 2011; Pynoos et al., 2009; Scheeringa et al., 2006). As a result, researchers historically have found it problematic to develop a measure of infant trauma that is both valid and generalizable (Carter et al., 2004; Egger & Angold, 2006; Jones & Cureton, 2014). In an effort to clearly define traumatic experiences, the National Child Traumatic Stress Network (NCTSN) has proposed the following definition of early childhood trauma: trauma is “a frightening, dangerous, or violent event that poses a threat to a child’s life or bodily integrity” (NCTSN, n.d.). Because this definition is vague, it provides limited usefulness in terms of developing a valid and generalizable measure, but it does provide a useful starting point for reviewing the literature on trauma. With this framework of trauma, the paper will be further divided into physical and emotional trauma to explain how unique types of trauma are related to productive language acquisition. Though this paper will not comprehensively address all trauma, it will review the two predominantly discussed forms of trauma as they relate to language development.

### Defining Productive Language

Trauma is known to interfere with infant development, leading to negative outcomes such as lower productive language (Jacobsen et al., 2013). Productive language represents the words an infant can say, rather than just understand (Swingley, 2009). For example, an infant may reach out their hands for food when a parent asks if they want more, but until the infant can verbally produce the word “more,” it is not considered part of their productive vocabulary. Most current research includes measures of productive language (Costantini, 2017;
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Eigsti & Cicchetti, 2004). As a result, this paper will also focus on productive language to provide a current assessment of trauma’s relationship with language development. Receptive language, the words an infant can understand, is also an important indicator of a child’s language skills. However, receptive language requires an assumption about what the infant can understand, so researchers typically measure language with productive language.

Physical Trauma

Physical trauma includes any serious injury to the body (Sheets et al., 2013). Frequently, infants experience physical trauma at birth or directly after birth as a result of the birthing process or sudden adjustment to life outside the womb (Osofsky et al., 2017). Common complications include injuries from breech placement during birth, respiratory distress, and illnesses such as jaundice and colic (Miceli et al., 2000). Preterm infants are at increased risk for this trauma due to lower birth weight, underdeveloped circulatory, respiratory, or nervous systems, and birthing complications (Blencowe et al., 2013). Although not all preterm infants are physically traumatized, early births are regularly characterized by complicated procedures, extended time spent in the hospital, and prolonged issues after returning home from the hospital (Platt, 2014). Thus, because preterm infants are an easy-to-study, at-risk group, the majority of the research on traumatized infants compares samples of preterm infants to full-term infants (Costantini et al., 2017; Cusson, 2003; Foster-Cohen et al., 2007; Suttora & Salerni, 2011). Other types of physical trauma, such as abuse, serious illness, and accidents are less commonly studied. Particularly with cases of abuse, ethical barriers can also be difficult to navigate (Kesler et al., 2008; Reijneveld et al., 2004). For example, in order to fully understand how a child has been abused, the researcher may have to ask about sensitive or triggering information which may disturb the child or current caretakers. Ideally, future trauma research should aim to more accurately represent these groups with larger samples, without violating these ethical concerns.

Studying preterm infants as a traumatized sample provides limited generalizability because each preterm infant case is unique and it requires an assumption that all preterm infants have undergone trauma (Platt, 2014). Some preterm infants may be fully developed at birth and experience little to no developmental delays or complications. Nonetheless, there are common patterns
that have emerged from studying preterm infants that may help researchers understand the risk factors of impaired language (Costantini et al., 2017; Cusson, 2003; Foster-Cohen et al., 2007; Suttora & Salerni, 2011). As a result, the next section will discuss the patterns found while examining preterm infants and then discuss the research that is available for other specific medical trauma in full-term infant samples. The combined research from preterm infants and physically traumatized infants will provide a clearer picture of how to develop productive language in vulnerable populations.

**Preterm Infants**

A consistent pattern of lower productive vocabulary in preterm infants has emerged from recent research (Cusson, 2003; Foster-Cohen et al., 2007). These infants typically have a delayed onset of talking, and when they do begin talking, their language is less complex. In an article by Cusson (2003), preterm infants were compared to full-term infants when they were 7, 13, and 26 months old. Preterm infants do not have as much time in utero to develop compared to full-term infants, so developmental delays are bound to occur. However, Cusson (2003) found that, in terms of overall development, preterm infants had caught up to full-term infants by 26 months. However, at 26 months, productive language development in preterm infants was still delayed by 3–5 months. This pattern was confirmed by Foster Cohen et al. (2007) who found that preterm infants had lower receptive and productive vocabulary than full-term infants at age two, even after controlling for family variables such as maternal education, maternal age, and socioeconomic status. Because the preterm infants are at a developmentally comparable level to full-term infants, it can be reasoned that trauma is uniquely related to language acquisition. Although traumatized infants are able to catch up to full-term infants on other developmental milestones, they are still at risk for language deficits. In other words, trauma seems to have more long-term effects on language development than other developmental domains. This conclusion, is, again, assuming that all preterm infants have undergone some form of trauma.

Cusson (2003) and Foster-Cohen et al. (2007) also identified additional risk factors for lower language skills. Cusson (2003) suggested that vocabulary development may be negatively related to the length of hospital stay at birth and positively related to birth weight, maternal sensitivity, and Apgar score (a measure
of the infant’s overall health at birth: Appearance, Pulse, Grimace, Activity, and Respiration) Foster-Cohen et al. (2007) found that younger gestational age related to lower vocabulary. In summary, infants who are born prematurely are at risk for delayed language development. The risk may be exacerbated if the infant has to stay longer in the hospital at birth, has an environment with low maternal sensitivity, or has a lower birth weight, Apgar score, or gestational age (Cusson, 2003; Foster-Cohen et al., 2007). Because these articles did not control for all of the physical differences between premature infants, the specific factors that puts these infants at risk for delayed language remain open. To determine what types of physical trauma warrant the most concern for language development, future research will need larger samples of infants with diverse physical traumas.

Researchers are also unsure whether language deficits in premature infants are a result of physical disabilities, external social factors, or both. Suttora and Salerni (2011) and Constantini et al. (2017) investigated this question by examining premature infant language deficits from the perspective of mothering. Suttora and Salerni (2011) found that mothers typically adapt their speech based on infant motor cues. When the child begins to walk, it seems to cue the mother that her infant is older. As a response, the mother adapts her infant-directed speech to a more complex speech. However, it is possible that if premature infants have a motor delay which prevents them from walking on a normal developmental trajectory, then mothers will not adapt their speech and the infant will fall behind in language competency (Suttora & Salerni, 2011). This could put the infant at risk for long-term language delays.

Constantini et al. (2017) found that mothers’ mind-mindedness, a mother’s tendency to view their infant as an individual with a mind, is similarly related to infants’ language development. Furthermore, mind-mindedness is more strongly related to preterm infants’ language development than full-term infants’ language development (Constantini et al., 2017). The perception that a mother has of her infant is related to the infant’s cognitive skills. The mother will adjust her speech engagement towards the infant based on her perception of where the infant is at developmentally. If the mother does not feel the infant is ready to speak, then the mother will be less likely to encourage speaking. In some cases, this may be developmentally appropriate, but in other situations, the infant may be ready to speak, despite the mother’s perception. This scenario suggests that delayed language may be a result of socialized deficits rather than actual physical deficits (Meins, 2013). In other words, the infant may be cognitively capable of
processing more complex language, but because of physical appearance, the mother does not respond with appropriate scaffolding. When the mother does respond by increasing the complexity of her language despite physical cues, preterm infants may be spared against language deficits (Bernier et al., 2017). Despite physical delays, infants may still develop typical productive language when the response is intentional.

**Physical Trauma in Preterm or Full-Term Infants**

Preterm infants are at higher risk for physical trauma, but full-term infants can also be impacted (Blencowe et al., 2013; Prasad et al., 2005). Any physical condition which damages hearing structures, speech structures, or the brain structures that support language puts infants at risk for lower productive language capabilities (Mayberry, 2002; Miyahara & Möbs, 1995). However, this portion of the review will primarily address trauma which causes deafness and neurological dysfunction due to the relative severity of the productive language outcomes (Toppelberg & Shapiro, 2000). Exposure to teratogens or infections transmitted in the womb, such as meningitis or measles, tumors, abuse, birth complications, and accidents such as automobile crashes may lead to deafness and neurological disorders (Ciurea et al., 2011; Toppelberg & Shapiro, 2000). Though there are overlaps in the outcomes of deafness and neurological disorders, they will be discussed separately to highlight the differences. Furthermore, it is important to note that it would not be considered a traumatic event if the infant was born with deafness or born with neurological disorders, so these sections address deafness and neurological disorders that strictly resulted from trauma.

**Deafness**

Deafness prevents infants from processing their environments and practicing speech sounds because they lack sufficient auditory stimuli (Mayberry, 2002). It should be noted that deafness has not been correlated with lower productive vocabulary in infants who have had experience signing since birth (Orlansky & Bonvillian, 1985). In an article by Orlansky and Bonvillian (1985), deaf infants with deaf parents began producing language (signing) at 8.5 months, whereas hearing infants in typical homes did not begin producing language until 11 months. However, in another article, infants were studied after suddenly
becoming deaf or suffering hearing loss after birth through a traumatic experience; these infants were not prepared with communication skills and were at risk for lower productive vocabulary (Griswold & Commings, 1974). For this vulnerable population, the research shows that communication practice can moderate the effect of sudden deafness on language delays (Lederberg et al., 2013). When caregivers were intentional about maintaining communication with their infants and teaching their infants alternative methods to communicate, the infants developed language at the same rate as hearing infants. Thus, deafness puts infants at risk for lower productive language. However, if the infant knows how to communicate, the risk is mitigated.

**Neurological Disorders**

Neurological disorders impact infants’ abilities to process and produce sounds (Miyahara & Möbs, 1995). For example, dysarthria is a neurological condition which weakens the infant’s speech muscles, making it difficult for the infant to generate words (Safaz et al., 2008). Another neurological disorder, apraxia, disrupts the communication between the brain and speech structures (Byrd & Cooper, 1989). Infants with apraxia can understand how to generate words and have a willingness to speak, but the execution is difficult or impossible (National Organization for Rare Disorders, 2020). These physical conditions limit the ability of the infant to communicate when they need help and put the infant at a disadvantage in terms of vocabulary exposure (Mayberry, 2002); thus, infants who have been traumatized and suffer neurological disorders are also at risk for lower productive vocabulary. Because productive vocabulary allows the infant to express their needs, it is important to be aware of the potential negative consequences of these conditions.

**Emotional Trauma**

Infant trauma research also includes emotional trauma, which can be defined as damage to the psychological well-being of the infant (Cascade Behavioral Health, 2020). Unlike medical trauma, emotional trauma does not alter speech structures, but it can be equally detrimental to infant productive vocabulary (Holmes et al., 2018). Emotional trauma can include neglect, emotional manipulation, domestic violence, or mental illness (Shemesh, 2005). It remains
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an open question if emotional manipulation, domestic violence, and mental illness are related to lower productive vocabulary in infancy, but neglect has been studied as a predictor of language development deficits (Allen & Oliver, 1982; Fox et al., 1982; Holmes et al., 2018). This line of research stems from the idea that infants require stimulating environments, attentive adults, and sensitive parenting in order for language to develop.

Allen and Oliver (1982) and Fox et al. (1988) found that neglected infants, specifically infants who were consistently neglected, had lower levels of productive vocabulary. The authors concluded that neglect is a strong predictor of vocabulary development because the infant is receiving less language stimuli and does not have the encouragement or opportunity to practice language (Allen & Oliver, 1982; Fox et al., 1988). When digital language exposure (television, phones), replaces responsive parenting, the child is also deprived of this productive language practice (Plowman et al., 2010). This research suggests that infants need consistent in-person interactions for optimal productive vocabulary development.

There is also a significant body of literature with samples of infants from abusive homes (Coster et al., 1989; Eigsti & Cicchetti, 2004; Jacobsen et al., 2013; Robinson et al., 2012). These infants have experienced emotional trauma, but it is not always clear what form of emotional trauma they have experienced. In these samples, infants had lower productive language compared to infants from nurturing, caregiving homes (Coster et al., 1989; Eigsti & Cicchetti, 2004; Jacobsen et al., 2013; Robinson et al., 2012). Coster et al. (1989) and Eigsti and Cicchetti (2004) specifically emphasized that infants from abusive homes are less descriptive and cohesive and speak less in comparison to infants from non-abusive homes. Not only do maltreated infants have less productive vocabulary, but their words are also less effective for communicating. This could be explained by the lack of effective communication modeled in their homes. Thus, the literature points to the pattern that infants with emotional trauma are also likely to have lower language skills. A meta-analysis by Lum et al. (2015) confirms these findings with an analysis of over 26 studies on infant abuse and vocabulary. Lum et al. (2015) concluded that infants from abusive households are a high-risk group for low communication skills and language development deficits in infancy. Robinson et al. (2012) extended these findings through observation of 7-year-old children who were in abusive homes as infants and then adopted into foster care. These
children still had lower productive vocabulary than non-maltreated children, possibly pointing to the long-term consequences of emotional trauma in infancy.

**Recommendations to Promote Resilience**

Because emotional trauma and physical trauma put infants at risk for delayed language development, researchers have also searched for resilience factors that protect against those deficits. Holmes et al. (2018) identified infant social and cognitive skills and caregiver warmth as protective factors. Coster et al. (1989) identified maternal speech about emotional states as a protective factor, encouraging mothers to talk more about their emotional states to elicit emotion talk from their infants. Furthermore, Cusson (2003) identified maternal sensitivity as a protective factor. A trusting relationship between parent and infant will encourage modeling of the parent’s talk, giving infants necessary communication practice. When parents have warm relationships with their infants, are intentional about identifying and responding to their needs, and talk to their infants about their own emotions, the infant may be protected from some of the potential negatives of trauma. In summary, a responsive environment is a strong predictor of infant productive language.

As part of developing a responsive environment, research encourages caregivers to be reactive to discrepancies between infants’ physical appearances and cognitive skills (Costantini et al., 2017; Suttora & Salerni, 2011). As previously discussed, infants’ physical appearance provides a cue to signal parental speech (Suttora & Salerni, 2011). As a result, those who look or act physically younger than they are cognitively may be at risk of falling behind in language development. Caregivers can avoid this deficit by being aware that their infant’s physical appearance may not reflect their cognitive capabilities. Spending time with typically developing infants and their parents may help parents of physically delayed infants to keep their speech patterns paced with the infant’s cognitive abilities (Suttora & Salerni, 2011). Similarly, as suggested by Costantini et al. (2017), caregivers should be deliberate about viewing their infants as intelligent beings. Viewing infants as intelligent will encourage more complex speech and interactive conversation, thus promoting productive vocabulary.

Furthermore, though parents have limited control over length of hospital stay after birth, birth weight, and infant Apgar score, Cusson (2003) recommends following medical advice to increase the chances of a healthy pregnancy and
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birth, thus preemptively avoiding the risk of infant physical trauma. Common advice to reduce infant trauma includes maintaining a healthy weight before and during pregnancy, avoiding alcohol and drugs, and regularly attending pregnancy checkups. The interdisciplinary expertise of healthcare workers, developmental psychologists, sociologists, and family researchers will provide a more comprehensive understanding of the factors that contribute to healthy pregnancies and healthy infant outcomes. Having multiple perspectives will provide important insight about contributing factors that may have been otherwise overlooked.

Many infants who have had traumatic abuse experiences are placed in the foster system. Smyke et al. (2009) recommends that infants in these situations are placed in homes before they are 15 months old; this allows enough time to implement interventions during a sensitive period of language development, optimizing the infant’s chance of avoiding language deficits. Early care education programs may also be helpful in reducing the risk of language deficits for infants who were abused. (Merritt & Klein, 2015). Trained staff can help to create responsive environments that emphasize language exposure and communication practice in a safe environment. When other interventions are not possible or additional help is needed, the National Children’s Traumatic Stress Network (n.d.) promotes family cognitive behavioral therapy, child–parent psychotherapy, and meeting with speech pathologists. These professionals can help parents to understand their child’s developmental needs and provide them with appropriate reinforcement and practice.

In summary, recommendations to promote resilience against language deficits include being responsive to the infant’s cognitive abilities, optimizing infant physical health by following the direction of medical personnel, and placing infants in safe, stimulating environments from young ages. By implementing these practices, we can help infants to have the best possible language outcomes despite adverse experiences.

Conclusions, Remaining Questions, and Directions for Future Research

The research on physical trauma highlights a variety of physical disabilities that increase an infant’s risk for lower productive vocabulary (Toppelberg & Shapiro, 2000). Because preterm infants are susceptible to these physical disabilities, they
Infants may also be at risk for delayed language development due to social factors unrelated to physical disability, though it remains an open question if language deficits in premature infants are a result of physical disabilities, external social factors, or both. Some research suggests that both physical differences and social environments interact to predict vocabulary (Constantini et al., 2017; Suttora & Salerni, 2011). Future research should continue to look at the intersection of the physical and the social to provide a holistic understanding of language development. Through this understanding of the physical and social factors at play, more effective interventions for resilience can be developed.

Infants who are emotionally traumatized are also at risk for lower productive vocabulary (Coster et al., 1989; Eigsti & Cicchetti, 2004; Jacobsen et al., 2013; Robinson et al., 2012). Specifically, infants from situations of neglect and abuse are predicted to have lower productive vocabulary because of unstimulating and unresponsive environmental conditions (Allen & Oliver, 1982; Fox et al., 1982; Holmes et al., 2018). However, it researchers are unsure whether emotional manipulation, domestic violence, and mental illness are related to lower productive vocabulary in infancy. Future research should seek out infants who have had experience with these types of emotional trauma to provide insight on other risks to language development. Because it is difficult to study samples of traumatized infants, researchers should also pursue ways to ethically collect more data on trauma.

Future research could also be strengthened by examining productive language over the child’s lifespan. Robinson et al. (2012) has demonstrated that emotional trauma in infancy may predict productive vocabulary in childhood, but more longitudinal research is needed to understand the full picture of trauma’s impact beyond childhood. By examining the development of productive vocabulary
throughout the course of an infant’s life, the specific mechanisms that lead to productive language development may become clearer.

By implicating these suggestions in future research and searching for answers to remaining questions, infants will have a better chance of success both during infancy and throughout their lives. A better understanding of how physical and emotional trauma are related to productive language may help protect infants, despite the negative consequences of trauma. Through productive language, infants gain power over their lives and have the chance to turn a negative situation into a positive opportunity. Thus, it is vital that professionals are united in understanding this relationship in order to protect a vulnerable population.

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Reducing College Student Burnout: Predictive Factors, Harmful Effects, and Preventative Strategies

Eden Semu
Brigham Young University

Abstract

Academic burnout is defined as experiencing emotional exhaustion, having cynical attitudes toward other people and one’s studies, and feeling unable to achieve one’s academic goals (Schaufeli et al., 2002b). Academic burnout has been observed among college student populations, and its prevalence is increasing as college students are more susceptible to psychological illness, are experiencing peak levels of life stress between ages 18 and 33, and are learning to handle novel demands associated with emerging adulthood (APA, 2012; NAMI, 2019). Internal factors, such as motivational style, attitude, and coping mechanisms, have been shown to mediate the relationship between demands and burnout (Gan et al., 2007; Vizoso et al., 2019). Universities that create burnout prevention programs based on development of soft skills to help students process demands in healthy ways may decrease the number of students who need curative psychological services and contribute to the overall well-being of their students long after graduation.

Keywords: Academic burnout, burnout prevention, college students
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The Twitter account @CollegeStudent showcases a unique hybrid of cartoon images, pop culture references, and random Internet videos to illustrate life as a 21st century college student. The account has amassed over two million followers, with hundreds of thousands of retweets and comments on posts about stress, lack of sleep, skipping one class to do homework for another, and living on free snacks from obscure campus events. Although these online snippets of student life are coated in satire, the content is driven by real, shared experiences representing what it means to be a college student—in a crude sense, to be overstressed, overtired, and underfunded.

For many young adults, entering the college years presents a sharp increase in independence and responsibility to meet a variety of intense and sustained demands. Such demands affect nearly all aspects of life: academic, psychological, social, financial, and emotional (Sarros & Densten, 1989). University upperclassmen and graduate students continue to experience the stress of balancing the demands of being a student (Jacobs & Dodd, 2003; McLuckie et al., 2018). While the profile of a stressed college student is a norm in the media and on campus, many studies have illuminated the negative effects of sustained or chronic stressors on physical and psychological health (Schneiderman et al., 2005). College students are expected to handle a variety of demands and are susceptible to the negative consequences of those sustained stressors.

The trend of psychological burnout, originally studied as a phenomenon in social-service workers, is now seen in university students. According to Schaufeli et al. (2002b), student burnout is characterized by emotional exhaustion, cynical attitudes toward other people and one’s studies, and feeling unable to achieve one’s academic goals. The categories of emotional exhaustion, depersonalization, and personal efficacy are concepts found in the popular Maslach Burnout Inventory (MBI) initially designed for use in the workplace. Burnout is reliably characterized by these three measures, as the inventory has been administered to people with various occupations, nationalities, and languages (Schaufeli et al., 2002a). Researchers have primarily focused on factors that mediate the relationship between demands and burnout, as not all who experience heavy workloads automatically...
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experience the effects of burnout (Schaufeli et al., 2002b). However, little research currently exists on how to apply such findings to enhance student well-being.

The attention that the psychological community dedicates to student burnout is merited by its association with other mental illnesses, effects on future job performance, role in premature college exit, and overall negative impact on well-being (Cortes et al., 2014; May et al., 2018; Peterka-Bonetta et al., 2019; Salmela-Aro et al., 2011). Burnout is pathologically unique because many of the environmental factors that could be precursors to burnout are also key elements of engagement, which engagement is similarly characterized by intense effort and exertion in meeting the demands of one’s lifestyle (Stoeber et al., 2011). Fortunately, research on engagement and burnout has revealed that a student’s attitudes, traits, and coping strategies can predict whether their life demands will lead to engagement or burnout (Jacobs & Dodd, 2003). It is imperative that students recognize the symptoms of burnout in themselves and become educated on which coping strategies are most effective to prevent and reduce burnout.

While many universities have recognized the need for services dedicated to student well-being, they are becoming increasingly overextended with the rising number of students who seek psychological services (Center for Collegiate Mental Health [CCMH], 2020). Because academic burnout is a relatively new phenomenon in comparison to anxiety and depressive disorders and the environmental factors involved in burnout are common to most college students, there are few formal services that address burnout. Universities should mandate formal education about psychological burnout and teach valuable coping strategies for how to avoid it.

**Burnout in College-Aged Young Adults**

The demands and dynamism of young-adult life, especially college student life, justify studying burnout in students. Burnout was originally studied in older adults who were established in the workforce, but researchers began to notice that the pressures many college students face could also lead to burnout because school environments and work environments are comparably stressful (Vizoso et al., 2019). Given that burnout is considered a detrimental psychological and physiological condition, it is more likely to affect populations who are already compromised by other health challenges and life instabilities (Schaufeli et al., 2002b; Vizoso et al., 2019). Examining common young adult health challenges
and the nature of burnout illuminates why college students are especially susceptible to burnout.

**Conceptualizing Burnout**

The concept of burnout is closely related to stress and mental illness and has recently gained attention in the literature for its harmful effects on young adults. Student burnout is typically measured through self-completion of the Maslach Burnout Inventory–Student Survey (MBI–SS), which measures emotional exhaustion, cynicism toward schoolwork, and lack of self-efficacy or inability to successfully meet academic demands (Schaufeli et al., 2002b). Researchers do not agree on how long it takes for students to experience burnout or if their year of school (i.e., freshman, sophomore, junior, senior) matters for burnout score. Studies have been conducted at the beginning of the school term, at the halfway mark, and the week before finals, with first through fourth year students in undergraduate programs, and even with medical students (Jacobs & Dodd, 2003; Law, 2007; McLuckie et al., 2018). Students reported significant levels of burnout in a variety of settings and times in the school year, suggesting that the causes of burnout can be attributed to more than present scholastic pressures and that its effects may extend after the school year is over.

**Health Challenges in Young Adults**

Many studies have found that college students are vulnerable to psychological and physiological illnesses (Jacobs & Dodd, 2003; Law, 2007; Williams et al., 2018). Stress is defined as the body’s physiological and psychological response to internal or external change (American Psychological Association [APA], 2020), and current research shows that young adults are typically more stressed than children or the elderly (APA, 2012). Although short-term stress can be helpful in physiological performance and mental concentration, the harmful effects of long-term stress are well-documented in published literature. These effects include immune system depression, lower-quality sleep, increased strain on interpersonal relationships, and lower academic performance (Law, 2007; Schneiderman et al., 2005; Towbes & Cohen, 1996). Stress is also thought to be related to mental illness, which is becoming increasingly prevalent among college-aged students (CCMH, 2020). According to the National Alliance on Mental Illness (NAMI, 2019), the median age of onset...
for mental disorders ranges from late teens through early 20s, and most lifelong mental illnesses are diagnosed by age 24. This indicates that people may be more likely to experience high stress or develop mental illness in their college years than in other stages of life, which could increase their susceptibility to developing comorbidities.

Effects of Burnout

The negative effects of burnout in students are similar to those found in earlier studies with human-service workers, such as low job or school attendance, decreased quality of work, and increased likelihood of quitting or dropping out (Law, 2007). In some cases, the effects of burnout may be more intense for students because most of the academic workload is handled outside the classroom, whereas paid work stressors are typically confined to the workplace (Law, 2007). Kuo et al. (2018) found that high levels of burnout led to avoidance-coping strategies, which were related to increased academic stress and negatively impacted academic success. Jacobs and Dodd (2003) further suggested that burnout was associated with negative temperament, insomnia, and increased drug and alcohol use. In addition, the long-term effects of burnout appear to extend to increased likelihood of dropping out of college, experiencing job burnout after college, developing cardiovascular disease, and developing hypertension (May et al., 2018; Peterka-Bonetta et al., 2019; Salmela-Aro et al., 2011). Although the environment in which burnout occurs is academic, its consequences appear to negatively impact many present and future aspects of life for students.

Because burnout is an amalgam of three different negative internal states (emotional exhaustion, cynicism and lack of self-efficacy), some effects of burnout are more strongly associated with certain constituent states. Jacobs and Dodd (2003) observed that emotional exhaustion was associated with negative temperament and higher perceived levels of workload. They also found that reduced self-efficacy was associated with lower perceived social support and less time spent in extracurricular activities. Cynicism toward studies has been more extensively studied in relation to its proposed opposite, which is optimism. Vizoso et al. (2019) concluded that optimism was negatively related to other dimensions of burnout and maladaptive coping strategies. More research is needed to clarify the unique
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The effects of cynicism as a function of burnout, but emotional exhaustion and decreased self-efficacy both appear to pose threats to student well-being.

**Preventative and Coping Strategies in Formal Settings**

The establishment of grassroots organizations like NAMI near the turn of the 21st Century and the rise of social media as a platform to speak openly about mental illness have contributed to the further establishment of mental health services (NAMI, 2020). But these services are relatively new, and schools are finding that their clinics are being overloaded with students requesting help, despite measures to expand staff (CCHM, 2020). These trends suggest that achieving healthy student populations may require a more sustainable approach than treating the afflicted.

Although academic burnout is linked to many harmful psychological and physiological disorders, it currently does not appear in the Diagnostic and Statistical Manual of Mental Disorders, which suggests that students who experience academic burnout may not receive the help they need unless they exhibit symptoms for other illnesses that are more easily diagnosed (American Psychiatric Association Publishing, 2020). Fortunately, research about academic burnout has elucidated many predictive factors that could be used to form more effective prevention courses and targeted treatment programs. In order to reduce academic burnout, and consequently the prevalence of other mental illnesses on campus, schools should implement research-based preventative and curative programs like those used to teach soft skills in primary and secondary schools.

**Effectiveness of Internal Factors to Mediate Burnout**

Many studies on academic burnout have shown that the demands students face and the experience of burnout are not directly correlated; instead, many internal factors and soft skills are thought to mediate the relationship between demands and burnout (Brisette et al., 2002; Chang et al., 2016; Woo Kyeong, 2013). Some students with demanding workloads and social pressures do not experience burnout, but instead experience engagement, which is “a positive, fulfilling, work-related state of mind that is characterized by vigor, dedication, and absorption” (Schaufeli et al., 2002b, p. 74). One popular theory as to why internal factors mediate demands and burnout is the demand-resource theory.
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which was originally posed to explain work stress (Williams et al., 2018). In an academic context, students typically experience burnout when their personal resources are exhausted by their perceived demands. Factors studied by other researchers (such as motivation, attitude, and coping skills) tend to act as personal resources for students. Although most burnout studies do not focus on the theoretical origins, the research is rapidly growing in support of the impact of motivational style, personal attitude, and coping skills on predicting academic burnout.

Motivation

Student motivational style has been shown to mediate the relationship between demands and burnout. Motivational styles have been operationalized in many ways, including the study of perfectionism, passion, and intrinsic or extrinsically located constructs. Stoeber et al. (2011) found that when students were passionately engaged in academic activities because they were personally fulfilling, they experienced decreased exhaustion, cynicism, and inefficiency. Chang et al. (2016) similarly indicated that students who reported acting on self-imposed perfectionism and high personal standards to achieve their goals experienced less burnout than students who felt their experience of perfectionism was socially prescribed. According to Rubino et al. (2009) intrinsic motivation was a protective factor against academic burnout, and external regulation significantly predicted exhaustion and cynicism. Motivation based on the personal importance of work is associated with less burnout, and externally prescribed motivation appears to increase the likelihood of burnout.

Attitude

Attitude toward demands (such as academic workload or social obligations) is thought to act as a cognitive expression of motivational style and has been shown to predict the occurrence of burnout in students. The role of optimism in predicting mental illness is consistently found in research on burnout. According to Vizoso et al. (2019), optimism negatively predicted emotional exhaustion; similarly, Brissette et al. (2002) found that students who reported feeling high levels of optimism at the start of school experienced smaller increases in stress and depression over the course of a semester than their less optimistic peers.
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Although optimism does not typically decrease objective workload or eradicate psychological distress, it appears to have a clear mitigating effect. Research also indicates that a student’s appraisal of their workload is more closely related to burnout than their objective workload, which means that students who believe they have intense workloads are more likely to experience burnout than students who do not (Jacobs & Dodd, 2003). These findings suggest that attitude is a powerful mediator between demands and burnout because of the predictive significance of optimistic perspective.

Coping

Both motivational style and attitude can be expressed behaviorally as coping mechanisms, which play a key role in predicting and preventing burnout. Adaptive and culturally appropriate coping strategies, coping flexibility, and practicing self-compassion all negatively predict burnout. According to Vizoso et al. (2019), adaptive coping strategies such as problem solving, cognitive restructuring, expressing emotions, and social support negatively predicted exhaustion and cynicism and positively predicted efficacy. However, what may be an adaptive coping mechanism in one situation could be maladaptive in another context, which highlights the role of coping flexibility (Gan et al., 2007). Students who can adjust their coping mechanisms depending on if their problem is mental, emotional, or social are also less likely to experience burnout (Gan et al., 2007). Coping flexibility is thought to be related to socio- or ethnocentric coping strategies, which are coping strategies that increase in-group connection and social acceptance because they reflect social norms (Kuo et al., 2018). Effective utilization of culturally relevant coping strategies has shown to decrease emotional exhaustion, which is a key component of burnout. Self-compassion, which is a form of adaptive cognitive restructuring, is also related to lower levels of burnout and increased psychological well-being (Woo Kyeong, 2013). Together, these findings suggest that burnout can be prevented as students learn adaptive coping strategies and understand when to appropriately use them.

Teaching Burnout Prevention

There are unique barriers to teaching burnout prevention as an intervention program in college communities. If burnout intervention programs are structured
as optional classes, it may be difficult for students to devote time, attention, and money to taking such optional credits due the academic rigor of college. Meta-analyses on burnout and stress psychoeducation programs also show that most programs are implemented in conjunction with work or primary-school attendance (Awa et al., 2010; Kragg et al., 2006). The nature of work and school environments is typically one of daily attendance with interactions between stable social groups, whereas college students interact more superficially with a wide variety of peers and authority figures, which could hinder implementation of a daily intervention program.

Studies reviewing teaching methods and results of psychoeducational programs show that programs are generally effective in reducing stress and preventing burnout over time, and specific modifications to existing methodology could make programs successful for college students despite the aforementioned limitations (Awa et al., 2010; Kragg et al., 2006). In a meta-analysis conducted by Awa et al. (2010), skills commonly taught in burnout prevention programs included cognitive behavioral training, counseling, communication skill training, relaxation exercises, and social support skills. Successful psychoeducational programs typically depend on in-class education and at-home practice, so even if students do not have class time every day, their practice time implementing the soft skills learned in class can still be effective (Awa et al., 2010). Based on the research elucidating motivation, attitude, and coping skills as key mediating factors between demand and burnout, there is room for improvement to existing psychoeducational models. These modifications for burnout prevention teaching include addressing the importance of intrinsic motivation, healthy passion for achievement, optimism, self-compassion, and coping skills.

**Conclusion**

Though the pseudonymous @CollegeStudent attributes all their problems to the academic rigor and various pressures of student life, it is more accurate to state that they are suffering from a lack of personal resources to handle their demands and, consequently, are experiencing burnout. Social media platforms such as Twitter let students share their school stress with people who can relate, but this practice may ultimately contribute to the rise of student burnout because
the roots of the problem, such as attitude, motivation, and coping skills, are internal.

The young adult years, including the college years, are typically dynamic and demanding, which is thought to contribute to increased susceptibility for burnout. Young adults are typically more stressed than older adults and are likely in the process of making decisions with lifelong consequences such as choosing a career path or selecting a life partner (APA, 2012). During the college years, young adults are more likely to develop mental illness than at any other stage in life, which may lead to developing unhealthy habits or coping skills later (NAMI, 2019). Young adult psychological and physiological challenges, with the additional demands of being a student, may contribute to the risk and prevalence of burnout, which appears to have harmful short- and long-term effects on academic and professional careers as well as on mental and physical health.

Campus psychological services and options, such as wellness and recreational courses, can help students who experience mental illness, but there are few services to prevent burnout (which is often a precursor to mental illness), and they would be most effective if built on the research about the relationship between demands and burnout. Students are increasingly requesting psychological services, especially for anxiety and depressive disorders, so implementing programs that could keep students out of curative services may help reduce the patient load of campus psychologists (CCMH, 2020). By implementing mandatory courses to educate students on the predictors of burnout and by teaching them to develop the soft skills that control how they process demands, university educators may create healthier campus communities and more successful alumni in the workplace.

Although the demands that college students typically face ultimately allow them to experience new challenges that are important to the process of becoming financially, socially, and emotionally self-sufficient, these young adults are a vulnerable population psychologically and deserve resources to teach them how to manage the novel and intense demands of adulthood. Research shows that students can be healthily engaged with many life demands, and those who are intrinsically motivated, optimistic, and use adaptive coping strategies flexibly are more likely to avoid burnout than those who do not understand their role in handling demands successfully (Gan et al., 2007; Rubino et al., 2009; Vizoso et al., 2019). If students are educated as part of their university curriculum about how to develop the soft skills to avoid burnout, they are more likely to be
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psychologically and physiologically healthy and successful in college and in the workforce.

Research on college student burnout is relatively new, which means there are limitations that may affect the application of findings and there is room for future studies. Many studies on burnout were conducted on undergraduate populations even though burnout has also been identified in graduate school students, so it is possible that different mediating factors between demands and distress exist at different levels of one’s educational career (McLuckie et al., 2018). Researchers may also use different surveys to measure burnout besides the MBI–SS, which variation could contribute to varying interpretation of results.

Universities most often address stress through relief programs or services. As schools move to prevention models of treatment, effective practices can be synthesized into existing hypothetical models of effective burnout-prevention courses or programs. Although the research supporting prevention programs is still growing, conclusions thus far are consistent: burnout tends to be pervasive on campuses and detrimental to student health, and it can be effectively reduced with the right preventative strategies.

References


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Appendix

Figure 1

*ERI Model for Educational Contexts*

Imbalance maintained...

- If no alternative choice is available
- If accepted for strategic reasons
- If individual is overcommitted to their work

*Note.* Students who feel that their efforts are not adequately matched by rewards may experience academic burnout, and the contributing factors to such imbalance as mentioned above may be modified through student motivational style and attitude. Adapted from “More Pain than Gain: Effort–Reward Imbalance, Burnout, and Withdrawal Intentions Within a University Student Population,” (Williams et al., 2018).

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The Need for a More Holistic Approach for the Treatment of Irritable Bowel Syndrome

Haylee E. Dahlin
Brigham Young University

Abstract

Irritable bowel syndrome (IBS) has been shown to be associated with psychological symptoms as well as physical. Despite this correlation, physicians are more likely to focus on and provide treatments primarily for the physical aspects of IBS, which may result in a less-than-ideal treatment of the disorder. This literature review examines many IBS-related studies which show the existence of psychological components of IBS and the efficacy of treatment methods based in psychology. The conclusion of this research is that the current medical treatments of IBS are insufficient, and patients would likely see more improvements if physicians were to create a more holistic, individualized treatment plan for each patient by assessing for and treating the psychological aspects of IBS in addition to the physical aspects.

Keywords: irritable bowel syndrome, individualized treatment, antidepressants, psychotherapy, holistic treatment
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Irritable bowel syndrome (IBS) is a gastrointestinal disorder characterized by periodic abdominal pain and abnormal bowel movements which affects approximately 10–20% of adults in Western countries (Lovell & Ford, 2012). Although the disorder is not life-threatening, it can have debilitating, if not devastating, effects on the social, professional, and personal lives of those who have it. Not only does IBS have encumbering physical symptoms and social effects, but research has found psychological connections as well (Tosic-Golubovic et al., 2010). IBS is commonly comorbid with psychological disorders such as depression and anxiety. Several studies have demonstrated the efficacy of a holistic approach, incorporating psychological treatment as well as physical treatment, in improving symptoms of IBS (Craske et al., 2011; Ljótsson et al., 2014; Muscatello et al., 2010).

There is a need for improvement in the way people with IBS are diagnosed and treated due to the evidence that physicians currently focus primarily on the physical aspects of IBS, often leaving patients dissatisfied (Harvey et al., 2018; Shivaji & Ford, 2015). Despite the benefits of holistic treatment methods, evidence suggests that clinicians are more likely to use or recommend traditional medicinal treatments, such as soluble fiber and antispasmodics, rather than therapy or medication focused on the mental aspects of IBS (Shivaji & Ford, 2015). Additionally, many physicians view IBS simply as a diagnosis of exclusion; this means that, rather than using the gastroenterologist-developed diagnostic criteria to specifically address IBS, many physicians provide an IBS diagnosis only after ruling out other gastrointestinal issues. Moreover, many who suffer from IBS have expressed dissatisfaction in the process of seeking treatment, specifically in a lack of individualized care shown by clinicians (Harvey et al., 2018). The improvement of individual IBS patients may depend on the improvement of the individualization of the IBS treatment process.

More personalized treatment would likely be more effective in treating IBS, thus providing those who suffer from this disorder with more relief, freedom, and a better life overall. Although most of the symptoms are physical, it would be beneficial if clinicians were to go beyond diagnosing and treating only the physical aspects of IBS by assessing and presenting a holistic treatment plan tailored to the patient’s psychological needs as well. This kind of individualized diagnosis and treatment is warranted for the following reasons: assessing for psychological
issues may provide good indication for which treatments will be most beneficial for the individual, psychopharmacological treatments have shown great potential for alleviating IBS symptoms, and psychotherapeutic treatments can also have a significant impact on both the physical and psychological aspects of IBS.

**Methods**

To find the articles included in this review, I searched the APA PsycInfo database for the terms “irritable bowel syndrome or IBS” AND “mental illness” AND “treatment.” I narrowed the search to peer reviewed articles from the years 2000–2020, which yielded 21 results. I also conducted a similar search with only the terms “IBS” AND “mental illness,” and then I searched for “IBS” AND “treatment.” After reading through the abstracts of these articles, I selected the ones that were most relevant to the subject I was studying, which is the interaction between mental illness and irritable bowel syndrome and the treatment methods which take this interaction into account. Additionally, I found other sources referenced within some of those articles which were also relevant to this review and have thus included them.

**The Value of Psychological Assessments in Diagnosing and Treating IBS**

To ensure that each patient receives an individualized, holistic, and therefore more effective treatment plan, psychological assessments should be administered to patients to evaluate their levels of predicting psychological factors as part of the diagnostic process for IBS. Between all the different kinds of therapies, medications, and other treatment options for patients with IBS, prescribing an effective and feasible treatment plan is a complicated task for clinicians (Shivaji & Ford, 2015). Studies have shown that the treatment option that will work best for a certain person can often be predicted by psychological factors such as anxiety, depression, trauma, alexithymia, and somatization (Creed et al., 2008; Farnam et al., 2014; Mohamadi et al., 2019; Porcelli et al., 2017). To measure these factors, simple (but reliable) questionnaires could be given to patients such as the Visceral Sensitivity Index, Toronto Alexithymia Scale, Hospital Anxiety and Depression Scale, Recent Physical Symptoms Questionnaire, and the Comorbid Medical Conditions Questionnaire (Creed et al., 2008; MacLean et al., 2012; Muscatello
et al., 2010; Porcelli et al., 2017). Paired with follow-up questions or interviews, these tests would give physicians a more in-depth analysis of the psychological components of the disorder rather than the physical components alone, allowing them to identify the best treatment option for that specific patient.

Testing for Comorbid Mental Illnesses

Several studies done in recent years have shown patterns of comorbidity with IBS and psychological disorders; that knowledge of an individual’s comorbidities can lead to the implementation of effective treatment options (Cho et al., 2011; Mohamadi et al., 2019; Muscatello et al., 2010). The psychological aspects of IBS appear to be bidirectional, so whether IBS symptoms cause or are caused by psychological issues like anxiety and depression, clinicians’ knowledge of and treatment tailored to these specific characteristics in individuals will lead to better quality treatment (Muscatello et al., 2010). A study conducted by Tosic-Golubovic et al. (2010) illustrated this by comparing the anxiety and depression levels of IBS patients to both people experiencing a depressive episode and healthy individuals. The levels of depression and anxiety in IBS patients were significantly closer to the participants experiencing a depressive episode than to those considered healthy. While not every person with IBS has high levels of depression or anxiety, if physicians are knowledgeable about these issues, they can help address them with the treatment that best fits each patient’s individual experience. For example, in a study by Mohamadi et al. (2019), positive psychotherapy was shown to improve levels of overall quality of life, while mindfulness-based cognitive therapy (MBCT) was shown to lower levels of perceived stress than the other therapies tested. By understanding this research and assessing an individual patient’s needs, a physician can prescribe more effective treatments catered to the individual—for example, prescribing MBCT to patients with higher stress levels.

In addition to anxiety and depression, trauma is highly associated with IBS and should therefore be assessed for and treated in IBS patients. One study found that PTSD and IBS had a 23% comorbidity rate among Iraq and Afghanistan veterans (Maguen et al., 2014). Mindfulness-based stress reduction has shown potential as an efficacious treatment for veterans with IBS and PTSD (Harding et al., 2018). In addition to being prevalent among veterans, IBS is also common among victims of abuse (Creed et al., 2005). In a study of patients with severe
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IBS, Creed et al. found that victims of sexual abuse experienced significant improvement in IBS symptoms after undergoing psychological treatment (either psychotherapy or antidepressants), while those who received only the usual treatment experienced little to no change. By screening IBS patients for PTSD symptoms and signs of abuse, clinicians can recommend effective treatments, especially psychological treatments like those previously discussed.

Testing for Alexithymia

Alexithymia, the inability to discern or express one’s own emotions, is prevalent among the IBS population and can exacerbate IBS symptoms, which makes assessing and being aware of the condition important for physicians (Farnam et al., 2014). In fact, Farnam et al. reported that patients with IBS had higher scores in all three measured areas of alexithymia compared to the scores of a normal population when their participants completed the Toronto Alexithymia Scale. These findings are consistent with the findings of Porcelli et al. (2017), which also show that alexithymia is a significant predictor of IBS symptom severity. More than just finding the rates of alexithymia among IBS patients, Farnam et al. (2014) also found an effective treatment method for this population: emotional awareness training. Simply by attending two 30-minute group training sessions and recording their emotions every day, IBS patients with high levels of alexithymia experienced noteworthy improvement over the 12 weeks of the study; of the group who received only medical treatment, 36% reported a significant decrease in pain, while 54% of those who received emotional awareness training experienced significantly less pain. Similar percentages to these were reported for the decrease in frequency of pain as well. These findings provide extremely valuable insights for physicians treating IBS: it is important to assess for alexithymia, and if assessments show that a patient has high alexithymia levels, emotional awareness training may become a critical component of the treatment plan for that patient.

Testing for Somatization

Another factor that should be measured in IBS patients along with psychological comorbidities and alexithymia is somatization, which is the recurrent production of multiple bodily symptoms without a perceptible physical
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source (MacLean et al., 2012). Van Tilburg et al. (2013) found somatization to be one of the highest predictors of IBS severity in a study measuring the effects of psychological factors on IBS. In 2008, Creed et al. conducted a study to examine how somatization affects the efficacy of treatment for patients with severe IBS. The study revealed that not only did patients with higher somatization levels have more severe IBS, but they also responded much more positively to psychological treatment than to the usual treatment and experienced more dramatic improvement than the participants with lower somatization levels. This study demonstrates the practicality of assessing somatization levels in addition to levels of anxiety, depression, trauma, and alexithymia in IBS patients and prescribing a treatment plan that goes beyond usual medical care to include psychopharmacological and/or psychotherapeutic treatments.

The Effects of Psychopharmacological Treatments on Physical and Psychological Aspects of IBS

Psychological medication is one promising method of treatment for patients with IBS. Despite the common comorbidity of IBS and psychological disorders such as depression and anxiety, few studies have been done to examine the effects of psychopharmacological treatments such as selective serotonin reuptake inhibitors (SSRI) and serotonin-norepinephrine reuptake inhibitors (SNRI) on IBS. Those that have tested the impact of these drugs on IBS patients have found positive results on both the physical and mental symptoms of IBS, indicating the drugs’ potential value and the pressing need for more testing on the subject (Kaplan et al., 2014; Kuiken et al., 2003; Vahedi et al., 2005). As more studies show the benefits of psychopharmacological treatments, clinicians can prescribe these medications as part of an individualized treatment plan for their patients.

One SSRI that has shown potential in the treatment of IBS is paroxetine. In a study conducted in 2002, Masand et al. compared the effects of paroxetine on the IBS symptoms of 10 IBS patients with a comorbid anxiety disorder and 10 IBS patients without an anxiety comorbidity. Following 12 weeks of the SSRI treatment, most participants in both groups reported improvement in severity and frequency of pain, constipation, and diarrhea. Although there was greater improvement reported in the anxiety group, the difference was not enough to be considered statistically significant, meaning that both those with and those
without an anxiety disorder benefited from the treatment almost equally. While this study indicates promising benefits of paroxetine in treating IBS symptoms, some limitations are the small sample size and the lack of a placebo group. However, a different study conducted by Masand et al. in 2009 did compare the effects of paroxetine and a placebo on patients with IBS with a much larger sample size of 72 participants (36 in each group). Although this study did not find a statistically significant difference in the pain levels reported by both groups, it did find significantly more improvement in the paroxetine group in other measured areas such as Clinical Global Impression-Improvement and Clinical Global Impression-Severity. While additional research should be done, the results of these studies do indicate that paroxetine is a treatment option worth considering for patients with IBS.

SNRIs also have great potential as a medical intervention for IBS, particularly the drug duloxetine. Kaplan et al. (2014) conducted a study to examine the effects of duloxetine on the symptoms of IBS and generalized anxiety disorder in patients who experience both conditions comorbidly. After receiving 12 weeks of treatment, nine of the 11 participants who completed the study showed significant improvements in areas such as anxiety levels, IBS symptom severity, and overall quality of life as it relates to IBS. A similar study was conducted by Brennan et al. in 2009 in which duloxetine was given to eight IBS patients for 12 weeks. Despite the fact that none of the participants had major depression, the antidepressant proved to be effective in lowering levels of anxiety, pain, and severity of illness while increasing quality of life in participants. Despite small sample sizes and other limitations which indicate the need for more research, these studies demonstrate the potential benefits of medication designed for psychological disorders on the mental and physical aspects of IBS, both for those with comorbid mental illnesses and those without.

The Effects of Psychotherapeutic Treatments on Physical and Psychological Aspects of IBS

Psychotherapy is another effective non-traditional treatment method for individuals with IBS. In an interview-based study conducted by Harvey et al. (2018), more than 50% of participants with IBS reported a general aversion to taking medications for IBS. Many patients believed that rather than treating the underlying causes of their disorder, the medications simply masked their symptoms.
While IBS may not always be caused by psychological factors, the frequency of comorbidity with psychiatric disorders suggests that psychotherapeutic methods of treatment may be helpful in addressing the core origins of the disorder in some patients, as opposed to using purely medical interventions. This is especially true in the frequent cases in which traumatic experiences like war or abuse are concurrent with IBS (Creed et al., 2005; Maguen et al., 2014). Perhaps because of this common cooccurrence of mental illness and IBS, several different kinds of therapies have proven to be successful in treating both the psychological and physical symptoms of this disorder and should therefore be considered for the personalized, holistic treatment of IBS.

**Effective Psychotherapeutic Models**

One therapeutic model shown to be especially efficacious for IBS is MBCT. A study of women with IBS found that compared to a wait-list control group, the group that took part in MBCT sessions specifically adapted for IBS reported significant improvements in IBS symptom severity, levels of depression and anxiety, and quality of life (Henrich et al., 2020). Another study measured and compared the effects of different therapy techniques (dialectical behavior therapy, MBCT, and positive psychotherapy) on the perceived stress and quality of life of people with IBS (Mohamadi et al., 2019). While the results showed greater improvements in each of the therapy groups than in the control group, it also found that MBCT in particular was more effective than the other therapies in lowering participants’ perceived stress levels. Due to its apparent positive impact on somatic and psychological aspects of IBS, MBCT should be considered by clinicians as a prospective treatment option for patients with IBS.

Exposure therapy, which involves intentionally putting the patient in anxiety inducing situations, is another highly effective treatment for anxiety disorders and has shown promise as part of a therapeutic treatment of IBS. Craske et al. (2011) conducted a study to test the efficacy of a treatment which combined aspects of cognitive-behavioral therapy (CBT) and exposure therapy. When compared with a control group and a stress management group, the group that received the CBT treatment featuring interoceptive exposure to visceral sensations (meaning the strategic introduction of feared feelings within the internal organs) experienced significantly better results in several categories, including IBS-related anxiety and pain vigilance. A similar study was conducted by Ljótsson et al. (2014) which
directly compared the effects of two internet-delivered CBT treatments, with the only difference being that one treatment included systematic exposure to IBS-related symptoms and experiences, while the other did not. The study found that the group who experienced the systematic exposure had greater improvement in IBS symptom severity than the group that received CBT alone. While CBT has been shown to be an effective treatment, the addition of exposure therapy can lead to even greater improvements in physical and psychological effects of IBS.

**Alternative Options to Traditional Psychotherapy**

While one argument against using psychotherapeutic treatment methods for patients with IBS is the inaccessibility thereof for many people, there are several potential alternatives to regularly meeting individually with a therapist which are also helpful for treating IBS. For example, studies have shown that gut-focused hypnotherapy (involving progressive relaxation and therapeutic suggestions focused on improving IBS symptoms) can produce significant positive results in improving physical and mental well-being in IBS patients, even when administered by a medical nurse or over Skype rather than in person by a psychologist (Hasan et al., 2019; Lövdahl et al., 2015). Another alternative psychotherapeutic treatment option was tested by Hunt et al. (2015) in a study where participants with IBS were given a CBT self-help workbook specifically for IBS. Despite a small sample size and other limitations, the success found in those who did complete the study is an indication that self-help workbooks based on IBS-focused psychotherapy techniques may be viable components in the treatment of IBS. Therefore, even in circumstances where traditional therapy may be impractical, clinicians do not have to rule out psychotherapeutic treatment options.

Another option to make these therapeutic treatments more accessible to the general public without losing the benefits of a trained therapist is administering them in the form of group therapy sessions. Because of the ability to accommodate more patients at a time, group therapy is generally less expensive, which provides a more accessible option for patients with IBS seeking psychotherapeutic treatment (Berens et al., 2018). Ljótsson et al. demonstrated the effectiveness of group therapy in their 2010 study. The study involved 34 individuals with IBS who participated in 10 weeks of group therapy sessions focused on exposure and mindfulness. The results indicated improvement in levels of pain, bloating, anxiety, social functioning, and other variables. Although
this study had limitations such as the lack of a control group and small sample size, its findings are supported by a study done by Berens et al. (2018). This study measured the effects of group therapy designed specifically for patients with IBS and found moderate success, indicating that group therapy is a suitable treatment option. Due to the success found in these studies, clinicians can recommend group therapy as a viable psychological treatment for individuals with IBS.

**Conclusion**

The main limitation of this literature review is a lack of recent studies on this important subject. In order to more fully help IBS patients, more research should be done on IBS treatments, specifically psychology-based treatments. While there is a lot of evidence to back up the use of psychotherapy as a treatment for IBS, more research is required to get a better picture of which psychopharmacological treatments are effective and to what degree they are effective (Henrich et al., 2020; Ljótsson et al., 2014). A study should also be done comparing patients’ experiences with the current “traditional” (medical-focused) method of treatment versus experiences with a clinician who provides psychological questionnaires and then develops an individualized treatment plan based on those results. This further research and implementation of the principles discussed can make an incredible difference in the lives of thousands of people who suffer from IBS.

IBS is a complex disorder with unique components for each patient, making it necessary for patients to receive individualized treatment. Many studies have demonstrated that IBS can be more than a physical illness and that integrating psychopharmacological and psychotherapeutic interventions into a holistic treatment plan can have great benefits for people with IBS (Craske et al., 2011; Ljótsson et al., 2014; Muscatello et al., 2010). By assessing the psychological aspects of each patient’s individual diagnosis, physicians can gain a better idea of an effective treatment plan for that individual, potentially including medication like antispasmodics or antidepressants and therapeutic treatments like MBCT. This review provides an analysis of several treatment methods (specifically those with foundations in psychology) in order to illustrate that integration of psychological and physical treatments into a more holistic approach is a viable way to combat the lack of individualization. In addition to being valuable for physicians treating IBS, these findings are also important for patients who suffer
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from this disorder since they can also look into different treatment options and discuss them with their physicians. For many, integrating psychological-based methods into their treatment plan could make all the difference for both their physical and mental health.

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Plea to Professors: A Passionate Approach to Controversy in the Classroom

Adriana Meredith
Brigham Young University

Abstract

Scholars have warned of a student-driven movement to turn campuses into comfort zones free from any material that may be seen as controversial (Lukianoff & Haidt, 2015). Despite this movement, the notion that professors ought to shelter their students as opposed to exposing them to challenging ideas is anti-intellectual and counterproductive to the development of critical thinking (American Association of University Professors, 2014). If the goal of education is indeed to foster critical thinking, it is crucial for professors to be willing to discuss controversial subjects (Schneider, 2013). Such openness in the classroom requires students to analyze the origin and value of their own thoughts as well as the origin and value of opposing perspectives (Osborne et al., 2009). Students are more open to and appreciative of opposing opinions once given the opportunity to engage in academic controversy (Gervey et al., 2009). While professors may face pressure to strip the classroom of all controversial material, those who model how to think critically as well as how to appropriately engage with those who espouse opposing views may be more effective in helping students develop the ability to think critically.

Keywords: critical thinking, emotion, higher education
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In a 2010 article titled “Why I Like Being a Professor,” Marybeth Gasman, a renowned professor at Rutgers University, described the many factors that drew her to the world of academia as well as the most rewarding aspects of her career. She explained that the one thing that makes the exhausting long hours, cutthroat academic pressure, and often subpar financial compensation worth it, is the relationships she is able to build with her students. She helps them grow into their intellectual selves and take on a scholarly identity (Gasman, 2010). Such personal investment in students and their futures is not unique to Gasman but rather speaks to a widespread attitude held by a majority of university faculty.

Despite noble intentions on behalf of both parties, this traditionally strong relationship between professors and their students is especially at risk in higher education. In a well-known article, “The Coddling of the American Mind,” Lukianoff and Haidt (2015) spoke of the primarily student-driven movement to turn campuses into comfort zones that lack potentially provoking thoughts, conversations, and questions. The American Association of University Professors (2014) released a statement to explain that while these attempts to clean up the classroom might appear to respect student sensitivities and wishes, “the presumption that students need to be protected rather than challenged in a classroom is at once infantilizing and anti-intellectual” (p. 2). Educators are being asked to shield their students from any content that could possibly make the students feel uncomfortable. Coddling the collegiate mind in this way creates an educational environment where people are afraid to speak up because there is such a high risk of offending someone or being seen as insensitive. The goal of education is to foster critical thinking as a means of preparation for life outside of the classroom (Lukianoff & Haidt, 2015). A common definition of critical thinking involves identifying assumptions, making logical deductions, and evaluating the source of information (Ennis, 2011). While these are crucial skills, critical thinking also involves the uncomfortable experience of questioning beliefs and ideas and as such critical thinking must be an integration of both thoughts and feelings (Osborne et al., 2009). One way professors can assist in the development of critical thinking is to be willing to discuss controversial subjects and venture into topics that might be uncomfortable and could cause some tension for their students (Schneider, 2013). While professors should always...
look to respect their students, learning to navigate discomfort is important to intellectual development.

The development of critical thinking is centered around the often uncomfortable but necessary process of questioning the contestable beliefs and opinions of oneself and of others. The purpose in discussing controversial topics is not to decide which ideologies to accept or reject but rather to understand how differences come to be (Osborne et al., 2009). To attempt to teach or discuss controversial topics without requiring students to examine their own ideas, understand where opposing ideas are coming from, and appreciate the fact that those differences exist, can create an environment of intolerance and ignorance (Osborne et al., 2009). Sensitivity is not likely to be sufficiently developed in a sterile classroom. Openness in the classroom can foster an environment in which students can be exposed to different opinions and are required to go through the mental work of evaluating the merits of views that are not their own.

Professors should not act merely as facilitators. To simply teach methods and principles is insufficient. Instead, professors are to be role models in which they demonstrate to students how to critically question others and oneself (Oppenheimer, 2004). As they model how a successful thinking mind approaches controversy, their students can find the courage and incentive to do the same (Oppenheimer, 2004). This particular model for the development of critical thinking may at first resemble the general theory of critical pedagogy but differs in its focus on the educator’s need to actively model effective critical thinking for students, rather than simply participating in it. These professors prepare their students to prosper both inside and outside the classroom as they show students how to properly question themselves, and attempt to understand others.

While professors may realize the positive impacts of this bold pedagogy, they face many challenges in creating such an environment. Fear of poor student evaluations, accusations of microaggression, along with various university policies can be enough to persuade any passionate professor to take a step back. Despite this mounting pressure faced by faculty in higher education to shelter students from challenging material, passionate and authentic pedagogy in a collegiate setting can help students learn how to better navigate a world of conflicting voices and opinions. Professors who embrace this style of teaching can effectively
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show students how to think critically as well as how to appropriately engage with those who espouse opposing views.

**Modeling Critical Thinking**

The educational world looks to foster critical thinking, a skill often talked about but too often misunderstood. If classrooms strive to be “comfort zones,” an over emphasis on censoring challenging material may stunt students’ intellectual and emotional development. While critical thinking does involve dissecting beliefs and ideas, an under-recognized, but equally important aspect is the ability to integrate thoughts and feelings in the process. Students who can think critically know how to analyze and understand concepts as well as how to allow their feelings to appropriately inform their thoughts rather than determine them (Osborne et al., 2009). Having the ability to experience both the intellectual and emotional elements of critical thinking in a classroom setting helps students appropriately reflect on the merits of an idea. This reflection is necessary in helping students decide what ideas are or are not worth believing (Ennis, 2011). Professors’ attempts to stifle the expression of their own opinions sets a precedent that feelings can be felt but cannot influence thoughts. By nature, critical thinking requires both mental and emotional work (Osborne et al., 2009). This work can seem daunting to students, but as professors show this kind of mind at work, their students are more likely to step into uncomfortable spaces where they have the opportunity to better understand and expand their perspectives.

**Comfort Zones and Emotionality**

In order to further explore how professors can help students step out of their comfort zones and create an environment that fosters the development of critical thinking, it is important to understand the nature of education. Niemi and Niemi (2007) wanted to understand the influencing effect of teachers’ expressing their opinions, or lack thereof, had on students. Even though this particular study was carried out among 11th and 12th graders, the results may have implications for collegiate classrooms as well. Niemi and Niemi (2007) spent many months observing six high school governments and politics classes. Most of the teachers expressed a strong desire to keep discussions neutral and even went as far as to announce to their classes that they would not disclose their personal opinions on
some subjects. One of the teachers stood out from the others, claiming that he was willing to share his opinions in class but that he would not tell his students how to think for themselves. This teacher stated, “You can’t pretend you don’t have an opinion” (Niemi & Niemi, 2007, p. 41). As Niemi and Niemi (2007) further analyzed these classrooms, they found that even the teachers who had said they would withhold their opinions failed to do so. While at first glance their words might have been neutral, they actually exposed their opinions as strongly as the teacher who made no effort to mask his (Niemi & Niemi, 2007). This study reaffirmed the assertion of Freire (2000) that education can never be neutral. Even honorable efforts to create a neutral classroom fail to do so. Educational theorists such as Goodlad et al. (1990) have also suggested that education is a moral endeavor, further emphasizing how necessary it is for educators to create intellectually challenging environments where students can practice stepping out of their comfort zones. Being able to appropriately address and discuss contestable issues may help students more effectively process and develop their own thoughts and opinions.

How can professors foster the kind of environment where students understand that emotions and learning come hand in hand? Professors must model how to appropriately allow feelings to influence thoughts. This necessary aspect of critical thinking can come about as both students and professors learn to genuinely express, apply, and question their emotions (Titsworth et al., 2010). As students and professors struggle to suppress strong emotions while only expressing those deemed socially acceptable, such underlying feelings may fester (Sorić et al., 2013). The suppression of emotion and opinion tends to be unhealthy and counterproductive to the development of critical thinking (Boostrom, 1998). Since critical thinking involves asking hard questions, students are likely to experience strong emotion. Students must learn how to allow their emotions to guide thoughts rather than control them and should not be sheltered from hard topics that stir up emotion (Osborne et al., 2009). Professors become more effective teachers if they can authentically express emotion and opinions while allowing students to do the same (Frisby, 2019). Remaining inside students’ comfort zone may be tempting, as it appears to mean a classroom is free of conflict, when in reality the absence of conflict can lead to greater emotional polarization and an inability to think critically (Gayle et al., 2013). Boostrom (1998) posited that when critical thinking is the goal, professors should learn how to manage conflict rather than stamp it out. As students are encouraged to confront, respond to, and challenge their
own ideas and emotions, they refine their ability to think critically (Boostrom, 1998). Professors who successfully model the relationship between emotional and critical thinking can create an environment where students are able to evaluate and think critically about their own ideas and emotions.

**Student Feedback**

In order to learn how to think critically, students must at times experience the discomfort of questioning beliefs and teachings, yet many professors are evaluated on criteria that distracts from efforts to create such environments (Schneider, 2013). A large part of professors’ professional evaluations comes from their student evaluations. Schneider (2013) took an in depth look at the issues surrounding professor evaluations as they are presently carried out. He found that evaluations often report a professor’s likeability, willingness to grade easily, and efforts to avoid controversial topics. With their careers and reputation on the line, professors often find themselves in a position where they have to succumb to practices that adhere to students’ comforts rather than challenge their students intellectually. This trend is discouraging because past research on student experience in the classroom has shown that professors who are willing to dive into hard subjects provide some of the best facilitators of student learning. Schneider (2013) pointed out the irony because, while an easier pedagogy might appear to appease the crowd in the short run, it hurts student satisfaction in the long run. The educational world would greatly benefit from student evaluations that focused on the professor’s role in the development of critical thinking as opposed to being evaluated on short-term reports on accounts of likability and easiness. Schneider (2013) suggested a list of alternative student evaluation questions to better emphasize the role of critical thinking in the classroom as opposed to professor likeability (see Appendix). Students often express that in hindsight they prefer professors who give easy grades, avoid hard conversations, and are generally likeable. However, research suggests that in the long run, students show great appreciation for professors who challenge them and push them out of their comfort zones. With that being said, few professors currently have access to long-term evaluations that could help paint a better picture of student growth and experience. Evaluations that ask students to report on criteria, such as those proposed by Schneider (2013), that are more closely related to critical thinking,
could be a step in helping incentivize professors who rely on positive short-term evaluations to not back away from teaching challenging subjects.

Educators may be able to help students understand the emotional aspect of critical thinking by giving them lectures that take away the comfort zone. Gervey et al. (2009) showed support for this idea while testing a debate-centered teaching model in various classrooms. They had students rate their initial reaction to the introduction of a program that would require them to pick a stand, formulate an argument for that point of view, and present it for the whole classroom to debate on instead of having a traditional lecture. Even though the goal of this trial was to teach critical thinking, the students initially reacted negatively. Despite poor initial reactions, most students later reported high degrees of satisfaction with the course and higher levels of comfort when approaching hard topics (Gervey et al., 2009).

Professors can and should push students by challenging the way they look at the world (Leib, 1998). While reporting on his own experiences as well as his research in the classroom, Leib (1998) stated that as students confronted difficult issues and differing opinions, they were better able to examine and understand their own core beliefs. Professors should aspire to foster critical thinking by modeling the positive integration of thoughts and emotions experienced when faced with the necessary discomfort of challenging material. By doing so, students may be better prepared to navigate real life experiences (Oppenheimer, 2004). Being challenged and confronted with difficult ideas can be uncomfortable, but what makes students uncomfortable in the short run can ultimately make students stronger. Professors who go forward with a bold, challenging, and impassioned pedagogy can successfully prepare their students for the real world by helping them develop the ability to think critically.

Engaging with Opposing Views

When speaking of passionate and opinionated teaching, people often fear that professors will only show students one perspective: their perspective. And as a result, be coerced into supporting someone else’s opinion rather than developing their own. A professor expressing his or her opinion and being passionate about that opinion does not necessarily mean they are teaching one-sidedly. It is important for students to not only learn about controversial issues but also to learn how an opinion is formed and how one ought to engage with those who...
may disagree (Oppenheimer, 2004). While being passionate and opinionated, professors need to be humble enough to allow their students to disagree with them. Unfortunately, the media rarely portrays appropriate and respectful disagreement, so seeing healthy, productive disagreement in the classroom can help students develop these necessary skills (Cargas, 2016). Lukianoff and Haidt (2015) asserted that education may fail students who enter the real world unable to learn from those who espouse any views but their own. This ability to learn from those with whom one disagrees is a form of humility that Oppenheimer (2004) explained is crucial to real world functioning. If the professor’s example can set a precedent for respectful and open communication in the classroom, then the students can learn the skills needed for healthy disagreement.

The goal of education is not to produce graduates that all think the same, but rather to teach students critical thinking in a way that prepares them to ask important questions about themselves and about others. With this objective in mind, it is important to clarify that learning to understand another’s views does not mean that those views have to be accepted (Osborne et al., 2009). Ignorance can be avoided as students learn to identify the origins of their personal beliefs as well as the beliefs of others. This sort of understanding allows students to appreciate the fact that different views exist and be able to approach controversy in a productive manner (Osborne et al., 2009). Gervey et al. (2009) supported this theory during their study of debate-centered classrooms. As part of this program, students were required to research a particular perspective of an issue and formulate a debate. Later during class, a more formal debate was held, and students were given the opportunity to listen to and present the various sides of a controversial issue. When listening to well-researched arguments, students were able to better understand where each perspective came from. This study replicated what many other studies have found to be true: students can be more open to and appreciative of opposing opinions once given the opportunity to engage in academic controversy (Gervey et al., 2009). Avoiding controversy in the classroom, as opposed to approaching it, typically fosters ignorance and belief polarization (Osborne et al., 2009). Professors can invite and manage healthy debate in the classroom as they are transparent about their development of their own beliefs (Leib, 1998). Following the example of their professors, students are better able to advocate for their own opinions while still appreciating the perspectives of others (Bull, 2007). Avoidance cannot be an option in the
classroom if students are to grow and develop into strong members of society who can confidently add their voices into these crucial conversations.

One the other hand, passionate and opinionated professors should not adopt the doctrine of laissez-faire by simply introducing controversial discussions and allowing them to take their natural course. Looking to understand effective ways to approach hard topics in the classroom, Gayle et al. (2013) conducted an experiment with students enrolled in courses specifically meant to address controversial topics such as gender, race, socioeconomic status, and sexual orientation. Prior to diving into course material, the classes collectively created rules of communication. Some of the most recurring rules were that everyone should feel comfortable sharing their opinions, people should feel free to ask questions without the fear of offending, and everyone must agree to listen to and attempt to understand where others are coming from. With these rules explicitly laid out, the classes began their discussions of these controversial topics (Gayle et al., 2013). These rules did not allow students to remain in their comfort zones and avoid controversial subjects. Instead, they created a safe environment wherein people were willing to say hard things, be corrected, listen, and ask questions without the risk of offending someone. Students reported that while such an environment was not always comfortable, it allowed them to analyze their own ideas, identify points of prejudice in their own thoughts, and correct those weaknesses through dialogue (Gayle et al., 2013). Professors who explicitly define and model effective rules and habits of communication can best create an environment where students can effectively participate in respectful debate.

**Conclusion**

It seems as though everyone has their own ideas of what makes an effective professor. The fact that those differences exist is important, because students benefit from different styles of teaching at various points in their lives (Leib, 1998). Teaching is a dynamic experience that allows both student and professor to realize intellectual potential (Gasman, 2010). People do not become professors for the glamorous paychecks or the easy hours, they become professors because they are passionate about their fields of study and more importantly, they are passionate about their students (Gasman, 2010). This passion is what draws people to education, yet professors are constantly pressured to strip the classroom of emotions and opinions. The guiding roles of passion, emotions,
and opinion in critical thinking must be protected if students are to grow and develop the skills necessary to go out and make an impact in the world.

The world is not a sterile environment. If students graduate and enter the workforce having never experienced confrontation, controversy, and opposing views, education will have done them a great disservice (Lukianoff & Haidt, 2015). Life outside the classroom will require students to interact with people who harbor differing views or even, at times, incorrect views. If students have not experienced some level of idea inoculation, they will be unprepared to meet the challenges of the professional world. On the contrary, if professors can successfully model critical thinking, then students can be prepared to engage in productive conversations with all people, even those with whom they may not agree (Lukianoff & Haidt, 2015). The uncomfortable moments that are bound to occur when discussing hard topics will prepare students by giving them opportunities to practice critical thinking.

Students will likely find that the critical thinking habits they develop in the classroom trickle down into all aspects of their lives. The ability to think critically is not a neutral process but rather a sort of thinking that requires emotional processing as well (Osborne et al., 2009). As critical thinkers, students are better able to allow emotions to guide their thoughts as they reflect on their experience as well as that of others in an inquisitive, open-minded way (Ennis, 2011; Osborne et al., 2009). Students who practice this form of critical thinking may be able to better understand their own thoughts, emotions, and beliefs while effectively engaging with those who may disagree.

Critical thinking lies at the center of education, but professors cannot instill this behavior in their students by simply talking about how to think critically. The true pedagogic role of a professor is to act as a role model, exemplifying what it looks like to be passionate and opinionated. (Oppenheimer, 2004). As students are able to interact with and learn from a professor who models these skills, they are better able to brave tough conversations and are better prepared for life outside the classroom. The role of a professor is not an easy one, but the influence that they can have on the lives of their students is augmented as they
are true to those passions that brought them to the classroom in the first place. Students need professors who are willing to be open, passionate, and opinioned.

References


Plea to Professors: A Passionate Approach to Controversy in the Classroom


Appendix

Figure 1.

Sample Student Evaluation

- Does the instructor require students to be prepared for each class?
- Does the instructor involve all students in classroom activities, regardless of whether they voluntarily offer input?
- Does the instructor expect students to use assigned materials both in class and on tests and papers even if such materials were not discussed in class?
- Does the instructor encourage students to recognize and to confront ambiguity and value assumptions in arguments?
- Does the instructor frequently offer alternative viewpoints?
- Does the instructor require students to evaluate the evidence offered in arguments?
- How often does the instructor ask questions that require students to form and then support conclusions?
- Does the course follow a logical sequence? How often does the instructor require students to relate new ideas to those that had been covered earlier?
- Does the instructor require students to consider the linkages among ideas and arguments?
- Does the instructor provide a personal model of someone who is interested in ideas and learning?
- How often, if ever, does the instructor direct students to outside reading that is related to course material?

Student Evaluation Questions that Highlight Critical Thinking. Adapted from “Student evaluations, grade inflation and pluralistic teaching: Moving from customer satisfaction to student learning and critical thinking” by G. Schneider, 2012, Forum for Social Economics, p. 133.
The Power of Human Connection: Autism and the Suicide Risk

Rachel Barton
Brigham Young University

Abstract

As researchers continue to understand autism spectrum disorder (ASD), one outstanding factor is causing concern within the psychological community: those with ASD are at a much higher risk of suicidal tendencies. These tendencies include suicidal ideation, attempting suicide, and death by suicide. Possible contributing factors to this increased risk include high levels of loneliness, pressure to conform to societal norms, as well as depression and anxiety. To decrease suicidality among the ASD population, further research is needed to fully understand why this behavior occurs at such a high percentage. Research is also needed to find appropriate and effective solutions to these issues. Within this literature review, I will delve into the possible causes of high suicidality rates among ASD individuals as well as propose potential solutions to this serious problem. These solutions will be based on current research within the field of positive psychology, including concepts like self-compassion, exercise, and supportive relationships.

Keywords: autism spectrum disorder, suicide, prevention, loneliness, connection
The Power of Human Connection: Autism and the Suicide Risk

In 2017 the Center for Disease Control (CDC) listed suicide as the 10th highest cause of death within the United States (CDC, 2017). As suicide continues to present a serious problem in the United States, one population is more at risk for both suicidal ideation and attempted suicide: those with autism spectrum disorder (ASD; South et al., 2020). Since 2014 it is estimated that 1 in 59 children are born with ASD (CDC, 2019). This means that out of the 73.8 million children in the United States (Forum, 2021), roughly 1.3 million of those children will have autism and therefore may be more vulnerable to suicidal tendencies. This statistic also suggests that out of the 308 million current adults living within the United States (United States Census Bureau, 2019), over 5 million will potentially experience higher levels of vulnerability to suicidal ideation and suicide attempts because of the emerging relationship between autistic traits and the related struggles and suicidality.

Autistic traits are defined as the following: deficits in social, emotional, and communicative reciprocity; restrictions in behavior that are manifested in repeated movements; and obsessive interests or a rigidity about completing ritual practices (Autism Speaks, 2019). These diagnostic criteria provide insight into why a person with autism may experience higher levels of suicidal vulnerability. Difficulties in social, emotional, and communicative reciprocity are significant because these challenges may often be exacerbated by the increased anxiety individuals with autism feel at having to perform well in social situations. This finding could explain the high levels of loneliness and isolation, as well as the pressure to conform to a cultural standard that contribute to the “increased vulnerability” to suicidality (South et al., 2020, p. 2).

Though autism and its effects on suicidal ideation are relatively new and understudied, even less is understood in the way of suicide prevention for autistic individuals (Cassidy & Rodgers, 2017). Therefore, the possible solutions proposed within this literature review will focus on the available research about factors, such as mental health issues, loneliness, and societal pressures, that are potentially contributing to higher levels of suicidality in autistic individuals and
how these issues are treated in the typically neurologically developed population within the view of the field of positive psychology.

**Rates of Suicidality, Depression, and Anxiety in the Autistic Population**

Suicidal ideation includes the following factors: thoughts about suicide, suicidal behaviors (e.g., self-harm), and attempted and completed suicide. A meta-analysis of studies about suicidality within the ASD population found 10.7–50% of samples displayed suicidal ideation, which is an alarmingly high number (Segers & Rawana, 2014). In another study, South et al. (2020) found that 46% of the autistic individuals sampled self-reported that they had created a specific plan for suicide, with 16% of the sample actually attempting their plan. Within the same sample, 76% were also found to have mild to severe depression and 81% were found to have mild to severe anxiety. These rates could indicate that high levels of anxiety and depression are adding to the high percentage of suicidal ideation within the autistic population. These numbers are also a testament to the mental pain that autistic individuals feel on perhaps a daily basis. For many of these people, these symptoms of mental anguish seem inescapable because they are not divisible from ASD.

**Possible Causes for Suicidality, Depression, and Anxiety in ASD Individuals**

A contributing factor to the high rates of suicidality within the ASD population may be due to around half of autistic and potentially autistic individuals (51.2% and 54.5%, respectively) going undiagnosed for mental health disorders such as depression or anxiety (Au-Yeung et al., 2018). Au-Yeung et al. found that the lack of diagnoses is because autistic individuals, caretakers, and medical professionals might not recognize that depression and anxiety are not necessarily fundamental aspects of autism, therefore confusing symptoms of depression and anxiety as inherent by-products of autism. These misunderstandings may also occur among diagnoses given by medical professionals, since the link between mental health and autism is under researched and symptoms of depression may be overlooked because of the symptoms of ASD and vice versa (South et al., 2020). This oversight could be another contributing factor to high suicidality rates in
the ASD population, as those without the capacity to recognize their mental health issues may be less likely to seek help for them. When those individuals do seek help, medical professionals may not be adequately equipped to prescribe the appropriate support because they do not have enough information about the complexity of the relationship between mental health issues and autism.

Another possible explanation for depression and anxiety within the autistic community may be the extreme sensitivity to sensory information (Liss et al., 2008). Sensory overloads may occur when an autistic individual experiences extreme discomfort at a particular sound, visual stimulus, touch, taste, or smell, and that discomfort may illicit an extreme reaction (Autism Speaks, 2020). That reaction might cause an autistic individual to refrain from social situations, as the uncomfortable stimuli coupled with socializing may prove to be overwhelming. This type of social isolation may be a cause of loneliness within ASD individuals, who are significantly more prone to feelings of loneliness than are the non-autistic population (Deckers et al., 2017). Even though the choice to socially isolate may reduce discomfort caused by unpleasant sensory information, isolation is likely more detrimental than helpful due to the link with higher levels of loneliness. Such high levels of loneliness may have a significant effect on levels of depression, and therefore suicidal ideation, on the autistic population because loneliness is also shown to be highly associated with both depressive symptoms and suicidal ideation in other non-autistic populations (Teo et al., 2018).

Another potential reason for increased anxiety, depression, and suicidality among autistic individuals may be the set of techniques autistic individuals employ to mask social deficits, which is called ‘camouflaging’ (Hull et al., 2017). Lack of social prowess and normal social functioning is one of the hallmark traits of autism (Autism Speaks, 2020). The lack of these skills has created a negative stigma for those with autism as they engage in social interactions in unexpected and sometimes socially unacceptable ways. Camouflaging techniques may include concealing ticks, mimicking other socially successful people, or creating scripts on how to act in certain environments (Hull et al., 2017). Though these techniques may create a perceived social competence to the observer, they often come with many negative side effects, such as exhaustion and anxiety, that could significantly increase suicidality in the autistic population (South et al., 2020). Finding ways of decreasing the need for social camouflaging may prove to be an
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effective way of both decreasing suicidality and enriching the relationships of the autistic population.

**Why the Autistic Population Camouflages**

During adolescence, autistic individuals experience an increased desire to have meaningful social interactions, but the attempts are often unsatisfactory, possibly leading to higher levels of loneliness (Deckers et al., 2017). Considering the significant anxieties people with autism feel about socializing, some may find this desire for social connection surprising. However, Warren (n.d.), a positive psychology professor at BYU, describes this desire for social connection as a “fundamental human need” (Supportive Relationships Module, A Fundamental Human Need Subsection). He teaches that social connection is rooted in human evolution, since social networks would have been essential to our ancestors’ survival throughout history. We might use this idea to argue that those with autism seek social connection on the same fundamental level that typically developed people do. This may explain why those with autism enact camouflaging to appear socially competent in social situations, despite the negative effects (which will be explored in the following section).

In one study, when asked about their motivations for camouflaging, most participants said it was to blend in with normal people (Hull et al., 2017). This suggests that, not only do autistic people think they are abnormal in a negative way, but that those abnormalities must be covered in order to properly socialize and be considered normal. This belief is present in adults with autism that were diagnosed much later in life (Leedham et al., 2019). This finding may indicate that those with autism either camouflage naturally or that they somehow recognize their differences from a young age and perceive that those differences are not welcomed by the social majority. This raises interesting questions as to whether social camouflaging is a natural process for those with autism or if societies’ ingrained stigmas towards autistic behavior drives autistic people to try to “act natural.” Either way, camouflaging can come with significant emotional and
mental costs that may answer why those with autism suffer from higher rates of anxiety, depression, and suicidality.

**The Costs of Camouflaging**

Camouflaging for an autistic individual may be so extreme that they may present a completely different personality to those around them than the personality they exhibit privately (Hull et al., 2017). This study also found that getting ready for the day is like putting on a costume, and that the ASD population achieves positive social interactions by copying speech patterns and body language from others. This type of behavior may be considered a type of experiential avoidance. Experiential avoidance is the psychological processes a person may go through to avoid uncomfortable mental situations (Harris, 2006). Autistic individuals may use camouflaging to avoid the possible pain caused by exposing their autistic symptoms to their social circle. Harris (2006) states that experiential avoidance actually exacerbates mental issues, instead of easing them. The same also seems to be true of camouflaging, as those with autism who engage in this practice tend to suffer from extreme mental, emotional, and physical exhaustion, as well as the feeling that they are fakes and liars (Hull et al., 2017). These negative factors could be contributing to the increased rate of suicidality in autistic individuals.

Another possible consequence from camouflaging is the lack of proper medical help women with autism receive, as they tend to be diagnosed at a much older age than their male counterparts (Leedham et al., 2019). Autistic women have gone without appropriate care for longer periods of time because their camouflaging is so effective that health professionals diagnose for only depression and anxiety, not autism. However, even depression and anxiety may go unnoticed because of successful camouflaging. The internalization of these traits and emotions may be the reason why autistic women could be one of the most vulnerable populations to suicidality, as they are least likely to receive proper care (South et al., 2020). This consequence could open up new paths of discussion regarding autism and suicidality, since gender seems to create differences in the expression of autism and its possible negative repercussions. More research would be needed to see how race, socioeconomic status, religion, and other sociological concepts intersect to affect the risk of suicidality in the
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autistic population. By researching this, we may be able to find solutions to the problem of high suicidality within autistic individuals.

**Potential Helps for High Levels of Suicidality Among the Autistic Population**

The high rates of suicidality within the autistic population are drastically different from those who are typically developed; therefore, prevention strategies must be suited to these risks (Cassidy & Rodgers, 2017). Because so little is understood about the relationship between autism and suicidality, and even less is known about possible solutions, finding successful treatments quickly could be problematic. Many suggest that traditional methods of psychotherapy could successfully treat autistic individuals and suicidality, but others believe that these traditional methods based in symptom reduction are much more likely to create clinical disorders (Harris, 2006). However, no current research has fully investigated the effect that positive psychology methods can have on the quality of life for ASD individuals. With this in mind, we will explore the field of positive psychology, its impacts on the typically developed, and how it may aid those with autism.

According to Warren (2020), positive psychology includes the following aspects: purpose, mindfulness, savoring, gratitude, supportive relationships, compassion, personal growth, self-compassion, and physical exercise. Though all these principles have the potential to bring valuable treatments to the autistic population, this paper will only focus on human connection (both to other people in supportive relationships and to our bodies in the form of exercise) and how these principles may be adapted to an autistic individual for maximum possible benefit.

**Real Friendships for Those With Autism**

Having meaningful relationships is consistently linked with living longer, being healthier, and experiencing greater happiness (Waldinger, 2016). One study encouraged the mothers of autistic children to write letters of gratitude about their child to help relationships flourish between the autistic and the typically developed (Timmons et al., 2017). Mothers who did this were better able to point out the positive personality traits of their child and expressed hope for their
child’s future. Gratitude may be a principle that helps typically developed people build better friendships with those who are autistic because the focus remains on the good qualities of the autistic individual instead of the deficits. This practice may allow an autistic child or adult to be freer with their expression of autistic traits as they feel more accepted by the people around them, potentially reducing the need for social camouflaging.

Autistic individuals may also have trouble creating meaningful and lasting relationships because of deficits in communication skills, such as understanding verbal & non-verbal cues (Autism Speaks, 2020). However, this particular explanation fails to recognize the role of a typically developed person in such a relationship, as all relationships require at least two participating members. As previously mentioned, autistic individuals will go to great lengths to camouflage their autistic traits to fit into social situations, suggesting they care greatly about forming normal friendships (Hull, 2017). Perhaps helping the autistic population to create more supportive relationships begins with greater acceptance and understanding from the non-autistic population.

The Undeniable Benefits of Exercise

Research indicates that thirty minutes of exercise a day for five days a week reduces risk of depression, anxiety, fatigue, chronic illness, arthritis, and diabetes, as well as actively reducing any negative symptoms of these diseases already present in an individual (Warren, 2020). We might argue that exercise may also prove successful at treating anxiety and depressive symptoms in autistic individuals, just as it does for the neurotypical population; however, exercises may need to be tailored to each individual. This is because autistic individuals may experience barriers when it comes to incorporating regular exercise into their life. As previously discussed, people with autism may have negative reactivity to certain sensory input (Autism Speaks, 2020). This sensitivity may mean that certain sights, sounds, smells, or touch sensations at gyms, swimming pools, or outside environments may cause distress and make finding a safe environment to exercise difficult for those with autism. Autistic individuals might also engage in repetitive motor movements called stimming (e.g., energetically rocking back and forth) to cope with sensory information (Hull et al., 2017). These repetitive movements may inhibit exercising, and incorporating new exercise habits into an already established routine may cause significant distress in some autistic
individuals. The distress may counteract any positive effect on stress that the exercise is supposed to promote. Since autistic traits are so diverse among the autistic population, individual considerations should be taken into account to see how exercise might benefit an autistic individual.

Another biological effect of exercise is that it produces brain-derived neurotrophic factor (BDNF) (Cotman & Bechtold, 2002). BDNF is a protein used for growth in the brain and has been linked to preventing cell degeneration, maintaining cell circuitry, and stimulating neurogenesis or building new brain cells (Warren, 2020). This may be a benefit to autistic individuals because they may have fundamental biological differences in the brain that contribute to their psychological thought processes and behavior (Grandin & Panek, 2014). Stimulating BDNF in the brain through exercise may help autistic individuals cultivate their best brain possible, potentially leading to greater plasticity and better neural connections in areas where those individuals may experience deficits. Though it is very unlikely exercise will stop all difficulties an autistic individual may experience, regular exercise may still have the power to significantly help autistic individuals in many aspects of their lives.

Lastly, Looking for Potential Solutions in the Example of Temple Grandin

Temple Grandin is a well-known autistic author that advocated for proper socialization of autistic children through supportive and loving parents (Grandin & Panek, 2014). Though she was on track to become mute through severe auditory and verbal developmental deficits, Grandin became an independent and socially competent person through the constant support of her mother. This may have significantly helped Grandin’s quality of life because poor social skills are linked to anxiety and depression in ASD individuals due to the lack of communicative abilities (Liss et al., 2008). Within Liss et al.’s study, lack of communication skills was diminished with high parental support, where parents consistently taught the child how to communicate their feelings appropriately. This finding also seems to have been successful for Grandin. In these cases, the ability to label emotions may decrease distress, anxiety, and depression because the individuals are able to appropriately communicate a need for help when desired. These communication skills could potentially reduce the cases of undiagnosed depression and anxiety within ASD individuals. As children and adults with autism become more
capable of communicating their symptoms, medical professionals may be less likely to overlook problematic symptoms that lead to higher cases of suicidality.

Despite the assumption that autism is considered a hinderance to financial and career success, Grandin is a famous creator of humane cattle enclosures at farms all over the United States (Grandin & Panek, 2014). She attributes this success to her autistic traits. Grandin’s cognitive processes are based in thinking primarily in pictures. By thinking in pictures, she is able to easily and accurately identify visual elements that may be causing stress and fear in cattle and causing issues for cattle farmers. Grandin’s self-acceptance is an aspect of positive psychology that could have beneficial effects for other autistic individuals. Acceptance is a crucial part of mindfulness, an aspect of positive psychology that has been tested and correlated to significant reduction of anxiety and depression (Ma et al., 2018). Individuals with autism can increase satisfaction with their lives by practicing self-acceptance and recognizing their unique talents. As a result, autistic individuals can decrease their rates of depression, anxiety, and suicidal ideation.

**Conclusion**

High numbers of autistic people are suffering from elevated levels of suicidality (South et al., 2020). Not enough is known as to why this happens or how to prevent it (Cassidy & Rodgers, 2017). Current suggested causes are higher levels of depression and anxiety linked to lack of proper diagnoses and communication skills, loneliness through social isolation because of sensory sensitivity, and exhaustion due to camouflaging for social acceptance. Positive psychology may hold the keys to helping the autistic population socially and biologically. Cultivating positive psychology principles may have the potential to change the perspectives of the typically developed public, fostering more acceptance for autism. Encouraging routine exercise could have the power to increase brain functioning, lowering stress and anxiety levels, while also fostering a healthier relationship between the mind and body. The human connection that may alleviate the suffering of the autistic population may not only be a social connection, but also connection to the self. This connection makes room for autism instead of seeing the diagnosis as an obstacle to be removed. Ultimately,
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the psychological community has a duty to study and conduct more research on these issues in order to aid a population that is suffering deeply.

References


Think About It: Using Mindfulness as a Means to Treat Eating Disorders

Gabriella C. Breen
Brigham Young University

Abstract

Eating disorders are complicated and prevalent issues among the general population; it is estimated that 30 million people are affected in the United States alone (Foundation for Research and Education in Eating Disorders, 2018). Because of the complex psychological nature of eating disorders, it is difficult to find a treatment that is broadly effective. Traditional therapies include cognitive behavioral therapy, dialectical behavioral therapy, and acceptance and commitment therapy. In recent years, mindfulness has emerged as a potentially effective way to treat eating disorders due to its ability to reduce maladaptive coping strategies, improve emotional regulation, and treat anorexia nervosa (Cowdrey & Park, 2012; Hernando et al., 2019; Kerin, Webb, & Zimmer-Gembeck, 2018). Unlike other therapies, mindfulness can be used as a preventative measure as well (Atkinson & Wade, 2016; Klassen-Bolding, 2018). Since the practice of mindfulness as a therapy is a fairly new development, further research on its long-term effects is warranted.

Keywords: mindfulness, eating disorders, therapy
Think About It: Using Mindfulness as a Means to Treat Eating Disorders

Much of everyday life revolves around food. For many people, food is heavily involved in spending time with friends, family gatherings, and a variety of celebrations. For those who suffer from an eating disorder, however, a dysfunctional relationship with food can make even the most basic of days difficult. Though many people are unaware of the prevalence of eating disorders, studies estimate about 30 million people (20 million women and 10 million men) in the United States suffer from an eating disorder (Foundation for Research and Education in Eating Disorders, 2018). Many of those affected do not seek help due to the stigma associated with eating disorders. When an individual decides to seek help, they can utilize many forms of therapy to regain control of their eating habits.

One of the most common types of therapies available is cognitive behavioral therapy (CBT). In the context of eating disorders, this therapy seeks to change the negative beliefs and attitudes that the client holds toward food. While other forms of therapy are available in eating disorder treatment, such as dialectical behavior therapy and acceptance and commitment therapy, CBT appears to be most efficacious in treating bulimia nervosa and binge-eating disorder (Linardon et al., 2017). In a meta-analysis of studies done on the efficacy of CBT, Linardon et al. (2017) found that the positive effects of CBT were maintained once treatment had ended. Thus, if a person suffering from an eating disorder were to seek therapy and wanted to prevent relapse, CBT may be an effective means of achieving recovery.

While CBT can be successful in treating eating disorders such as bulimia nervosa and binge-eating disorder, researchers and therapists are constantly looking for new ways to help clients improve (J. Clark, personal communication, October 23, 2019; Linardon et al., 2017). Mindfulness is another kind of therapeutic intervention that has recently come to light. Mindfulness is “awareness of one’s internal states and surroundings...[used] to help people avoid destructive or automatic habits and responses by learning to observe their thoughts, emotions, and other present-moment experiences without judging or reacting to them” (“Mindfulness,” 2018, para. 1). While mindfulness can be used to treat anxiety, stress, and depression (Querstret et al., 2018), researchers are also turning to it as a tool for eating disorder treatment and prevention. The purpose of CBT is to change negative attitudes that a person holds toward food. Mindfulness, however, teaches a person to recognize the negative thoughts or
emotions they hold toward food. As these thoughts come and go, mindfulness helps the person to choose to accept the thoughts and not judge them (Tsai et al., 2017).

There may be advantages to utilizing mindfulness in conjunction with or instead of CBT. Eating disorders are often associated with maladaptive coping strategies such as rumination (the repetitive focus on negative emotions, symptoms, and events) and experiential avoidance (avoiding thoughts, feelings, and other internal processes even though the effect may be harmful) (“Rumination,” 2018; Tyndall et al., 2019). In a study involving individuals with a history of anorexia nervosa, Cowdrey and Park (2012), found that increased levels of rumination and experiential avoidance were negatively correlated with mindfulness, leading them to conclude that an increase in mindfulness may lead to a decrease in these maladaptive coping strategies. In another case study, a female with a history of restricted eating was taught mindfulness strategies and implemented them over the course of 15 individual therapy sessions. After learning and applying mindfulness strategies to her eating, she saw an increase in her BMI and caloric intake (Albers, 2011). In terms of scope, CBT can effectively treat individuals with bulimia nervosa and binge-eating disorder but has had less success when treating anorexia nervosa (Linardon et al., 2017). Mindfulness, on the other hand, has shown positive results when used to treat individuals with bulimia nervosa, binge-eating disorder, and anorexia nervosa (Albers, 2011; Cowdrey & Park, 2012; Lavender et al., 2009; Woolhouse et al., 2012). Since mindfulness has been successful in treating individuals with these disorders, it may be a more effective means of treatment than CBT.

An additional benefit of practicing mindfulness in relation to eating habits is that it can be used as a preventative measure. Studies by Atkinson and Wade (2016) and Klassen-Bolding (2018) showed a decrease in eating-disorder symptoms when mindfulness was used as a preventative measure. While the short-term effects of mindfulness have been shown (Atkinson & Wade, 2016), its long-term validity is unknown. Although CBT is typically effective in treating a variety of eating disorders, therapeutic mindfulness may be even more beneficial.
due to its ability to reduce maladaptive coping strategies, to improve emotion regulation, to treat anorexia nervosa, and to be used as a preventative measure.

Reduction Maladaptive Coping Strategies

According to the APA Dictionary of Psychology (American Psychological Association, 2018), coping strategies are the thought processes or actions used to confront stressful situations or experiences. Unlike defense mechanisms, which are unconscious reactions to stressors (American Psychological Association, 2018), coping strategies are consciously employed to deal with a problem (American Psychological Association, 2018). Some healthy coping strategies include writing in a journal, talking to supportive people, reading, participating in a hobby, or taking a walk (The Eating Disorder Foundation, n.d.). Maladaptive coping strategies, on the other hand, are negative cognitive processes that have been found to be associated with eating disorders (Hernando et al., 2019). Because mindfulness focuses on the nonjudgmental observance of negative thoughts and feelings, it can help reduce these harmful coping strategies.

Rumination

Rumination is one of several maladaptive coping strategies associated with eating disorders. Rumination is the repetitive, negative focus on thoughts, emotions, and events (“Rumination,” 2018). This coping strategy is common among those who suffer from eating disorders such as anorexia nervosa and bulimia nervosa (Hernando et al., 2019). Individuals who suffer from these disorders are often preoccupied with concerns about their weight, eating habits, and body shape, which allows their disorder to persist (Rawal, Park, & Williams, 2010). If they wish to recover from their disorder, this negative train of thought should be broken. If rumination is allowed to continue, recovery could be a near impossible task.

Although rumination can be a difficult habit to overcome, the practice of mindfulness can help. Findings from a study performed by Hernando et al. (2019) compared mindfulness, rumination, and effective coping levels between a healthy group of females and a group of females with various kinds of eating disorders. They found that the patients who were being treated for eating disorders had significantly lower mindfulness and effective coping levels in
comparison to the healthy control group (see Table 1). They also found that higher mindfulness levels were associated with the lower likelihood of an eating disorder diagnosis (Hernando et al., 2019). Thus, an increase in mindfulness may result in a reduction of rumination among eating-disorder patients. Furthermore, mindfulness could be increased through intervention therapies. As mindfulness increases and rumination decreases, the patient may be more likely to recover.

**Experiential Avoidance**

Another maladaptive coping strategy that is commonly found among individuals with eating disorders is experiential avoidance. In a study conducted by Hayes and Feldman (2004), experiential avoidance was one of the maladaptive coping strategies that contributed to the vast majority of eating disorders and other cognitive and mental disorders as well. Unlike rumination, which only involves negative thoughts, experiential avoidance involves all of an individual’s unpleasant thoughts, feelings, and experiences and their attempts to avoid or change them (Fahrenkamp et al., 2019; Rawal et al., 2010). The individual in question recognizes that a certain situation (such as eating dinner) would be unpleasant, and therefore tries to avoid being present for that event (Fahrenkamp et al., 2019). This coping strategy can hinder the individual’s ability to overcome his or her eating disorder because it involves avoiding the very experience that the individual needs to have a normal relationship with food.

Similar to rumination, experiential avoidance has been shown to have a negative relationship with mindfulness. While examining the correlation between experiential avoidance, rumination, and mindfulness, Cowdrey and Park (2012) found that experiential avoidance was positively correlated with eating disorder symptoms and negatively correlated with mindfulness. In eating disorders in which overeating is common, if an individual employs experiential avoidance in response to a food craving, they are more likely to participate in emotional eating and/or overeating (Fahrenkamp et al., 2019). In this instance, the individual uses food as a means to escape from the negative emotions that they are experiencing. Mindfulness-based therapy, however, can teach an individual how to deal with negative emotions in a healthy manner. Then, instead of turning to...
food to mitigate those feelings, they may be able to turn to other healthy coping strategies.

**Emotion Regulation Improvement**

Emotion regulation is an individual’s ability to regulate how they feel when confronted with certain situations (“Emotion Regulation,” 2018). When an individual suffers from an eating disorder, the emotions they hold toward food can be very powerful and difficult to control. In eating disorders such as bulimia nervosa and binge-eating disorder, maladaptive emotion regulation typically results in overeating as a response to negative emotions (Kerin et al., 2018; Lattimore et al., 2017). This overeating, in turn, can lead to feelings of guilt that feed into a vicious cycle of negative emotions that is difficult to escape.

Maladaptive emotion regulation is not limited to bulimia nervosa or binge-eating disorder. It is a prominent psychological aspect of all eating disorders and often contributes to their development and persistence (Lattimore et al., 2017; Woolhouse et al., 2012). Improvement in emotion regulation, however, may improve eating habits and weight control as well (Kerin et al., 2018). This can result from implementing mindfulness as a therapeutic method either by itself or in conjunction with CBT (Kerin et al., 2018; Woolhouse et al., 2012). The focus on present-moment awareness through mindfulness is likely a contributing factor to emotion regulation. Instead of allowing an individual to instinctively act in a negative manner, mindfulness teaches them to take a step back and observe their emotions before taking action (Woolhouse et al., 2012). With this comes greater self-control and an increased likelihood of positive emotion regulation.

**Ability to Treat Anorexia Nervosa**

Anorexia nervosa is one of the most difficult eating disorders to treat. According to the National Eating Disorder Association (2018), individuals who suffer from anorexia nervosa struggle to maintain a normal body weight for their height and age and often perceive their bodies in a distorted manner. While mortality rates among individuals with eating disorders are high, the highest mortality rates are among those that suffer from anorexia nervosa (Arcelus et al., 2011). Studies also indicate that less than 50% of individuals who suffer from this eating disorder fully recover (Arcelus et al., 2011; Danielsen et al., 2016).
Unfortunately, psychiatric comorbidity (the presence of two psychiatric diseases occurring at once) is common among individuals who suffer from anorexia nervosa, meaning that they often struggle with other psychiatric illnesses, such as depression or anxiety, in conjunction with the eating disorder (Danielsen et al., 2016). Thus, it is essential to find a treatment that can not only treat these co-occurring disorders but also enables a larger percentage of individuals who suffer from anorexia nervosa to fully recover.

Due to the complex psychological nature of anorexia nervosa, it is difficult to find one treatment that works for the vast majority of individuals. Family-based therapy is generally recommended when treating adolescents, but researchers have yet to find a consistently successful treatment that works for adults (Brockmeyer et al., 2018; Danielsen et al., 2016). Some promising research has been performed in regard to using enhanced cognitive behavioral therapy to treat anorexia nervosa in adults, but more research should be conducted (Danielsen et al., 2016). Although a single therapy will not be effective for everyone, it may still be beneficial to find a therapy that could help the majority of individuals, regardless of their age.

While the research pertaining to the effects of mindfulness on anorexia nervosa is limited, results from studies that have been performed on the topic show promise. Psychiatric illnesses, such as depression and anxiety, often occur in comorbidity with anorexia nervosa (Danielsen et al., 2016). Anorexia nervosa is also associated with repetitive, ruminative thoughts (Cowdrey & Park, 2012). Mindfulness, however, has shown positive results when used to treat anxiety, stress, and depression (Querstret et al., 2018) and is inversely related to ruminative thoughts (Cowdrey & Park, 2012; Hernando et al., 2019). Thus, it may be concluded that if mindfulness were implemented as a therapeutic measure, it could result in the decrease of symptoms of anorexia.

Mindfulness as a Preventative Measure

While the necessity of treating eating disorders cannot be denied, it is better to prevent them from occurring in the first place. The ideal time to prevent an eating disorder from occurring is during, but not limited to, adolescence (Warschburger & Zitzmann, 2018). Prevention is ideal because treatment can prove difficult once a disorder develops (Warschburger & Zitzmann, 2018). If an
eating disorder develops, various forms of therapy are available, such as CBT, dialectical behavioral therapy, and acceptance and commitment therapy. These methods, however, are used to treat disorders and are not used as a means of prevention. Mindfulness, on the other hand, can function as both (Atkinson & Wade, 2016; Cowdrey & Park, 2012; Klassen-Bolding, 2018). This sets it apart from other therapies, such as CBT, because it can help individuals before a disorder develops.

As mentioned, an ideal time to implement eating-disorder prevention is during adolescence. This is because body dissatisfaction typically increases during puberty, and disordered eating is more likely to occur (Warschburger & Zitzmann, 2018). Therefore, it is crucial to develop the skills necessary to accept and not judge one’s body during this time. Klassen-Bolding (2018) found this to be true in a mindfulness-based group intervention for preteen girls. In this group intervention, the girls met together on a weekly basis to learn about body perception, controlling strong emotions through mindful techniques, and healthy eating (Klassen-Bolding, 2018). At the end of the five-week period, participants reported that the mindfulness techniques they were taught helped them to gain greater control over their emotions and develop a better relationship with their bodies and with food (Klassen-Bolding, 2018). In a similar study, Monshat et al. (2013) found that adolescents in a mindfulness-based training program felt they had more control over their lives and emotions due to the techniques and practices they had learned. Indeed, it appears that the implementation of mindfulness-based interventions and trainings affect not only an individual’s relationship with their body and food but can positively impact other aspects of their life.

Mindfulness-based interventions can also be effective in reducing eating disorder symptoms in those who have already developed body-image concerns. Atkinson and Wade (2016) observed that young adult women in mindfulness-based intervention groups showed significant improvements in areas such as weight and shape concern and eating-disorder symptoms in comparison to individuals who were placed in dissonance-based intervention groups. The dissonance-based group focused on taking counter-attitudinal stances against socially accepted body ideals in order to reduce weight and shape concerns. The mindfulness-based group, however, focused on nonjudgmental body image awareness and acceptance and discussing the internal experiences and body image concerns of those in the program. These interventions took place in one-hour sessions over a period of three weeks. While the effects were largely lost over a six-month follow-
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up period, mindfulness is likely to provide more consistent benefits if practiced over a longer time period (Atkinson & Wade, 2016). If given the proper training and time to practice mindfulness, those who have body-image concerns or are at risk of developing an eating disorder may find that their concerns diminish over time. Training would likely be most efficacious if consistently practiced in a group setting where participants could support each other in their endeavors.

Conclusion

Eating disorders are complex psychological illnesses. While a number of therapies are available to treat eating disorders, they vary in efficacy. Some disorders, such as anorexia nervosa, do not respond well to many treatments (Brockmeyer et al., 2018; Danielsen et al., 2016), while others, such as bulimia nervosa and binge-eating disorder, respond to various therapies, including CBT (Linardon et al., 2017). The ability to treat and overcome an eating disorder is crucial to the well-being of the individual who is suffering, so their life is not restricted by their poor relationship with food.

While therapies such as CBT may work for many who seek help, the therapeutic use of mindfulness can be even more beneficial. Due to its focus on the nonjudgmental recognition of negative thoughts and emotions, it typically enables an individual to reevaluate their negative attitudes toward food in a way that promotes a healthy relationship with food (Klassen-Bolding, 2018; “Mindfulness,” 2018). The practice of mindfulness is also beneficial due to its ability to decrease maladaptive coping strategies such as rumination and emotional avoidance (Cowdrey & Park, 2012). Emotion regulation can also be improved as individuals practice mindfulness, which may result in improved weight control and eating habits (Kerin et al., 2018; Woolhouse et al., 2012). Unlike CBT, mindfulness has been shown to positively affect those who suffer from anorexia nervosa, which is an extremely complex and difficult disorder to treat (Brockmeyer et al., 2018; Cowdrey & Park, 2012; Danielsen et al., 2016; Linardon et al., 2017). Due to the benefits that mindfulness offers, it may be a viable treatment option for individuals who are affected by eating disorders.

Although the research involving the effect of mindfulness on eating disorders is limited, this type of therapy shows promise. Given that mindfulness therapy has been shown to have short-term efficacy (Atkinson & Wade, 2016), studies should be developed to examine its long-term effects. With further
development and research, this therapy could become a way that eating disorders are treated more effectively.

References


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and dysfunctional thinking in eating disorders. *Behaviour Research and Therapy, 48*(9), 851-859. https://doi.org/10.1016/j.brat.2010.05.009


### Appendix

#### Table 1

*Comparison of means and independent samples t-test in mindfulness, rumination and effective coping between patients and healthy women groups.*

<table>
<thead>
<tr>
<th></th>
<th>ED M</th>
<th>ED SD</th>
<th>NO ED M</th>
<th>NO ED SD</th>
<th>t-test</th>
<th>Sig.</th>
<th>95% CI</th>
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</thead>
<tbody>
<tr>
<td>Mindfulness</td>
<td>33.42</td>
<td>6.17</td>
<td>37.36</td>
<td>4.68</td>
<td>-2.53</td>
<td>.015</td>
<td>-7.08</td>
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<td>Rumination</td>
<td>54.88</td>
<td>11.02</td>
<td>49.48</td>
<td>7.67</td>
<td>1.99</td>
<td>.052</td>
<td>-0.04</td>
</tr>
<tr>
<td>Effective coping</td>
<td>41.13</td>
<td>9.95</td>
<td>48.96</td>
<td>9.51</td>
<td>-2.82</td>
<td>.007</td>
<td>-13.42</td>
</tr>
</tbody>
</table>

*Note. Adapted from “Mindfulness, Rumination, and Coping Skills in Young Women with Eating Disorders: A Comparative Study with Healthy Controls” by Hernando et al., 2019. PLoS ONE, 14(3)*

https://scholarsarchive.byu.edu/intuition/vol15/iss2/14