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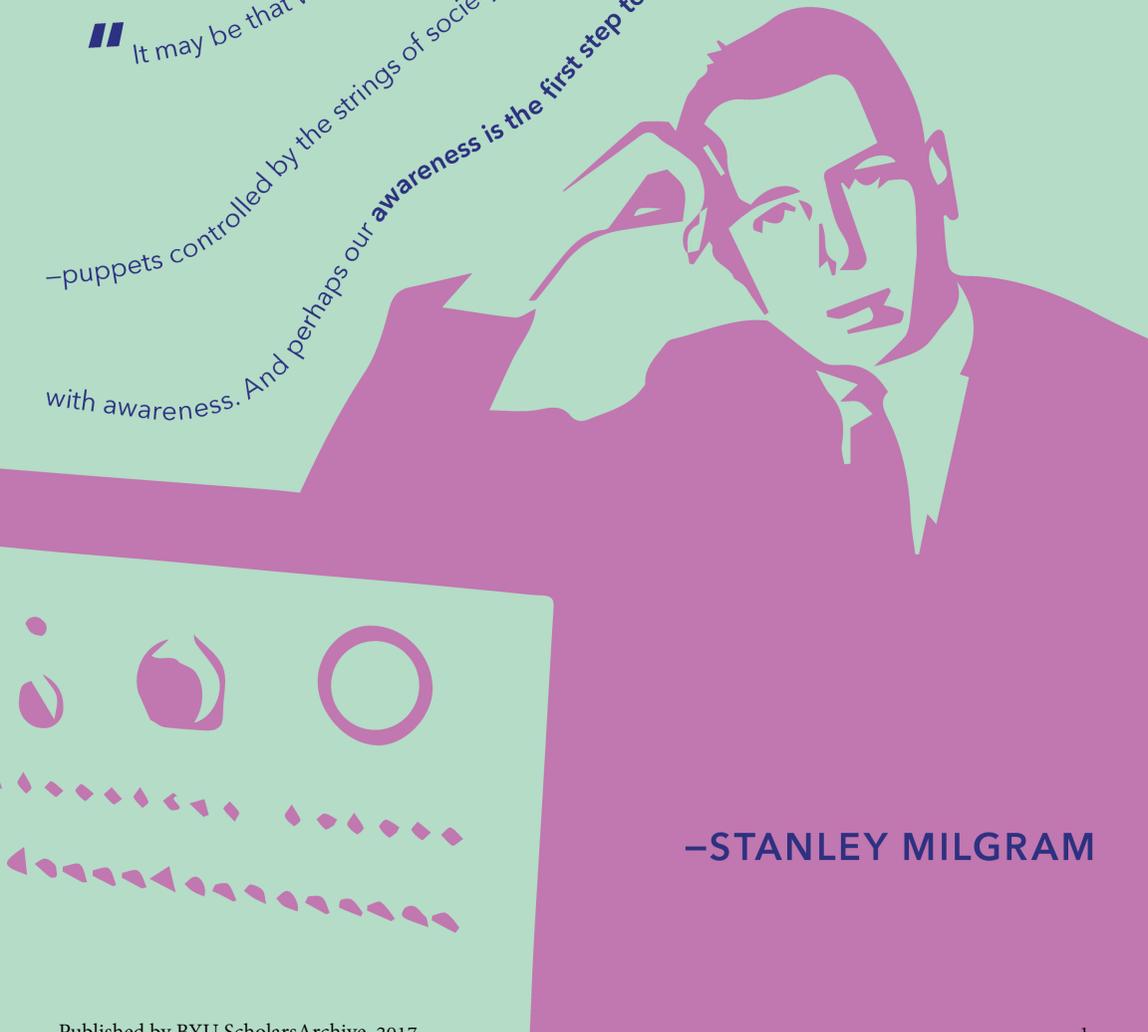
INTUITION:

THE BYU UNDERGRADUATE JOURNAL OF PSYCHOLOGY

“ It may be that we are **puppets**

—puppets controlled by the strings of society. But at least we are **puppets with perception,**

with awareness. And perhaps our **awareness is the first step to our liberation.** **”**



—STANLEY MILGRAM

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A Brief Background of Pornography and its Effects on Physical, Psychological, and Emotional Health in Youth

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*Intuition: The BYU Undergraduate
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Abstract:

The prevalence of pornography has been on the rise for several decades and the effects are becoming more prominent every day due to the accessibility, affordability, and lack of accountability associated with pornography use. It has, thereby, become more available to people of all ages, especially children and adolescents. This paper attempts to show that the viewing of pornography by children and adolescents is harmful to their development, both physically and emotionally. Group and individual therapy, as well as more parental control over what is viewed on the Internet, will be suggested as a way of overcoming or preventing pornography addiction in youth.

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It is common knowledge that pornography has been around for many years and that use has increased as pornography has become more accessible. According to Kraus and Rosenberg (2014) pornography is any media that describes or depicts sexual content and is viewed with the intent of heightening sexual pleasure or arousal. Access to this kind of material has only increased with the invention of the Internet. According to Cooper, Delmonico, and Burg (2000) in the year 1998, about nine million Internet users viewed one of the top five adult (pornographic or mature) sites. About two-thirds of young men and one-half of young women reported watching pornography is acceptable, and 87% of young men and 31% of young women said that they use pornography (Carroll et al., 2008). This means that it is highly likely that everyone knows at least one person who has viewed pornography at some point in their lives.

In conjunction with prevalence, the casual attitude towards pornography and its unrestricted use is problematic. Even though it seems to have become the social norm, pornography-use can have catastrophic consequences in social situations and can dramatically impact an individual's behavior and thoughts. For example, men who watched erotic

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material with a woman in the room, were more likely to inflict painful shocks on her in a competitive reaction-time test, if the woman seemed like she was accepting of the pornography viewing (Leonard & Taylor, 1983). This suggests that viewing pornography can influence people to be more aggressive with others. Such aggression could have a major impact on our society and how individuals function within that society. Pornography may have such an overarching grasp that it leads to many violent crimes such as rape and kidnapping. These implications become even more worrisome when placed in the context of children and young adult viewers; because youth are influenced by what they see, they are likely to mirror the behavior that they see (Bandura, Ross, and Ross, 1963).

Additionally, in a recent study by Kühn and Gallinat (2014), they discovered that pornography consumption is linked with reward-seeking behavior and that it can even affect the volume of gray matter in specific areas of the brain as well as decreased connectivity between portions of the brain. Therefore, not only are there behavioral aspects associated with pornography use, but it might cause problems with brain function as well. Fortunately, therapists have been able to solve the problems that pornography creates because they understand

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what part of the brain it affects.

Pornography's impact on society can create major emotional and psychological problems for those who use it; these problems might be solved by treating pornography as an addiction and by creating awareness about the effects of the use of pornography. There are several ways that pornography addiction could be treated. Emphasis will be placed on treating pornography addiction in a group setting, as well as an individual setting. In these two groups, pornography will be treated as an addictive substance and the suggested treatment will be Acceptance and Commitment Therapy (ACT). According to Twohig and Crosby (2010), ACT therapy appears to be promising in curing the maladaptive behavior in those addicted to pornography. Furthermore, another form of treatment that will be discussed is more focused on society and the role that society and parents should play in ending the acceptance of this habit. Society should become aware of the impact that sexually explicit material has and that it should not be viewed as normal or acceptable. Pornography has become even more acceptable because of the invention of the Internet. Many children are exposed to pornography, and most of them are exposed involuntarily (Twohig & Crosby,

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2010). The abundance of pornography in our culture has created a desensitization to it and it needs to be changed.

Pornography is a harmful and addictive substance to those who use it, especially to youth and our culture. The psychological community needs to take action to prevent youth from viewing this media.

The Rise of Modern Pornography

Pornography production in America primarily began during the Civil War. Two companies, G.S. Hoskins and Co. and Richards & Roche, sold pornographic pictures that could be easily concealed in items that the soldiers had on their person (Sarracino & Scott, 2008). Pornography later became compared to the norm in 2004 when photographer Timothy Greenfield-Sanders released his XXX exhibit. In this exhibit, he photographed pornographic films stars in clothing and set it next to an image of the same pornographic films star, only in the second image the star was completely naked. This set up allowed for the formation of an idea- the idea that pornography is not far from normal and is seen in everyday life. It created the idea that what is abnormal, like a completely naked person, is actually normal like a completely clothed person (Sarracino

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& Scott, 2008). However, pornography has recently become more enticing with the invention of the Internet. According to Cooper (1998) there are three particular aspects of Internet pornography that make it so enticing: the accessibility, affordability, and the anonymity. Prior to the Internet, these three facets of pornography consumption were often difficult to overcome. The Internet has revolutionized the way that people access pornography and has made it more available to people of all ages.

The three A's of Internet pornography not only make pornography more enticing, they also make it more dangerous. The accessibility aspect of the three A's particularly affects children because never before has it been so easy for people to get their hands on pornography. According to Cooper (1998), the Internet made it so that people could access millions of pornography sites 24 hours a day, 7 days a week. This sort of unlimited and unrestricted access has never existed before. It has made it easier for children and adolescents to obtain pornography because the ability to find pornography is on nearly every modern electronic device in America. Before the invention of the Internet, an individual would have to go into a store that sold magazines or rent pornographic videos;

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this is no longer the case. Currently the individual simply has to type the word porn into a search engine, and they will get millions of results that will show them sexually explicit material. Furthermore, there are no longer strict age restrictions on viewing pornography. All that is required now is the click of a button verifying that the viewer is 18 or older. Any child or young adult can click a button on a computer and thereby gain access to any sexual content that the Internet has to give them. According to Ybarra and Mitchell (2005), from a survey of young adults in a school in the Midwest, 21% of the adolescents surveyed had viewed a pornographic site for at least three minutes, if not longer. This information is alarming and one of the primary causes of this phenomenon is the accessibility to pornography that is created by the Internet and the ease of access to the Internet.

Affordability is another incredibly important point when it comes to children and adolescents being able to access pornography. Before the invention of the Internet, free pornography was essentially non-existent. Similarly, not many children or adolescents had the money to spend buying playboy magazines and renting pornographic videos. The Internet, on the other hand, has provided young adults with the opportunity

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to view adult content material without having to spend any money. Many pornographic sites offer free pornography as a way of hooking their audience into paying for it.

In conjunction with accessibility and affordability, anonymity makes it easier for youth to view pornography. Because there is no accountability involved, it is more tempting for young adults and children to experiment with pornography. It is easier for youths to explore the world of explicit content that is housed online more freely because they can hide behind a computer screen and no one is around to judge them. Their name is not associated with their actions; therefore, they believe there are no consequences tied to their actions. The anonymity justifies their behavior. Along with not being accountable, the Internet makes it easier for children and teens to gain access to adult context by pretending that they are older than they really are. According to the Kaiser Family Foundation (2005), 31% of teens have lied about their age to gain access into an adult website. Considering this survey was done in 2005, it can be assumed that this percentage has increased in the last several years, seeing as the Internet has only become more prominent in society. The average age for a first viewing of sexually explicit material is approximately 11 years old (Family Safe Media,

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2006). Thus, the increase in use of sexually explicit material amongst children and adolescents can be at least partially blamed on the accessibility, affordability, and anonymity of Internet pornography.

Because many children and adolescents can easily access pornography, society needs to be more aware of the effects that it can have. According to Freeman-Longo (2000), children and teens often frequent sites that show pornographic images. The study continued by giving a few examples of how some teens were affected by viewing these sites. One example was of a 14-year-old male who had frequently accessed pornographic material online including the Playboy website, as well as several others. He viewed videos of women stripping as well as images of nude women. He was later convicted of sexually abusing his stepsister. Pornography was not necessarily the only influence that made this 14-year-old boy sexually abuse someone; however, it can be assumed that it was a contributing factor in the cause of the incident. Of course, not all boys who view pornography end up being sexual abusers, however, it does introduce a topic into their lives a visual experience, which might have been portrayed as enticing, that may have been avoided otherwise. Children and teens often emulate

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the behavior seen in pornography because they believe it is reality like in this particular case. Another example was of a 13-year-old boy is given. He went to the library at his school and accessed pornography on the Internet. About a month later, he logged on and discovered that the school had password protected the computers, making it so that people could no longer access pornography on them. However, this young man figured out the password and proceeded to enter a chat room and asked a woman about her body (Freeman-Longo, 2000). These examples, though they may seem extreme, are fairly common among children and teens. Therefore, because of the easy accessibility of pornography, many youth are being influenced in a negative way by pornography.

Negative Effects of Pornography on Children and Adolescents

Pornography is an ever-increasing addiction that is influencing many individuals today with its impactful images and messages. It is a rapidly growing industry with an even larger audience. While a very small portion of research shows that there are no negative effects to viewing pornography or that these negative effects are very small, a majority of the research shows that

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pornography has at least some adverse effect on those that use it (Tsaliki, 2011). Children, pre-teens, and teenagers can have adverse effects from viewing pornography, even if they do not understand exactly what these effects are and what they can do to people. When children are exposed to pornography, they are introduced to a sexual experience that can be disturbing, and they do not know how to respond to what they have seen. Viewing pornography at such a young age can cause children to seek out sexual gratification before they are psychologically ready to handle such powerful emotions. If children repeatedly experience overwhelming explicit sexual impulses too soon, it can affect their social development in a way that can cause personality and impulse disorders (Hunt & Kraus, 2009). In terms of youth sexuality and viewing of pornography, those who viewed pornography could develop an unrealistic view of sexual behavior and beliefs, become more promiscuous, think about sexual behavior more often, and begin experimenting sexually earlier than those who do not watch pornography (Owens, Behun, Manning, & Reid, 2012). Watching sexually explicit material at a young age can have lasting emotional, developmental, and social effects on the viewer.

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The Physical Effects of Viewing Pornography as a Youth

While there are various consequences to viewing pornography, there are several effects that show up in nearly all cases.

These are primarily physical and psychological effects. These complications arise even more often and more glaringly in children and young adults. Moreover, the physical aspect is probably the less prevalent of the two types of responses to viewing pornography; however, it is incredibly troubling. The physical response can be measured much more easily than the psychological effect because it is easier to see. Therefore, the physical response is studied more. One of the most dramatic effects is that watching pornography can actually affect the measurable amount of material in your brain. According to Kühn and Gallinat (2014), there is a negative correlation between the number of hours of pornography consumed and the volume of gray matter in the right caudate of the brain. This means that the more pornography an individual consumes, the less gray matter he or she has in their brain. The implications of this discovery are tragic, as this could reflect a change in neural plasticity because of intense stimulation of the reward center of the brain.

Another physical effect that can take place doesn't

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become obvious until later in life. While some researchers disagree, there has been research in the area of sexual dysfunction as an adult as a result of consuming excessive amounts of pornographic material. In a study done by Park, et. al (2016) the researchers found compelling evidence that suggests that individuals who relied heavily on pornography use in their youth are unable to achieve sexual satisfaction as adults. This could be detrimental to marriages or any committed relationship as well as to the individual's self-esteem. This consequence of viewing pornography should be studied more and seeing as how it could have a major effect on an individual's ability to be confident in courtship settings.

The impact of pornography can also have physical manifestations in external behavior. This manifestation can be found most commonly in aggressive behavior towards others. College-aged females that were exposed to erotic material were significantly more likely to behave aggressively towards a provoker than those that were exposed to neutral or aggressive material (Cantor, Zillman, & Einsiedel, 1978). An increase in aggressive behavior in a child can create social problems. Children are still developing their social skills and if they are overly aggressive with their peers, this can create major social

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anxiety later in life. Both of these types of physical reactions could have catastrophic consequences on children and young adults. Because youth are still developing and their brains are still growing, watching pornography could have an even larger impact on them than it would an adult. Not only would it reduce the amount of dark matter that their brains have already developed, it could also possibly inhibit the proper development of the brain. The physical effects of viewing pornography are damaging to a child's growth and healthy development.

The Psychological Effects of Viewing Pornography as a Youth

In conjunction with the physical consequences of viewing erotic material, there are also psychological effects that should be of great concern. Though the psychological effects are less obvious than the physical affects, the impact that they can have on a young child or teenager are just as dangerous. According to Alexy, Burgess, and Prentky (2009), concerning children and adolescents that had a history as a juvenile sexual offender as well a history of pornography, 83% of them had a history of verbal bullying, 80% had a history of lying, and 79% had a history of theft. Additionally, 78% had a history of physical

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bullying, 70% had a history of conning, 65% had committed arson, 54% had run away from home, and 49% were truants. Though these results are for previously troubled children and teens, they are still significant. This shows that there is a correlation between viewing pornography and committing delinquent behavior. Following this further, youth that view pornography are more likely to have had sex, including same-sex sex, masturbated, and have had a one-night stand (Johansson and Hammarén, 2007). These psychological effects are incredibly important because they drive the interactions that people have with each other. If pornography really does have such an immense impact on an individual's psychological state and the actions that follow this state of mind, viewing pornography can effect society and how people relate to and interact with each other.

The implications of pornography use are dramatic, and it is important that people understand just how devastating pornography use can be. In addition to behavioral problems, pornography use can also cause emotional trauma for children and young adults. According to Aisbett (2001) 53% of Australian young people between the ages of 11 and 17 had experienced something they found to be offensive

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on the Internet. They reported that they felt sick, shocked, embarrassed, repulsed, and upset. Reports such as this are common. According to Benedek and Brown (1999), children who view pornography are at risk for emotional disturbance. This disturbance can be displayed in nightmares, anxiety, modeling behavior, and problematic attitude changes. These physical and psychological effects of pornography can have lasting consequences for the viewer even into adulthood (Benedek and Brown, 1999).

When children view pornography at a young age, it can have an extremely damaging effect on their life and personality. One individual shared their specific experience of what viewing pornography as a child did to him as an adult. He was supposedly a drifter and an adventurer obsessed with the lust that pornography had created. He lived a selfish life and this led him to get a divorce and leave his children without a father in the home (Paasonen et al., 2015). The effects can also be seen in the attitudes and ideals that long-time pornography users have. Benedek and Brown (1999) stated that pornography use over an extended period of time can cause the consumer to believe that less common sexual practices are more common than they really are. Also, they are less repulsed by extreme

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forms of pornography and are, thereby, more accepting of such practices. This has the potential to greatly affect society because as individuals become more accepting of objectionable material the more common it becomes. An example of this is rape. Rape is a semi-common theme amongst pornographic videos and the more acceptable rape is to watch, the more acceptable it becomes to actually rape someone. This could be catastrophic for society. Pornography addiction has become a part of our culture and if we do not stop it, pornography could overrun our society.

Discussion

Pornography should be considered a destructive force in society today. It is influencing the lives of many and creating problems for people of all ages; however, one of the most distressing groups that it is taking hold of is youth. Never before in the history of mankind has pornography been able to impact the lives of so many young people. According to Twohig and Crosby (2010), 12% of the Internet is made up of pornography. This abundance of material is what makes it so easy for pornography to sneak into the life of a child or young adult and according to Ayres and Haddock (2009), the

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amount of material continues to grow by 9.2% every year.

Taking this statistic into consideration, the lasting damage that pornography does is even more concerning. As for how to treat the effects of pornography and pornography addiction, there are several schools of thought. This discussion will focus primarily on how to use group and individual therapy as a treatment source; however, it is better to prevent than to treat. Methods of preventing children and teens from ever viewing pornography will also be suggested so that the potential damage of pornography can be avoided.

Possibilities for the Treatment of Pornography Addiction in Youth

The DSM-5 does not include pornography as a disorder; however, it is reasonable to conclude that it should be classified as a disorder just by looking at the effects that pornography has on people. Group therapy and individual therapy, with a specific focus on ACT therapy, are two of many of the suggested possibilities given to treat pornography addiction.

Group therapy has been effective in the areas where it has been tried because of the accountability that is involved in a group setting. According to Woods (2013), group members use the

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12-step program, and progress is made because the members help each other manage their compulsion. Additionally, the group provides intimacy for each of the participants, without that intimacy being sexual. The setup of the group allows for a kind of closeness that can rarely be found outside of a therapeutic group setting. This helps foster trust and real relationships. The closeness between group members helps them overcome their shame because they feel like they can rely on each other for support and that they have nothing to fear. This concept can easily be applied to children and young adults. Many youths in today's world simply want to fit in with those around them. By seeing that they have a place where they belong, they would most likely be more inclined to share their thoughts and feelings with those around them. Woods (2013) continues by mentioning the role the therapist plays. The therapist provides the attendees with the ability to see the abuse that pornography portrays and helps them to see reality in their relationships with others. The therapist teaches the attendees what is normal and acceptable sexual behavior and what is not. This, too, can be applied to children and young adults. After having viewed pornography, youths will not have a realistic grasp of what sexuality really is and the therapist can provide them with

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the clarification of what is acceptable behavior in a sexual relationship and what is not.

Another type of therapy that could be incredibly effective is individual therapy with a strict focus on ACT therapy. Individual therapy is currently used to treat pornography addiction and focuses on discovering what is causing the patient to have a pornography addiction and then dealing with that underlying problem. ACT therapy is a slightly different approach to the traditional therapy. According to Twohig and Crosby (2010), ACT therapy holds promise as a treatment to pornography addiction because its main focus is on the processes that are believed to cause the maladaptive behavior. In ACT therapy, the patient and the therapist set goals together for the patient to work on throughout a specified period of time. Through the use of ACT therapy, a group of 6 men had an 83% recovery rate from their pornography addiction (Twohig & Crosby, 2010). This recovery rate is astounding and though the sample size is fairly small, the results are still significant. If ACT therapy could have the same recovery rate across multiple spans of people, the impact would be dramatic.

A case study using ACT therapy. According to Collins

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and Adleman (2010), a patient named Bob was able to use a type of ACT therapy to overcome his pornography addiction. Bob was viewing pornography and masturbating when his young daughter happened to walk in on him. His wife divorced him and he was only allowed to see his daughter in the presence of a Child Protection Services employee. He then became a patient of Collins, the author, and began to set goals to become better. He found a woman and began a real, intimate relationship. Every morning and night, Bob reported to Collins about his day, what he did, and how he felt. He accepted that he had a problem with pornography and committed to work on it personally while receiving help and encouragement from Collins. This is just another example of how ACT therapy helped someone improve their life and heal from their pornography addiction. This approach can also easily be applied to children and young adults. It is easy to set goals and work on those goals with a child and see the progress that is being made as long as the child is willing to change. These two approaches could revolutionize the treatment of pornography addiction in our society.

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Preventing Pornography Addiction in Children and Young Adults

As great as it is to help someone overcome an addiction, it is even better to prevent the person from struggling with that addiction in the first place. In order to prevent pornography addiction in children and young adults, society should consider changing its perspective on pornography and its effects, and parents have to be more involved in their children's Internet activity. According to Mitchell, Finkelhor, and Wolak (2003), filtering and blocking software is one of the most effective ways to prevent pornographic images from appearing on the computer for children and teenagers to see. They work by either looking for specific words or terms and filtering them out or by not allowing access to preset, specific sites. This involves the parents because the parents have the responsibility of setting up the software, making sure that it works properly, and checking their child's history on the computer frequently. Another suggestion given by Williams (2005) is that warning systems be put in place to warn the viewer that they are about to enter a page that contains pornographic material, thereby allowing the viewer to close the page without the possibility of viewing the explicit content. A concern that Williams expresses

is that this may cause children and teenagers to feel that the site is “forbidden” and that creates more curiosity and more of a likelihood of the individual viewing the page. All of these variables should be taken into consideration when trying to prevent pornography addiction. More research is still needed in order to know the best possible route to take when trying to prevent pornography addiction and when trying to cure it.

References

- Alexy, E., Burgess, A., & Prentky, R. (2009). Pornography use as a risk marker for an aggressive pattern of behavior among sexually reactive children and adolescents. *Journal of the American Psychiatric Nurses Association, 14*(6), 442-453. doi: 10.1177/1078390308327137
- Ayres, M., & Haddock, S. (2009). Therapists' approaches in working with heterosexual couples struggling with male partners' online sexual behavior. *Sexual Addiction & Compulsivity, 16*(1), 55-78. doi: 10.1080/10720160802711952
- Bandura, A., Ross, D., & Ross, S. (1963). Imitation of film-mediated aggressive models. *The Journal of Abnormal and Social Psychology, 66*(1), 3-11. doi: <http://dx.doi.org.erl.lib.byu.edu/10.1037/h0048687>
- Benedek, E., & Brown, C. (1999). No excuses: Televised pornography harms children. *Harvard Review of Psychiatry, 7*(4), 236-240. doi: <http://dx.doi.org.erl.lib.byu.edu/10.1093/hrp/7.4.236>
- Cantor, J., Zillman, D., & Einsiedel, E. (1978). Female response to provocation after exposure to aggressive and erotic films. *Communication Research, 5*(4), 395-412. doi: 10.1177/009365027800500402
- Carroll, J., Padilla-Walker, L., Nelson, L., Olson, C., Barry, C., & Madsen, S. (2008). Generation XXX: Pornography accep-

- tance and use among emerging adults. *Journal of Adolescent Research*, 23(1), 6-30. doi: 10.1177/0743558407306348
- Collins, G., & Adleman, A. (2010). *Breaking the cycle: Free yourself from sex addiction, porn obsession, and shame*. Oakland, California: New Harbinger Publications, Inc.
- Cooper, A. (1998). Sexuality and the internet: Surfing into the new millennium. *CyberPsychology & Behavior*, 1(2), 187-193. doi:10.1089/cpb.1998.1.187
- Cooper, A., Delmonico, D., & Burg, R. (2000). Cybersex users, abusers, and compulsives: new findings and implications. *Sexual Addiction & Compulsivity*, 7(1-2), 5-29. doi: 10.1080/10720160008400205
- Family Safe Media. (2006). *Pornography Statistics* [Informational Website]. Retrieved from http://familysafemedia.com/pornography_statistics.html
- Hunt, S., & Kraus, S. (2009). Exploring the relationship between erotic disruption during the latency period and the use of sexually explicit material, online sexual behaviors, and sexual dysfunctions in young adulthood. *Sexual Addiction & Compulsivity*, 16(1), 79-100. doi: 10.1080/10720160902724228
- Kraus, S., & Rosenburg, H. (2014). The pornography craving questionnaire: Psychometric properties. *Archives of Sexual Behavior*, 43(3), 451-462. doi: 10.1007/s10508-013-0229-3
- Kühn, S., & Gallinat, J. (2014). Brain structure and functional connectivity associated with pornography consumption: The brain on porn. *JAMA Psychiatry*, 71(7), 827-834. <http://dx.doi.org/10.1001/jamapsychiatry.2014.93>
- Johansson T., & Hammarén N. (2007). Hegemonic masculinity and pornography: young people's attitudes toward and relations to pornography. *Journal of Men's Studies*, 15(1), 57-70. doi: 10.3149/jms.1501.57
- Kaiser Family Foundation. (2005, October, 30). *Sex on TV 4* [Informational Website]. Retrieved from <http://kff.org/other/event/sex-on-tv-4/>
- Leonard, K., & Taylor, S. (1983). Exposure to pornography, permissive and nonpermissive cues, and male aggression toward females. *Motivation and Emotion*, 7(3), 291-299. doi:

10.1007/BF00991679

- Mitchell, K., Finkelhor, D., & Wolak, J. (2003). Exposure of youth to unwanted sexual material on the internet: A national survey of risk, impact, and prevention. *Youth & Society, 34*(3), 330-358. doi: 10.1177/0044118X02250123
- Owens, E., Behun, R., Manning, J., & Reid, R. (2012). The impact of internet pornography on adolescents: A review of the research. *Sexual Addiction & Compulsivity, 19*(1-2), 99-122. doi: 10.1080/10720162.2012.660431
- Paasonen, S., Kyrölä, K., Nikunen, K., & Saarenmaa, L. (2015). We hid porn magazines in the nearby woods: Memory-work and pornography consumption in Finland. *Sexualities, 18*(4), 394-412. doi: 10.1177/1363460714550911
- Park, B. Y., Wilson, G., Berger, J., Christman, M., Reina, B., Bishop, F., & ... Doan, A. P. (2016). Is internet pornography causing sexual dysfunctions? A review with clinical reports. *Behavioral Sciences, 6*(3), 1-25. doi:10.3390/bs6030017
- Ramirez, J., Bryant, J., & Zillman, D. (1982). Effect of erotica on retaliatory behavior as a function of level of prior provocation. *Journal of Personality and Social Psychology, 43*(5), 971-978. <http://dx.doi.org/10.1037/0022-3514.43.5.971>
- Sarracino, C., & Scott, K. (2008). *The porning of America: The rise of porn culture, what it means, and where we go from here.* Boston, Massachusetts: Beacon Press.
- Tsaliki, L. (2011). Playing with porn: Greek children's explorations in pornography. *Sex Education, 11*(3), 293-302. doi: <http://dx.doi.org.erl.lib.byu.edu/10.1080/14681811.2011.590087>
- Twohig, M., & Crosby, J. (2010). Acceptance and commitment therapy as a treatment for problematic internet pornography viewing. *Behavior Therapy, 41*(3), 285-295. doi: 10.1016/j.beth.2009.06.002
- Williams, K. (2005). Facilitating safer choices: Use of warnings to dissuade viewing of pornography on the internet. *Child Abuse Review, 14*(6), 415-429. doi: 10.1002/car.920
- Woods, J. (2013) Group analytic therapy for compulsive users of internet pornography. *Psychoanalytic Therapy, 27*(4), 306-

318. doi: <http://dx.doi.org.erl.lib.byu.edu/10.1080/02668734.2013.853907>

Ybarra, M., & Mitchell, K. (2005). Exposure to internet pornography among children and adolescents: A national survey. *CyberPsychology & Behavior*, 8(5), 473-486. doi: <http://dx.doi.org.erl.lib.byu.edu/10.1089/cpb.2005.8.473>

The Use of ECT as a Standard Treatment for MDD

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Abstract:

The arsenal of effective, standardized treatment options for major depressive disorder (MDD) is shockingly low considering one in three individuals in the United States will experience clinical depression during their lifetime (American Psychiatric Association, 2013). MDD is usually limited to drug therapy and cognitive therapy, and alternative treatment methods are often disregarded as ineffective or unethical. This review explores the possibility of electroconvulsive therapy (ECT) as an alternative standard treatment for MDD. ECT has been used for decades for the treatment of mood disorders, but only recently has the medical community begun to understand how ECT affects the brain. With advancements in methodology, ECT has become a safe, efficient, and more permanent treatment option compared to drug therapy. This research discusses proposed causes of depression in the pathways of the brain, as well as specific areas of the brain affected by drug therapy and ECT. With recent research demonstrating the possibility of neurogenesis in the hippocampus being related to depressive symptoms, new perspectives on old treatment options must be explored. This review will propose the possibility of ECT as a standard treatment for MDD.

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Despite its controversial history, electroconvulsive therapy (ECT) is gaining respect as a treatment for intractable cases of major depressive disorder (MDD). Popular in the 1970s, ECT was used to treat a variety of disorders until its adverse effects restricted further use (Friedberg, 1977). Currently ECT is rarely used as a long-term treatment, but it is used in cases with high risk of suicide. However, recent studies suggest that neurogenesis occurs in the brain following electroconvulsive therapy. This growth of new neural tissue, specifically in the hippocampus, has been linked to long-term alleviation of depressive symptoms (Rotheneichner et al., 2014). Therefore, ECT should again be reviewed as a more standard treatment option for MDD.

Critical assessment of common current treatments for MDD reveals significant weaknesses. The most popular treatment is based on the theory that depression is linked to increased uptake of serotonin (Mann, 1999; Meyer et al. 2006). To reduce reuptake and allow serotonin to bind more on the postsynaptic receptors, selective serotonin reuptake inhibitors (SSRIs), such as sertraline (also known as Zoloft) or fluoxetine (also known as Prozac), are prescribed. These medications have many adverse side effects including heightened suicidal

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tendencies in low dosage (Ludwig & Marcotte, 2005). In stark contrast, modern ECT has little visible damage, both biologically and psychologically (Anderson, Wollman, & Dinwiddle, 2013). Over the course of thirty years and many studies, ECT has become sophisticated, controlled, targeted, and better understood (Hanson, Owens, & Nemeroff, 2011). Unlike SSRIs which treat systemically, ECT is a localized treatment that produces minimal systemic side effects (Eschweiler et al., 2007; Gomez, 1975). Both SSRIs and ECT appear to promote positive change in brain chemistry and structure, each modality having its own advantages and weaknesses (Madsen et al., 2000; Rotheneichner et al., 2014). Both modalities are based on the monoamine theory of depression, which dictates that serotonin is key to regulating mood.

Serotonin is thought to be regulated by the dentate gyrus, specifically the CA3 region of the hippocampus (Banar, Hery, Printemps, & Daszuta, 2004). Recent research suggests that certain types of stimulation of the brain trigger the generation of neural precursor cells (NPCs) which are correlated to neurogenesis within the dentate gyrus and the CA3 region (Banar et al., 2004; Hanson et al., 2011; Hellsten et

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al., 2002). Some stimuli include exercise, hypoxia in controlled doses, ECT, as well as conventional drug therapy, such as SSRIs (Kempermann, Kuhn, & Gage, 1997; Zhu et al. 2010; Malberg, Eisch, Nestler, & Duman, 2000). Due to the pronounced effect ECT has on the brain in regard to NPCs, many neuroscientists are now suggesting ECT as a more regular form of therapy for MDD (Hellsten et al., 2002; Bauer, 2003; Inta & Gass, 2015).

Research has shown that ECT and conventional drug therapy promote NPC generation in the area of the brain that regulates serotonin, which suggests stimulating this area of the brain can treat depression.

Diagnosing and Treating Depression

Over 14 million American adults (6.7% of the U.S. population) struggle with MDD (Heo, Murphy, Fontaine, Bruce, & Alexopoulos, 2008). The prevalence of MDD suggests that almost everyone has either experienced depression or known someone who has. Physicians use a standardized assessment to diagnose and then prescribe treatment, generally either medication, therapy, or both. There are many different medications, each with different properties and adverse side effects which range from fatigue or insomnia to increased risk

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of suicide or erectile dysfunction (Ferguson, 2001). Serotonin regulation occurs systemically, so side effects from SSRIs also manifest systemically (Camilleri, 2009). Many people experience adverse reactions to antidepressants because the standard starting dose may be excessively strong (Cohen, 2003). On the other hand, too low of a dose has been shown to lead to increased risk of suicide (Grunebaum et al., 2004; Ludwig & Marcotte, 2005). Because of this life-threatening risk, physicians generally take a cautious approach and prescribe a higher dose than necessarily needed (Cohen, 2003). Although depression is a prevalent problem in the US population, current treatment practices have many negative side effects and are not easy to prescribe in the proper dosage.

The Diagnosis of Major Depressive Disorder

No physical tests exist for the diagnosis of depression (National Health Service, 2014). Instead, a general practitioner uses one of the common rating scales to determine whether or not treatment should be administered. One such scale is the Hamilton Rating Scale for Depression (HAM-D), which outlines the major symptoms of depression (Khan, Khan, Shankles, & Polissar, 2002; Leucht et al. 2005). These symptoms

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include sadness, feelings of guilt, suicidal tendencies, insomnia, difficulty at work, and paranoia (Khan et al., 2002). The strength of the medication and treatment is determined by the evaluation and suggestion of the physician or psychologist.

Serotonin within the Hippocampus and its Biological Uses

Treatment for MDD focuses on the physical manipulation of serotonin. However, levels of serotonin rarely vary from an individual with depression from an individual without depression (Marken & Munro, 2000). The monoamine theory relates to synapses with transporters in the synaptic cleft and the effectiveness of serotonin within the brain, not with the actual amount of serotonin (Hirst, Price, Rattray, & Wilkin, 1998). Serotonin is involved in a number of functions, including digestion, mood, appetite, sleep, sexual desire and function, and memory (Buhot, Martin, & Segu, 2000; Labbate, Grimes, Hiaes, Oleshansky, & Arana, 1998; Portas, Bjorvatn, & Ursin, 2000; Zhu et al. 2010). This complex system is monitored within the hippocampus and functionally responds to the precursor to serotonin, 5-HT (Laplante, Diorio, & Meaney, 2002). The precursor 5-HT is derived from tryptophan, an amino acid that is obtained solely through diet (Smith, Fairburn, & Cowen, 1997). This only adds to the complexity

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regarding diagnosing and understanding mood disorders, where everything—from diet and exercise to brain chemistry—could have a major effect.

The hippocampus regulates serotonin, which is central to the limbic system and associated with memory processing (Battaglia, Benchenane, Sirota, Pennartz, & Wiener, 2011). This critical area of the brain also acts as a hub for communications across cortexes in the brain (Battaglia et al., 2011). Studies suggest that serotonin can affect the shape of the hippocampus, and that the shape of the hippocampus can affect its functioning (Voineskos et al., 2015; Smolders, Loo, Sarre, Ebinger, & Michotte, 2001). This could mean that the hippocampus's development, size, or shape may play a key role in understanding depression. This plasticity allows for subtle changes in brain chemistry and functioning. These modifications are often associated with the creation of new neuronal connections and neurons, known as neurogenesis.

In recent years, research has shown that neurogenesis is possible in adults (Gabriel et al., 1999; Hellsten et al., 2002; Malberg et al., 2000). Although studies are still ongoing on how neurogenesis occurs and how it can be stimulated, there have been a number of studies proposing that stress can decrease

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neurogenesis in the hippocampus (Schloesser, Manji, & Martinowich, 2009). Because the hippocampus is fundamental to the regulation of serotonin, some scientists speculate that the effect of stress on the hippocampus is linked to depressive behavior (Campbell & MacQueen, 2004). This theory opens the door to new ideas regarding treating depression through stimulating neurogenesis (Hellsten et al., 2002; Malberg et al., 2000). In particular, ECT is a promising option.

Neurogenesis within the Hippocampus

The hippocampus is a dynamic part of the brain (Abe, 2001). Stress, anxiety, depression, and other factors can cause atrophy in the hippocampus and lead to problems within the limbic system (McEwen, 1995). To combat this, the body regulates neural precursor cell growth and decay within the hippocampus through environmental cues given by neuronal pathways that pass through the hippocampus (Abe, 2001; McEwen, 1995). Some specific activities have been identified that encourage growth in the hippocampus, including aerobic exercise. One study done by Kempermann, Kuhn, and Gage, (1997) demonstrated that the dentate gyrus of adult rats increased in size when exposed to an environment with

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colors, toys, and other activities to keep the rats engaged.

This example demonstrates that it is not necessary to induce neurogenesis through artificial means. However, when negative cues persist, such as chronic stress or depression, damage to the hippocampus can effectively wipe out the body's ability to self-regulate (Campbell & MacQueen, 2004). In these cases, antidepressants, ECT, and other treatment options for depression become necessary because it may be difficult to overcome depression without assistance.

Stress doesn't only affect the hippocampus. The effects of stress extend beyond the hippocampus, dampening the relationship between the hippocampus and the main stress hormone system, the hypothalamo-pituitary-adrenal (HPA) axis (Schloesser et al., 2009). Severe chronic stress impairs HPA axis activity, which mutes the ability of the hippocampus to modulate downstream brain areas involved in stress response. In essence, the brain protects itself by destroying pathways that are overworked, and one of the damaging side effects is MDD (Schloesser et al., 2009). Of course, this type of manipulation of the HPA has damaging side effects, most notably MDD, but is primarily in place to protect the longevity of the brain. Although all the mechanisms and processes involved are as yet

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unclear, the importance of neurogenesis in the hippocampus to regulate stress and serotonin has become widely recognized.

ECT as a Treatment for MDD

Developed in 1938, ECT was found effective for treating a number of mood disorders, including depression (Endler, 1988). In its early development, however, ECT was done without precise measurements of voltage or any form of anesthetic by inducing seizures in patients (Endler, 1988). Over the course of the next decades as various forms of treatment began to appear, most notably drug therapy which had less severe side effects, ECT fell out of favor. Today ECT has advanced in sophistication, with more precise voltage calculation and use of anesthesia to literally eliminate the pain involved (Loo, Schweitzer, & Pratt, 2006). Although it has been recognized as one of the most effective treatments (Kellner et al., 2015), its general scope of use is focused on the most severe cases. Recent studies have begun to demonstrate why ECT is a valuable form of treatment. The use of ECT has been expanding over the past decade and continues to grow as research continues.

Although understanding of the mechanism of ECT

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has increased, there are still many concerns regarding its safety; these stigmas continue, even among professional psychiatrists (Carney & Geddes, 2003). Though death from ECT was a considerable risk thirty years ago. Refuting this fear, one study suggests that ECT in the mid-1990s was ten times safer than childbirth and that approximately six times as many deaths annually in the U.S. are caused by lightning than by ECT (Abrams, 1997). The most common side effects are temporary confusion and memory loss. Uppal, Dourish, and Macfarlane (2010) suggest that the most dangerous aspect of ECT treatment is being under anesthetic, and not the actual treatment. They argue that most concerns regarding ECT are mostly stigmatic superstition from decades ago.

Current ECT Use

ECT is generally viewed as a last resort for treatment-resistant depression by the psychiatric community (Al-Harbi, 2012). Although there are cases when ECT is regularly administered, its use is far from standard practice. Individuals that receive ECT usually have experienced adverse effects from medication or have been unresponsive to therapy (Al-Harbi, 2012). These individuals range from those who simply need a more rapid

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response than medications can provide, such as those suffering from delusions or suicidal tendencies, to those who suffer from catatonia (Al-Harbi, 2012). Those who receive ECT are highly likely to continue to receive treatment in the form of drug therapy (Bauer, 2003). The application of ECT is not limited to MDD, and is used to treat other mental disorders in similar circumstances. Regardless, the universal goal is to stabilize the patient so medications can be started or resumed.

Electroconvulsive therapy is performed with the goal of “as little as possible,” both in terms of voltage and number of treatments (Al-Harbi, 2012; Bauer, 2003). Typically, a single procedure will only last five to 10 minutes, not including preparation time and recovery. General anesthesia is administered so that pain is minimized. Patients are given a muscle relaxant to minimize seizure as well. The electrode pads are placed on the head either unilaterally or bilaterally, with location determined to best target the area of interest (“Electroconvulsive Therapy,” 2015). Electroencephalogram (EEG) is used to record electrical activity in the brain to make sure the procedure is done correctly and strongly enough to induce the desired seizure. Recovery usually lasts for about one hour before the patient is released. During this time,

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confusion and memory loss are a common side effect, either from anesthesia or from the treatment itself (“Electroconvulsive Therapy,” 2015). In the United States, ECT treatments are administered in sets of two to three times a week for a month, for a total of six to twelve treatments, depending on severity of the case and the physiological reaction to the treatments.

Due to careful localization of the treatment, most common side effects are temporary and isolated to the parts of the body affected by the procedure. Confusion, memory loss, and headache are common, but they generally subside within 24 hours. Long-term memory loss can take up to a few months to fully recover, but it is rare for memory loss to persist beyond that time (MacQueen, Parkin, Marriot, Begin, & Hasey, 2007). As with any medical procedure, especially those that use anesthesia, there are rare risks of complications, including cardiac arrest or other heart condition, stroke, and even death (“Electroconvulsive Therapy,” 2015). Considering the large success rate among patients suffering from depression and the minimal risks of ECT warrant ECT to be considered a potential alternative to conventional drug therapy.

422 ECT treatments: A neuropathological evaluation.

Much of the stigma surrounding ECT is unfounded, as

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illustrated by the following neuropathological evaluation. In 2013, an autopsy of an 84-year-old man revealed little-to-no brain damage despite his having received 422 ECT treatments over 8.6 years (Anderson, Wollman, & Dinwiddle, 2013). This man had been treated for a severe depressive episode that culminated in a suicide attempt. After many hospitalizations, ECT was prescribed, which continued until the time of his death. The postmortem report was completed immediately after his death, one month after his final ECT treatment. The report showed that there was no link between cause of death and his ECT treatments (Anderson et al., 2013). Although this is an isolated case, the authors linked a large number of similar reports from the past twenty years.

ECT has not been shown to cause brain damage according to this case study and other reports. Stigma regarding ECT and brain damage stems from postmortem reports dating to the 1940s, claiming that ECT causes harmful physical changes to the brain. This stigma remains in part because over the past four decades, few postmortem studies have been done due to the low mortality rate after the immediate treatment period of ECT patients. In the past two decades, computed tomographic brain imaging has shown no changes in brain

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structure after ECT (Anderson et al., 2013). Simply put, the notion that ECT causes brain damage is unfounded.

Discussion

MDD poses a problem for treatment because the precise mechanisms that cause MDD are unknown. However, correlations between treatments and behavioral changes spur innovation. Early ECT was done with minimal understanding of why it worked, but half a century later, neuroscientists have a better idea of how the brain is affected by ECT (Endler, 1988). Early monoamine oxidase inhibitors (MAOIs) were discovered serendipitously while trying to treat tuberculosis. Subsequent *in vitro* work led to a theory of the drug's mechanism of action (Ramachandriah, Subramanyam, Bar, Baker, & Yeragani, 2011). Over the next twenty years, MAOIs were replaced with SSRIs which have fewer side effects and are more potent. Along with these advances, ECT became safer and more controlled. Advanced methods of evaluation, brain scanning technology, and the ability to perform advanced experiments allow for a much deeper understanding of treatment options before ever being released to the general population. As understanding of the brain increases, methods become more refined.

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Technological improvement has influenced the way antidepressants are manufactured and the way ECT is performed. Studies on rats have demonstrated the effectiveness of ECT in treating induced depression on a biological level (Bauer, 2003; Inta & Gass, 2015; Kempermann, Kuhn, and Gage, 1997). Currently ECT is used as the last resort of treatment, despite evidence it is safe, effective and has few side effects. Antidepressants are more prevalent and have more common side effects that generally are present for as long as the patient is taking the prescription (Cascade, Kalali, & Kennedy, 2009). Antidepressants are an effective treatment, but as with any treatment, have their shortcomings and should not be the only offered solution. This is the precise reason ECT should be taken into consideration as a viable treatment option.

ECT as a Standard Treatment

The general consensus is that it is safer to take a pill than undergo ECT, which may be incorrect in the long-term. A meta-analysis study demonstrated that in severe cases, ECT is the most effective treatment option (Kellner et al., 2015). There is less evidence that ECT would be effective in less-severe cases other than studies on rats with induced depressive states (Madsen et al., 2000; Theilmann et al., 2014). The lack of studies

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may be attributed to the limited amount of ECT use in less-severe cases. In rats, ECT has shown to be effective regardless of perceived severity of the depression (Madsen et al., 2000; Theilmann et al., 2014). Although the triggering mechanisms of antidepressants and ECT are primarily different, the effect is primarily the same: encouraging neurogenesis in the dentate gyrus and CA3 region of the hippocampus (Malberg et al., 2000; Warner-Schmidt et al., 2008).

More detailed studies are required to confirm that ECT could be standardized as a treatment for MDD. ECT has been reexamined in a number of studies to advance understanding of the hippocampus and brain function in rats. If ECT were considered ethical and effective, another sophisticated tool would be given to the psychiatric community to better treat and understand depression and other mood disorders. Of course, more research is necessary to realize this possibility. In light of the current research of the effects of ECT on the brain, further research on ECT should be conducted to confirm its viability to become a more standard treatment option as an alternative to drug therapy.

References

USE OF ECT

- Abe, K. (2001). Modulation of hippocampal long-term potentiation by the amygdala: A synaptic mechanism linking emotion and memory. *Japanese Journal of Pharmacology*, 86(1), 18-22. doi:10.1254/jjp.86.18
- Abrams, R. (1997). The mortality rate with ECT. *Convulsive Therapy*, 13(3), 125-127. Retrieved from <http://www.ncbi.nlm.nih.gov/>
- Al-Harbi, K. S. (2012). Treatment-resistant depression: Therapeutic trends, challenges, and future directions. *Patient Preference and Adherence*, 6, 369-388. doi:10.2147/PPA.S29716
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.
- Anderson, D., Wollman, R., & Dinwiddle, S. H. (2013). Neuro-pathological evaluation of an 84-year-old man after 422 ECT treatments. *The Journal of ECT*, 30(3), 248-250. doi:10.1097/YCT.0000000000000062
- Banasr, M., Hery, M., Printemps, R., & Daszuta, A. (2004). Serotonin induced increases in adult cell proliferation and neurogenesis are mediated through different and common 5-HT receptor subtypes in the dentate gyrus and the subventricular zone. *Neuropsychopharmacology*, 29(3), 450-460. doi:10.1038/sj.npp.1300320
- Battaglia, F. P., Benchenane, K., Sirota, A., Pennartz, C. M., & Wiener, S. I. (2011). The hippocampus: hub of brain network communication for memory. *International Journal for Numerical Methods in Engineering*, 15(7), 310-318. doi:10.1016/j.tics.2011.05.008
- Bauer, M. (2003). Review: electroconvulsive therapy may be an effective short term treatment for people with depression. *Evidence-based Mental Health*, 6(83), 799-801. doi:10.1136/ebmh.6.3.83
- Buhot, M., Martin, S., & Segu, L. (2000). Role of serotonin in memory impairment. *Annals of Medicine*, 32(3), 210-211. doi:10.3109/07853890008998828
- Camilleri, M. (2009). Serotonin in the gastrointestinal tract.

USE OF ECT

- Curr Opin Endocrinol Diabetes Obes, 16(1), 53-59.
- Campbell, S., & MacQueen, G. (2004). The role of the hippocampus in the pathophysiology of major depression. *Journal of Psychiatry Neuroscience*, 29(6), 417-426.
- Carney, S., & Geddes, J. (2003). Electroconvulsive therapy: Recent recommendations are likely to improve standards and uniformity of use. *BMJ: British Medical Journal*, 327(7403), 1343-1344.
- Cascade, E., Kalali, A., & Kennedy, S. (2009). Real-world data on SSRI antidepressant side effects. *Psychiatry*, 6(2), 16-18.
- Clinical depression - diagnosis - NHS choices. (2014). Retrieved June 13, 2015, from <http://www.nhs.uk/Conditions/Depression/Pages/Diagnosis.aspx>
- Cohen, J. S. (2003). Antidepressants - Side effects. Retrieved from <http://chetday.com/antidepressantdrugsideeffects.htm>
- Electroconvulsive therapy (ECT) What you can expect - Mayo Clinic. (2015). Retrieved June 14, 2015, from <http://www.mayoclinic.org/tests-procedures/electroconvulsive-therapy/basics/what-you-can-expect/prc-20014161>
- Endler, N. (1988). The origins of electroconvulsive therapy (ECT). *The Journal of ECT*, 4(1), 1-12.
- Eschweiler, G. W., Vonthein, R., Bode, R., Huell, M., Conca, A., Peters, O., . . . Schlotter, W. (2007). Clinical efficacy and cognitive side effects of bifrontal versus right unilateral electroconvulsive therapy (ECT): A short-term randomised controlled trial in pharmaco-resistant major depression. *Journal of Affective Disorders*, 101(1-3), 149-157. doi:10.1016/j.jad.2006.11.012
- Ferguson, J. M. (2001). SSRI Antidepressant Medications: Adverse Effects and Tolerability. *Primary Care Companion*, 3(1), 22-27.
- Friedberg, J. (1977). Shock treatment, brain damage, and memory loss: a neurological perspective. *American Journal of Psychiatry*, 134, 1010-1014.
- Gabriel, S. E., Brigman, K. N., Koller, B. H., Boucher, R. C., Stutts, M. J., Baukowitz, T., . . . Gross, C. G. (1999). Neu-

USE OF ECT

- rogenesis in the neocortex of adult primates. *Science*, 286(5439), 548-552. doi:10.1126/science.286.5439.548
- Gomez, J. (1975). Subjective side-effects of ECT. *British Journal of Psychiatry*, 127(6), 609-611. doi:10.1192/bjp.127.6.609
- Grunebaum, M. F., Ellis, S. P., Li, S., Oquendo, M. A., & Mann, J. J. (2004). Antidepressants and suicide risk in the United States, 1985-1999. *Journal of Clinical Psychiatry*, 65(11), 1456-1462. doi:10.4088/JCP.v65n1103
- Hanson, N. D., Owens, M. J., & Nemeroff, C. B. (2011). Depression, antidepressants, and neurogenesis: A critical reappraisal. *Neuropsychopharmacology*, (36), 2589-2602. doi:10.1038/npp.2011.220
- Hellsten, J., Wennstrom, M., Mohapel, P., Ekdahl, C. T., Bengzon, J., & Tingstrom, A. (2002). Electroconvulsive seizures increase hippocampal neurogenesis after chronic corticosterone treatment. *European Journal of Neuroscience*, 16(2), 283-290. doi:10.1046/j.1460-9568.2002.02093.x
- Heo, M., Murphy, C. F., Fontaine, K. R., Bruce, M. L., & Alexopoulos, G. S. (2008). Population projection of US adults with lifetime experience of depressive disorder by age and sex from year 2005 to 2050. *International Journal of Geriatric Psychiatry*, 23(12), 1266-1270. doi:10.1002/gps.2061
- Hirst, W. D., Price, G. W., Rattray, M., & Wilkin, G. P. (1998). Serotonin transporters in adult rat brain astrocytes revealed by [³H]5HT uptake into glial plasmalemmal vesicles. *Neurochemistry International*, 33(1), 11-22. doi:10.1016/S0197-0186(05)80003-8
- Inta, D., & Gass, P. (2015). ECT and striatal plasticity. *Brain Stimulation*, 8(1), 166-167. doi:10.1016/j.brs.2014.11.007
- Kellner, C., Kaicher, D. C., Banerjee, H., Knapp, R. G., Briggs, M. C., Pasculli, R. M., . . . Popeo, D. M. (2015). Depression severity in electroconvulsive therapy (ECT) versus pharmacotherapy trials. *The Journal of ECT*, 31(1), 31-33. doi:10.1097/YCT.0000000000000135
- Kempermann, G., Kuhn, H. G., & Gage, F. H. (1997). More hippocampal neurons in adult mice living in an enriched envi-

USE OF ECT

- ronment. *Nature*, 386(6624), 493-495. doi:10.1038/386493a0
- Khan, A., Khan, S. R., Shankles, E. B., & Polissar, N. L. (2002). Relative sensitivity of the Montgomery-Asberg Depression Rating Scale, the Hamilton Depression rating scale and the Clinical Global Impressions rating scale in antidepressant clinical trials. *International Clinical Psychopharmacology*, 17(6), 281-285. doi:10.1097/00004850-200211000-00003
- Labbate, L. A., Grimes, J., Hiaes, A., Oleshansky, M. A., & Arana, G. W. (1998). Sexual dysfunction induced by serotonin reuptake antidepressants. *Journal of Sex & Marital Therapy*, 24(1), 03-12. doi:10.1080/00926239808414663
- Laplante, P., Diorio, J., & Meaney, M. J. (2002). Serotonin regulates hippocampal glucocorticoid receptor expression via a 5HT7 receptor. *Developmental Brain Research*, 139(2), 199-203. doi:10.1016/S0165-3806(02)00550-3
- Leucht, S., Kane, J., Kissling, W., Hamann, J., Etschel, E., & Engel, R. (2005). Clinical implications of brief psychiatric rating scale scores. *British Journal of Psychiatry*, 187(4), 366-371. doi:10.1192/bjp.187.4.366
- Loo, C. K., Schweitzer, I., & Pratt, C. (2006). Recent advances in optimizing electroconvulsive therapy. *Australian and New Zealand Journal of Psychiatry*, 40(8), 632-638. doi:10.1111/j.1440-1614.2006.01862.x
- Ludwig, J., & Marcotte, D. E. (2005). Antidepressants, suicide, and drug regulation. *Journal of Policy Analysis and Management*, 24(2), 249-272. doi:10.1002/pam.20089
- MacQueen, G., Parkin, C., Marriot, M., Begin, H., & Hasey, G. (2007). The long-term impact of treatment with electroconvulsive therapy on discrete memory systems in patients with bipolar disorder. *Journal of Psychiatry & Neuroscience*, 32(4), 241-249.
- Madsen, T. M., Treschow, A., Bengzon, J., Bolwig, T. G., Lindvall, O., & Tingström, A. (2000). Increased neurogenesis in a model of electroconvulsive therapy. *Biological Psychiatry*, 47(12), 1043-1049. doi:10.1016/S0006-3223(00)00228-6
- Malberg, J. E., Eisch, A. J., Nestler, E. J., & Duman, R. S. (2000).

USE OF ECT

- Chronic antidepressant treatment increases neurogenesis in adult rat hippocampus. *Neuroscience*, 20(24), 9104-9110.
- Mann, J. J. (1999). Role of the Serotonergic System in the Pathogenesis of Major Depression and Suicidal Behavior. *Neuropsychopharmacology*, 21(2), 99S-105S. doi:10.1016/S0893-133X(99)00040-8
- Marken, P., & Munro, J. (2000). Selecting a selective serotonin reuptake inhibitor: clinically important distinguishing features. *Prim Care Companion J Clin Psychiatry*, 2(6), 205-210.
- McEwen, B. S. (1995). Stress-induced atrophy of apical dendrites of hippocampal CA3c neurons: Involvement of glucocorticoid secretion and excitatory amino acid receptors. *Neuroscience*, 69(1), 89-98. doi:10.1016/0306-4522(95)00259-L
- McEwen, B. S. (1999). Stress and hippocampal plasticity. *Annual Review of Neuroscience*, 22, 105-122. doi:10.1146/annurev.neuro.22.1.105
- Meyer, J. H., Ginovart, N., Boovariwala, A., Sagrati, S., Hussey, D., Garcia, A., & Young, T. (2006). Elevated monoamine oxidase A levels in the brain: an explanation for the monoamine imbalance of major depression. *Arch Gen Psychiatry*, 66(12), 1304-1312. doi:10.1001/archpsyc.63.11.1209
- Portas, C. M., Bjorvatn, B., & Ursin, R. (2000). Serotonin and the sleep/wake cycle: special emphasis on microdialysis studies. *Progress in Neurobiology*, 60(1), 13-35. doi:10.1016/S0301-0082(98)00097-5
- Ramachandriah, C. T., Subramanyam, N., Bar, K. J., Baker, G., & Yeragani, V. K. (2011). Antidepressants: From MAOIs to SSRIs and more. *Indian Journal of Psychiatry*, 53(2), 180-182. doi:10.4103/0019-5545.82567
- Rotheneichner, P., Lange, S., O'Sullivan, A., Marschallinger, A., Zaunmair, J., Geretsegger, P., . . . Couillard-Despres, S. (2014). Hippocampal neurogenesis and antidepressive therapy: Shocking relations. *Neural Plasticity*. doi:10.1155/2014/723915
- Schloesser, R. J., Manji, H. K., & Martinowich, K. (2009). Suppression of adult neurogenesis leads to an increased hypo-

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- thalamo-pituitary-adrenal axis response. *Neuroreport*, 20(6), 553-557. doi:10.1097/WNR.0b013e3283293e59
- Smith, K., Fairburn, C., & Cowen, P. (1997). Relapse of depression after rapid depletion of tryptophan. *Lancet*, 349(9056), 915-919. doi:10.1016/S0140-6736(96)07044-4
- Smolders, I., Loo, J. V., Sarre, S., Ebinger, G., & Michotte, Y. V. (2001). Effects of dietary sucrose on hippocampal serotonin release: a microdialysis study in the freely-moving rat. *British Journal of Nutrition*, 86(2), 151-155. doi:10.1079/BJN2001360
- Theilmann, W., Loscher, W., Socala, K., Frieling, H., Bleich, S., & Brandt, C. (2014) A new method to model electroconvulsive therapy in rats with increased construct validity and enhanced translational value. *Journal of Psychiatric Research*, 53, 94-98.
Doi:10.1016/j.jpsychires.2015.02.007
- Uppal, V., Dourish, J., & Macfarlane, A. (2010). Anaesthesia for electroconvulsive therapy. *Oxford Journals*. doi:10.1093/bja-ceaccp/mkq039
- Voineskos, A., Winterburn, J., Felsky, D., Pipitone, J., Rajji, T., Mulsant, B., & Chakravarty, M. (2015). Hippocampal (subfield) volume and shape in relation to cognitive performance across the adult lifespan. *Human Brain Mapping*. doi:10.1002/hbm.22825
- Warner-Schmidt, J. L., Madsen, T. M., & Duman, R. S. (2008). Electroconvulsive seizure restores neurogenesis and hippocampus-dependent fear memory after disruption by irradiation. *European Journal of Neuroscience*, 27(6), 2008. doi:10.1111/j.1460-9568.2008.06118.x
- Zhu, X., Yan, H., Zhang, J., Qu, H., Qiu, X., Chen, L., . . . Li, S. (2010). Intermittent hypoxia promotes hippocampal neurogenesis and produces antidepressant-like effects in adult rats. *The Journal of Neuroscience*, 30(38), 12653-12663. doi:10.1523/JNEUROSCI.6414-09.2010

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Appendix A

Tables and Figures

Table 1

Descriptive statistics for critical values

	Mean	Std. Deviation	N
Eating disorders	75.5556	15.59547	63
Stress	23.3333	6.56481	63
Sleep quality	12.0794	7.03746	63

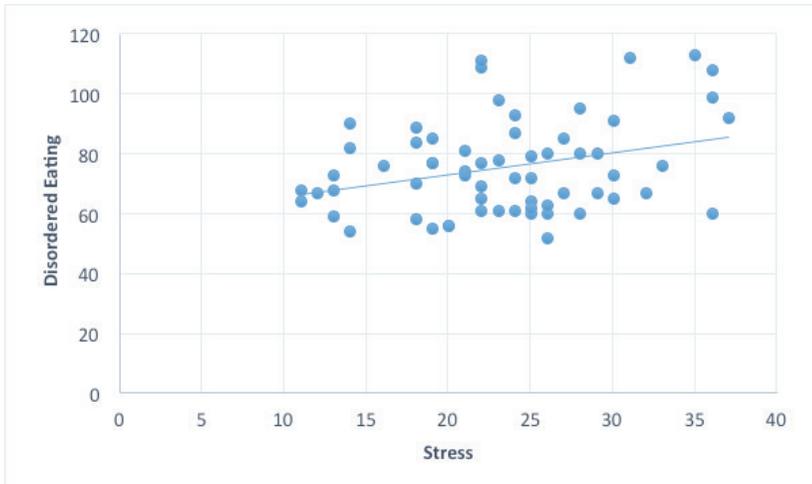


Figure 1. Regression line between stress (x axis) and disordered eating (y axis)

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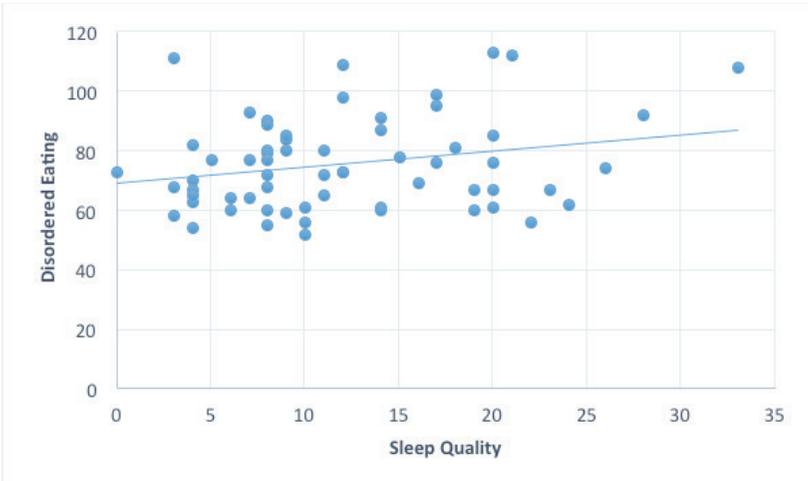


Figure 2. Regression line between sleep quality (x axis) and disordered eating (y axis)

The Influence of Group Dynamics on Eating Disorders

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Abstract:

Eating disorders can have a devastating effect on individuals both physically and psychologically. For this reason, it is important to understand diverse factors, including group dynamics, that affect the development of eating disorders. I examined the influence of group dynamics on whether eating disorders are viewed as acceptable. Further understanding of social influence may enhance the prevention of eating disorders.

Keywords: eating disorders, anorexia nervosa, bulimia, bingeing, binge eating, group dynamics, groupthink, in-groups, out-groups

Intuition: The BYU Undergraduate Journal of Psychology

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Formation

At a time when obesity is more common than ever before, the simultaneous preoccupation with pencil-thin bodies may be understandable (Ogden, Carroll, Kit, & Flegel, 2012). Eating disorders are associated with physical, such as anemia, constipation, and osteoporosis, and are often accompanied by mental disorders, such as depression, anxiety disorders, and substance abuse (American Psychological Association, 2011). Eating disorders develop from several factors (“Eating Disorders,” 2011). In particular, group interactions may be a key factor in the reinforcement of destructive eating patterns (Day & Keys, 2008).

Consequently, changing negative group dynamics might prevent the development of eating disorders. For example, Marcos, Sebastian, Aupalat, Ausina, and Treasure (2013) argued that harmful role models may promote the development of such disorders, and Kao, Rogers, Spitzmueller, Lin, & Lin (2014) urged that educational efforts led by positive mentors could reduce the prevalence of eating disorders.

Factors in the Development of Eating Disorders

Environmental and biological factors influence the

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development of eating disorders. Easter (2011) focused on the influence of genes, emphasizing the genetic predisposition to mental disorders, including addictions, as part of a “complex causal eating model” (p. 23). Other factors in the model included culture, gender, family, and personality.

Similarly, Fay and Lerner (2013) found that individuals with a higher likelihood of eating pathology and body dissatisfaction tended to be female, perceived themselves as overweight, had higher-than-average actual body weights, and experienced lower self-esteem. They authors reported that long-term participation in sports in general had no effect on the likelihood of eating disorders. Anderson, Petrie, Reel, and SooHoo (2013) studied body-weight pressures in female athletes and found that sports, such as gymnastics, presented a “greater risk due to a heightened focus on appearance as it relates to performance success” (p. 138).

Group Dynamics as a Factor in the Etiology of Eating Disorders

According to Cruwys et al. (2012) the groups a person interacts with play a critical role in her or his eating habits, for example, menu choices (see Ellisoin, 2014). Cruwys et al. found that

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the degree to which a person identified as a member of a group corresponded directly to the group's influence on menu preferences determine eating habits. Similarly, Howland, Hunger, and Mann (2012) found that, as Friend A in a dyad changed or restricted her or his eating habits, Friend B changed her or his as well and not only when around Friend A but also in private.

Marcos, Sebastián, Aubalat, Ausina, and Treasure (2013) reported that friends and family members influenced an individual's body image and body-image satisfaction. Crandall (1988) found that binge eating was a social norm among college women who belonged to sororities and that popularity increased with more frequent bingeing.

An Example of Media Influence

To illustrate the powerful influence of media, I will describe an extreme case of eating disorders as lifestyle. The online group Ana and Mia support anorexia nervosa and bulimia as personal lifestyle choices (Day & Key, 2008). This virtual group initially challenged the image that a person with an eating disorder is passive and helpless. Instead, they sought to empower women diagnosed with such disorders by providing dangerous "tips

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and tricks.” They also reinforced the thin-female body image (Harshbarger, Ahlers-Schmidt, Mayans, Mayans, & Hawkins, 2009).

Family Group Therapy for Eating Disorders

Brauhardt, Zwaan, and Hilbert (2014) reported on the treatment of eating disorders occurs within a treatment framework that may include admission to a hospital or specialized center in order to gain weight to a predetermined point; individual, group, and family psychotherapy or counseling; multidisciplinary social and occupational therapy; and prolonged outpatient follow-up after discharge (see also Ben-Tovim, 2003).

Family counseling and family therapy are often part of the treatment. For example, , a therapist might work not only the individual who has been diagnosed but with her or his family as well (Bean, Louks, Kay, Cornella-Carlson, & Weltzin, 2010).

The Maudsley method (McCullough, 2013).is a form of family therapy based on the idea that parents play an important role in a child’s recovery from an eating disorder and is aimed to empower the family to find solutions to problems associated

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with the disorder. (Rather than blaming the family for the disorder, they are viewed as a force for good (Bean et al. , 2010). The eating-disorder patient's parents have an essential role in reaching three treatment goals: restoring the patient's body weight to normal levels based on height and age, placing the responsibility for eating choices on the patient, and helping the patient work through emotional and physical developmental issues that may be restricting recovery (Bean et al., 2010). This method takes these aims and divides them into three phases. The first goal is to restore a healthy body in order to prevent common secondary health issues, such as malnutrition, primary hypothermia, cardiac dysfunction, psychological and cognitive deficits, and growth and hormonal changes. To achieve the second goal, the therapeutic process might include conversations about other settings, such as school or specific social events, and how the patient can maintain a healthy body weight within them. Throughout the course of family therapy, the therapist may help the patient and other family members to establish appropriate relational boundaries with the family (McCullough, 2013).

Initially, parents of children with eating disorders may feel powerless and guilty. In one family's experience (Parent

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& Parent, 2007), the parents observed their daughter Ann's g failed attempts at treatment. They began to educate themselves about treatment options and discovered the Maudsley method. After consulting with the family's Maudsley treatment team, which consisted of a child psychiatrist, his staff, and Ann's pediatrician, Ann began the process of refeeding. Her parents were encouraged to find ways to help Ann manage her eating. According to the parents, "We learn[ed]. . . her destructive behaviors and her insistence that she 'didn't want to get better' were all just symptoms of an illness over which she had no meaningful control" (p. 72). They reported that, as they were consistent in helping her eat and expressing their love for her, her body weight increased. Conflicts about weight gain were not as extensive as they were previously (McCullough, 2013). The last of her symptoms to remit were fear of eating and displeasure in eating. Four months after reaching her healthy body weight, Ann was able to return to school.

Other Approaches

As members of a group interact, one or more members of the group may model eating habits for other group members (Cruwys et al., 2012). Positive group dynamics, such as those

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in the case study described above, may lead to lasting recovery from eating disorders. Current methods for eating-disorder prevention include two strategies: “inoculation” and early-adolescence intervention. Inoculation refers to the effort to educate people about the negative effects of eating disorders (Brauhardt, de Zwaan, & Hilbert, 2014). It assumes that, if the devastating effects that permeate the media are understood, a person’s resistance to them will increase. Early intervention requires the detection of likely symptoms, such as body-image dissatisfaction and repetitive dieting, during adolescence and providing intervention promptly.

Mentoring can also be effective (Kao et al., 2014).

Schools may be an ideal setting for the implementation of such programs (Smith & Hollman, 2013). Older students could be selected to serve as mentors to younger students regarding exercise and wellness, healthy eating, and other factors related to the development of eating disorders.

References

- Allison, S., Warin, M., & Bastiampillai, T. (2014). Anorexia nervosa and social contagion: Clinical Implications. *Australian & New Zealand Journal of Psychiatry*, 48(2), 116 –120. doi: 10.1177/0004867413502092
- Parent, B. A., & Parent, T. C. (2007). Anorexia, Maudsley and an impressive recovery: One family’s story. *Journal of*

GROUP DYNAMICS AND EATING DISORDERS

- Pediatrics and Child Health, 44, 70–73. doi: 10.1111/j.1440-1754.2007.01235.x
- Bean, P., Louks, H., Kay, B., Cornella-Carlson, T., & Weltzin, T. (2010). Clinical observations of the impact of Maudsley therapy in improving eating disorder symptoms, weight, and depression in adolescents receiving treatment for anorexia nervosa. *Journal of Groups in Addiction & Recovery*, 5(1), 70–82.
- Ben-Tovim, D. (2003). Eating disorders: Outcome, prevention and treatment of eating disorders. *Current Opinion in Psychiatry*, 16(1), 65–69.
- Berel, S., & Irving, L. M. (1998). Media and disturbed eating: An analysis of media influence and implications for prevention. *Journal of Primary Prevention*, 18(4), 415–430.
- Brauhardt, A., de Zwaan, M., & Hilbert, A. (2014). The therapeutic process in psychological treatments for eating disorders: A systematic review. *International Journal of Eating Disorders*, 47(6), 565–584.
- Campbell, P. G. (1995). What would a causal explanation of the eating disorders look like? In G. I. Szmukler, C. Dare, & J. Treasure (Eds.), (pp. 49-64). Oxford, UK: John Wiley & Sons.
- Ciao, A. C., Loth, K., & Neumark-Sztainer, D. (2014). Preventing eating disorder pathology: common and unique features of successful eating disorders prevention programs. *Current Psychiatry Reports*, 16(7), 453. doi:10.1007/s11920-014-0453-0
- Condit, V. K. (1990). Anorexia nervosa: Levels of causation. *Human Nature*, 1(4), 391–413.
- Crandall, C. S. (1988). Social contagion of binge eating. *Journal of Personality and Social Psychology*, 55(4), 588–598. doi:10.1037/0022-3514.55.4.588
- Cruwys, T., Platow, M. J., Angullia, S. A., Chang, J. M., Diller, S. E., Kirchner, J. L., . . . Wadley, A. L. (2012). Modeling of food intake is moderated by salient psychological group membership. *Appetite*, 58(2), 754–757. doi:10.1016/j.appet.2011.12.002

GROUP DYNAMICS AND EATING DISORDERS

- Day, K., & Keys, T. (2008). Starving in cyberspace: A discourse analysis of pro-eating-disorder websites. *Journal of Gender Studies*, 17(1), 1–15.
- Easter, M. M. (2011). “Some sort of larger force at work”: Meanings and implications of genetics for women with eating disorders (Doctoral dissertation). Retrieved from ProQuest Information & Learning. Dissertation Abstracts International Section A: Humanities and Social Sciences. (UMI No. 3418516)
- Eating Disorders. (2011). National Institute of Mental Health. Retrieved from <http://www.nimh.nih.gov/health/publications/eating-disorders/index.shtml#pub3>
- Ellison, B. (2014). “I’ll have what he’s having”: Group ordering behavior in food choice decisions. *Food Quality & Preference*, (37), 79-86. doi:10.1016/j.foodqual.2014.04.012
- Evans, J., Rich, E., & Holroyd, R. (2004). Disordered eating and disordered schooling: What schools do to middle class girls. *British Journal of Sociology of Education*, 25(2), 123–142. doi:10.1080/0142569042000205154
- Fay, K., & Lerner, R. M. (2013). Weighing in on the issue: A longitudinal analysis of the influence of selected individual factors and the sports context on the developmental trajectories of eating pathology among adolescents. *Journal of Youth and Adolescence*, 42(1), 33–51. doi:10.1007/s10964-012-9844-x
- Harshbarger, J. L., Ahlers-Schmidt, C. R., Mayans, L., Mayans, D., & Hawkins, J. H. (2009). Pro-anorexia websites: What a clinician should know. *International Journal Of Eating Disorders*, 42(4), 367-370.
- Howland, M., Hunger, J. M., & Mann, T. (2012). Friends don’t let friends eat cookies: Effects of restrictive eating norms on consumption among friends. *Appetite*, 59(2), 505–509.
- Janis, I. L. (1972). *Victims of groupthink*. Boston, MA: Houghton Mifflin.
- Kao, K., Rogers, A., Spitzmueller, C., Lin, M., & Lin, C. (2014). Who should serve as my mentor? The effects of mentor’s gender and supervisory status on resilience in mentoring

GROUP DYNAMICS AND EATING DISORDERS

- relationships. *Journal of Vocational Behavior*, 85(2), 191–203. doi: 10.1016/j.jvb.2014.07.004
- Krentz, E. M., & Warschburger, P. (2011). Sports-related correlates of disordered eating in aesthetic sports. *Psychology of Sport and Exercise*, 12(4), 375–382. doi:10.1016/j.psychsport.2011.03.004
- Marcos, Y., Sebastián, M. J., Aupalat, L., Ausina, J., & Treasure, J. (2013). Peer and family influence in eating disorders: A meta-analysis. *European Psychiatry*, 28(4), 199–206. doi:10.1016/j.eurpsy.2012.03.005
- McCullough, C. B. (2013). Parental experience of phase one of a modified Maudsley treatment approach for their adolescent with an eating disorder: A qualitative study (Electronic Thesis or Dissertation). Retrieved from <https://etd.ohiolink.edu/>
- Overweight and Obesity Statistics. (2012). Washington, DC: National Institute of Diabetes and Digestive and Kidney Disease. Retrieved from <https://www.niddk.nih.gov/health-information/health-statistics/Pages/overweight-obesity-statistics.aspx>
- Ogden, C., Carroll, M., Kit, B., & Flegal, K. (2012). Prevalence of obesity in the United State, 2009–2010. *NCHS Data Brief*, (82).
- Peskin, M. F. (2010). Moving prevention research forward. *Journal of Primary Prevention*, 31(4), 189–190.
- Reel, J., Petrie, T., SooHoo, S., & Anderson, C. (2013). Weight pressures in sport: Examining the factor structure and incremental validity of weight pressures in sport—females. *Eating Behaviors*, 14(2), 137–144. doi:10.1016/j.eatbeh.2013.01.003
- Russel, L., & Laszlo, B. (2013). A group for men with eating disorders: When “lone wolves” come together. *Men and Masculinities*, 16(2), 252–259. doi:10.1177/1097184X1348
- Smith, L. H., & Holloman, C. (2013). Comparing the effects of teen mentors to adult teachers on child lifestyle behaviors and health outcomes in Appalachia. *Journal of School Nursing : The Official Publication of the National Association of School Nurses*, 29(5), 386–396. doi:10.1177/1059840512472708

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Why is it important to seek treatment for these disorders?

(2011). APA Help Center Online. Retrieved from <http://www.apa.org/helpcenter/eating.aspx>

Yuile, A., & McVey, G. (2009). The role of social influence in the prevention of disordered eating among girls. *Advances in School Mental Health Promotion*, 2(4), 47–60. doi:10.1080/1754730X.2009.9715716

The Effects of Daily Media Consumption on Adolescent Girls

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*Intuition: The BYU Undergraduate
Journal of Psychology*

Abstract:

Media infiltrates society so heavily that it can seem impossible to go an entire hour without viewing several different platforms of media. This paper seeks to explore the effects that daily media consumption has on teenage girls, as well as which types of media can be a foundation for eating disorders, self-esteem problems, loss of identity and heightened jealousy. An additional focus is how much of each media type can be consumed before these effects are evident.

Through examining studies that investigate the effects of Facebook, music videos, fashion magazines and television shows, evidence suggests that adolescent girls experience negative effects similar to those listed above. Facebook can increase feelings of envy and life dissatisfaction; music videos can twist the perception of healthy sexual relationships; fashion magazines can be correlated with eating disorders, and television can bring about a loss of one's self-esteem. By heightening parental involvement in adolescent's media intake, false perceptions of reality in body image or sexual relationships can be eliminated.

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Throughout recent decades, the use of media-based technology has heightened society's global connection. Media helps maintain friendships with loved ones that live across the globe and increases the ability to work away from home. However, there are limits to the benefits of media-based technologies. Research has shown that media can damage relationships and increase crime (Helfgott, 2015; Reizer & Hetsroni, 2014). The damaging effects of the media touch youth specifically; for them, social norms are developed from what they see in the media rather than in real life (Ayala, Mickens, Galindo & Elder, 2007).

Teenagers are no strangers to the media. In fact, adolescents in the United States of America spend an average amount of 6.75 hours a day using some form of media—most commonly television—and this usage typically occurs when a parent is otherwise occupied in another task (Roberts, 2000). As well, when teenagers graduate from high school, statistics show that they have spent as much, if not more, time watching the television than learning in the classroom throughout their whole lives (Roberts, 2000). While it is unknown exactly what the teenager is watching, research highlights that the most popular television shows among teenagers contain 6.7

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sexual scenes per hour, higher than other demographics (Wright, 2009) There are risks involved with watching a highly sexualized show that contains unrealistic body images, one of which is that women are portrayed as sex objects (Peter & Valkenburg, 2007). These hours in front of the television with no parental involvement can mean that youths may perceive all kinds of unrealistic lifestyles without filter.

Some believe that media consumption has increased, but this could be attributed to the multiple technologies that fall under the umbrella of “media” nowadays. Looking back in time, media was not used as much as it is today, but this could be due to how few media outlets there were (Mayer, 1993). In 1979, newspapers were the most common outlet of media (Mayer, 1993; Roberts, 2000). In today’s world, adolescents have access to much more exciting forms of media, like internet, movies, video games and social media. Even when using one form of media, young people’s appetite for consumption may still not be satiated, as 15% of total media time is spent using two or more media outlets concurrently (Roberts, 2000). Ultimately, it’s clear that the increase in media channels have elicited greater use among teenagers.

Although everybody can experience the effects of

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media use, this paper will focus on the effect that media has on adolescent girls. Adolescence is a period of life during which humans discover their identity, so their minds are very impressionable. Because of this, images depicted in the media can be seen as the standard for normality and popularity (Chia & Gunther, 2006; Young & Jordan, 2013). Females of this age are not the only people to experience the sinister effects of media consumption, but a lot of research has been dedicated to studying this specific demographic. The negative effects associated with media use may come because of a genetic predispositions associated with developmental age or gender (Baker et al., 2009; Culbert, Burt, McGue, Iancono, & Klump, 2009; Eliot, 2004;). However, adolescent girls could be consuming more of the types of media that lead to dangerous effects, or that trigger negative effects because of their genetic predisposition. These dangerous effects result in negative behaviors like disordered eating or unhealthy sexual behaviors (Ayala et al., 2007; Chia & Gunther, 2006; Peter & Valkenburg, 2007). Rather than focus on genetic predispositions, this analysis will seek to understand the role media plays in eliciting harmful effects.

This paper will focus on how much of the media's

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influence can be consumed before it can be considered “unhealthy” and what types of media are more commonly found to instigate harmful effects. However, it shouldn’t be concluded that the recent rise in media consumption will only have negative effects. But, the appropriate amount of usage and the risks that are run with each media outlet must be considered. Specifically, Facebook can lead to social comparison, music videos can lead to unhealthy or harmful sexual behaviors, fashion magazines can lead to eating disorders and television can lead to a lower self-esteem (Becker, 2004; Mabe, Forney, & Keel, 2014; Nesi & Prinstein, 2015; Peterson, Wingood, DiClemente, Harrington & Davies, 2007; Shaw, 1995).

Facebook

Having online friendships is positively correlated with life satisfaction ratings—that finding does not seem to be a negative outcome of Facebook use (McAndrew & Jeong, 2012). However, recent research is beginning to note the potential hazards of certain types of Facebook use. One study found that most Facebook users are predominantly females who have a desire to look at the profiles of other females of the same

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age range (McAndrew & Jeong, 2012). When compared to women who infrequently use Facebook, it has been noted that higher feelings of jealousy are present in women who often use Facebook (Muise, Christofides & Desmarais, 2009). This could be because Facebook is not only used for social interaction but also self-expression (McAndrew & Jeong, 2012). Women are also more likely to use Facebook for the purpose of impression management – trying to control the way other Facebook users perceive them (McAndrew & Jeong, 2012). Those with disordered eating behaviors are also more likely to un-tag themselves from photos perceived as undesirable for their profile (Mabe, Forney, & Keel, 2014). This shows impression management, a behavior that adolescent girls can fall into with compulsive Facebook use. Hence, the representations on the site may not always be accurate.

Commonly, most people use the Facebook app on their smart phone multiple times a day. Research shows that the average college student can spend up to 100 minutes on Facebook, especially looking at photos (Mabe et al., 2014; Meier & Gray, 2014). Research has found that there are higher rates of eating disorders among girls who use Facebook weekly (Mabe et al., 2014). This is attributed to the fact that Facebook gives

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rise to two pressures that reinforce the belief that thin is best: peers and media (Mabe et al., 2014; Meier & Gray, 2014).

Facebook photos most likely account for disordered eating because of the ability to edit them and because of the reinforcing nature of “likes” (Mabe et al., 2014). If an insecure teenage girl posts an unedited picture that receives minimal “likes,” it is possible that this outcome can reinforce her insecurity. Whereas, if a “popular” girl posts an unrealistically edited photo that receives a plethora of “likes,” her behavior has been reinforced and is more likely to be repeated. The insecure girl might see the edited image of the popular girl, and think that having skin as flawless or a waist as thin is what she needs to do to obtain “likes”. This is one example of how Facebook use can lead to disordered eating among teenage girls. Studies also found that great emphasis is placed on receiving positive comments or “likes” on photos (Mabe et al., 2014). Dissatisfaction can be felt when these positive reinforcements do not come, a dissatisfaction that can lead to eating disorders. It can be said that just Internet use as a whole could increase a female’s unhealthy body perceptions. However, studies have found that when compared to a control Internet group, Facebook use is correlated with a concern with

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bodyweight (Mabe et al., 2014; Sagioglou & Greitemeyer, 2015). Furthermore, it has also been found that it is the peer-comparison aspect of Facebook that can lead girls to feel dissatisfied with their own image (Mabe et al., 2014). Thus we can see that Facebook's aim to bring friends together can also backfire when people compare themselves to their friends.

It has been established that Facebook use could have a relationship with women's body image, but how it affects over all well-being is a similar topic of study. It has been found that overall well-being and life satisfaction decreases with increased Facebook use (Kross et al., 2013; Satici & Uysal, 2015). Researchers texted their participants up to five times a day for a total of 14 days with questions about life satisfaction (Kross et al., 2013). The questions they asked their participants surrounded physical and cognitive satisfaction with their lives after Facebook use (Kross et al., 2013). More complex than just attributing it to "Facebook use", multiple factors like "Facebook friends, perceived supportiveness of ones online network, depressive symptomology, loneliness and self-esteem" all contribute to the way that Facebook makes its users feel (Kross et al., 2013, pg. 1). We can see that it is not the initial Facebook use that decreases well-being, but rather the deciding factors

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are the pre-disposed life situation and happiness that the user is already subject to. Facebook can either increase or decrease according to the levels of happiness that are already present. Studies show that low life satisfaction can be a predictor of Facebook overuse (Satici & Uysal, 2015). This means that low levels of life satisfaction and Facebook use have a circular relationship – both influence one another.

Facebook can be central to young people's social lives, so it is difficult to say that it must be boycotted in order to maintain overall well-being. It could be almost impossible to completely avoid Facebook, but if youths were more educated on the risks of such use, problems with self-esteem and life satisfaction could decrease. Certain boundaries should be put in place to ensure positive Facebook use.

Adding to these findings, studies have shown that Facebook use can be directly related to mood. When compared to no Facebook use, it has been found that even 10 minutes of Facebook use each day can result in a more negative mood (Fardouly, Diedrichs, Vartanian, & Halliwell, 2015; Sagioglou & Greitemeyer, 2014). It seems counterproductive to use a social networking site designed to connect us with friends if it results in a more negative mood. If negative moods become

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frequent, they can become negative attitudes and negative outlooks. This is evident in how Facebook use has also been positively correlated with women's dissatisfaction with their face, hair and skin (Fardouly et al., 2015). Interestingly, it is not correlated with women's weight dissatisfaction (Fardouly et al., 2015). This could be explained with the high statistic of women who only post photos displaying themselves from only their shoulders and up (Fardouly et al., 2015). Without many images of the whole body, overall weight is not the focus of women's dissatisfaction. Still, Facebook clearly has an impact on women's perceptions of their bodies, manifested through moods and levels of satisfaction.

Additionally, depressive moods can be brought on as a result of different types of Facebook use. Passive Facebook use can be defined as using Facebook to view other people's profiles, while active Facebook use can be defined as using Facebook to post images or inform others about one's own life. After conducting a six-month study on 12-19 year olds, experimenters found that passive Facebook use increased feelings of loneliness and depressive moods, while active Facebook use decreased feelings of loneliness and depressive moods (Frison & Eggermont, 2015). These feelings are brought

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about regardless of whether the participant was using Facebook in a public or in a private setting (Frison & Eggermont, 2015). Studies have also looked into the effect that perceived social support on Facebook can have on adolescents. Results found that a lack of social support, or negative social support, strongly correlated with depressive moods (McCloskey, Iwanicki, Lauterback, Giammittorio, & Maxwell, 2015). Researchers concluded that Facebook cannot be used as a therapeutic intervention for depression (McCloskey et al., 2015). Thus it can be concluded that the way adolescent girls use Facebook, as well as what support they feel while online, can have a negative impact on depressive moods.

These results could be accounted for by another variable perhaps not taken into consideration; maybe those adolescents who are already feeling lonely feel no reason to post anything to Facebook, and as a result do not receive any “likes” or comments, and thus the loneliness increases. On the other hand, those who feel that they have a supportive network around them may have the confidence to post images and in turn receive feedback, thus increasing the belief that people care about them. While this study does not specify how much time can be spent using Facebook before these effects may occur, it

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does highlight an important concept: the way Facebook is used.

From each of these studies, it could be concluded that Facebook can lead users, especially adolescent girls, to feel envy towards other girls and to be dissatisfied with their own body image or life. This is because it can lead woman to make peer comparisons as well as reinforce the idea that comments and “likes” are an important validation. Ultimately, Facebook is a tool that can yield positive and negative effects dependent on how it is used.

Music Videos

Music videos are a more specific genre of media when compared to television or video games, so the effects that they have on audiences are only recently beginning to be studied. It seems as if sex and music videos go hand-in-hand. In fact, two-thirds of music videos contain sexual content and erotic behavior (Oosten, Petter, & Valkenburg 2015). Music videos by nature are shorter than films or time spent on Facebook. Usually, music videos last about 3-4 minutes. Exposure to sexual and violent content does not take long because of the shortness of the videos, meaning that even small amounts of intake yields high amounts of objectification (DuRant et al.,

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1997; Peterson et al., 2007). Even brief amounts of exposure can lead to higher amounts of sexual permissiveness before marriage and increased acceptance of anti-social behavior (Peterson et al., 2007). Hence, it's important that young women know the responsible way to watch music videos.

Music videos also reinforce harmful gender stereotypes. Typically, females are shown in submissive sexual roles while males are more dominant and sexually aggressive (Peterson et al., 2007; van Oosten et al., 2015). Females are even depicted as mere props to the overall *mise en scène* of the video (Frisby & Aubrey, 2012). Opinions about the definition of a healthy sexual relationship are being based on images of women who are being coerced into sex and images of female token resistance - the belief that when a woman says no to sexual advances, she is really just playing 'hard to get' (van Oosten et al., 2015). During adolescence, teenagers are forming ideas and impressions on sexual matters and these music videos may lead to the idea that these kinds of imbalanced sexual relationships are the norm (van Oosten et al., 2015). It's clear that young people—and especially young women— can quickly internalize the gender stereotypes represented in music videos.

In music videos, gender stereotypes are not the only

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representation of how women should act. Studies have found that when adolescent girls watch sexualized music videos, their beliefs in misogyny and male sexual dominance as the norm increase. Commonly, when adolescent females repeatedly see images like this, they learn that if they express their sexual desires explicitly, they are “bad girls” and instead should wait for sexual advances from males (van Oosten et al., 2015). Another experiment showed female college students a highly sexualized music video or a non-sexualized music video, then rated their perceptions of blame in a date-rape scenario (Burgess & Burpo, 2012). It was found that the girls who viewed a sexualized music video blamed the female victim of the date rape as being responsible for the event (Burgess & Burpo, 2012). This shows that sexual content in music videos leads young women to accept that men are not in control of their sexual desires and it is a woman’s fault if men desire them. Essentially these videos imply that women are objects designed to satisfy men’s sexual needs (van Oosten et al., 2015). Clearly, the misogynistic lessons learned by women are infiltrating their beliefs and actions.

In regards to genre, researchers have considered the effect music videos may have on African-American teenage

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girls, particularly rap music videos (Peterson et al., 2007). Rap music is most commonly associated and performed by African-Americans. So as young African-American girls watch these videos and see members of their own culture achieving fame through the means portrayed, they perceive highly sexualized images as the norm (Peterson et al., 2007). Common themes among rap music videos are “economic deprivation, racial injustice, social isolation, dysfunctional families, violence, hopelessness, pain, and struggle for survival” (Peterson et al., 2007, p. 1158). Recent studies have even shown that rap music and rock music contain more violence and use of weapons than other genres of music (DuRant et al., 1997). When African-American teenage girls watch rap music videos, research found that they are more likely to have multiple sexual partners, become engaged with drug and alcohol use, become involved with boys who do drugs and be tested positive for a sexually transmitted disease (Peterson et al., 2007). As seen, the false realities of music videos have very real effects on girls’ lives, regardless of ethnicity.

We can note that not every music video will damage the viewer. The types of music videos that are most likely to show sexual objectification are hip-hop, R&B, rap and pop, so these

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are the genres to take extra care with when viewing. However, these genres of music are among the most popular in today's music world. It can difficult to avoid, as they are usually the genre's that comprise the top 100. Negative beliefs about healthy sexual relationships can come about after minimal exposure to sexualized music videos. These beliefs can lead to negative sexual behaviors, specifically date rape, belief in female token resistance and body dissatisfaction (Peterson et al., 2007; Frisby & Aubrey, 2012). Ultimately, music videos are powerful in the ways they change how women perceive themselves and their relationships with men.

Fashion Magazines

Another media outlet that is associated with negative effects are fashion magazines. A high percentage of women struggle with self-loathing and eating disorders due to involvement in the fashion industry. For some women, even seeing the images of the thin models on the pages of magazines or catalogues, advertisements or shop windows gives them negative feelings about their bodies (Stice, Spangler, & Agras, 2001; Wiseman, Sunday, & Becker, 2005). Female models are now thinner than 98% of American women (Wiseman et al., 2005). Some studies

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have gone further to say that these effects are most obvious amongst adolescent girls, and girls with a pre-existing eating disorder, negative body image or lack of social support network (Stice et al., 2001; Wiseman et al., 2005). Not only this, but it has been found that viewing thin models can decrease women's satisfaction with their bodies and with their lives (Wiseman et al., 2005). Clearly, magazines, while small, carry a lot of weight.

When considering the effects of magazines, body dissatisfaction appears to be greater in adolescent girls than in adult women when viewing "adult" fashion images (Shaw, 1995). Researchers attribute this finding to how teenage girls are still developing their identity (Shaw, 1995). When adolescents see adult women portrayed in a certain way, it can become appealing to seek after a similar look. With that said, it cannot be generalized that every teenage girl will be categorized as being in a danger zone when viewing adult fashion images. The same study found that "age, weight and [pre-existing] bulimic tendencies" are a strong indicator on responsiveness of fashion images (Shaw, 1995, p. 20; Stice et al., 2001). Those of a lighter weight and younger age were less affected by the images they saw. Those who already showed signs of disordered eating were reinforced by the images that present a thin ideal. Regardless,

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there is a correlation between the amount of magazines read and the levels of body dissatisfaction for young women (Zuckerman, 2003) Ultimately, magazines tend to make women with image concerns more insecure.

Exposure to magazines does not have to be long in order to have an effect. Even when only presented with a quick fashion advertisement, young females experience high levels of body dissatisfaction (Fardouly et al., 2015). After measuring multiple variables of body dissatisfaction, only weight-related body dissatisfaction occurred after seeing pictures of skinny models (Fardouly et al., 2015). The other variables of body dissatisfaction included face, hair and skin variables as well as mood predictors. From this we can see that the fashion industry really targets young female's weight satisfaction. Sometimes it doesn't even have to take a fashion magazine, which by design seeks to tell women what they should look like, to encourage negative thoughts about one's own body; a 15-minute exposure to fitness and sports magazines resulted in a decrease of body satisfaction among female college undergraduates (Cameron & Ferraro, 2004). It's clear that women may compare themselves to others, no matter the magazine.

From these studies we can see that even brief exposures

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to fashion and fitness magazines result mostly in increased body dissatisfaction among women, particularly adolescents. These results do not mean that magazines should be avoided, but that girls should believe more forcefully that the bodies they see on magazine pages are digitally edited and portray an unrealistic lifestyle.

Television

In today's media saturated world, it is becoming almost impossible to go an entire day without viewing some kind of televised video. A study that looked into the effects that television usage had on Chinese females sought to demonstrate that there has been a significant rise in amount and type of media use (Peat et al., 2015). Results found that adolescent women watch television for an average of 1-½ hours a day on weekdays and 2 hours at the weekend (2015). Of the 820 adult women in the sample, almost 10% answered "yes" to the question "do you feel fat despite others thinking you are too thin?" (Peat et al., 2015). Results did not find statistically significant outcomes for the relationship between heightened use of television and heightened disordered eating. Despite not being statistically significant, television can account for more

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of the variability in disordered attitudes rather than actual disordered behaviors (Peat et al., 2015). This shows that there is a relationship between these two variables, but causation cannot be implied.

Television—particularly westernized TV—has been shown to have negative effects on teenage girls. In 1995, there was one case of an eating disorder in Fiji. Then, westernized television was introduced and shows like *Friends* began to air, gaining popularity. In 1998, 11.9% of adolescent girls were experiencing an eating disorder (Orbach, 2011). The experimenters decided to look into this sudden phenomenon of eating disorders by interviewing adolescent girls to examine their media intake and disordered eating symptoms (Becker, 2004). In a study of 65 Fijian adolescents who watched television for at least three nights a week, it was found that 50% feel overweight (Becker, 2004). Becker cannot attribute the body dissatisfaction and sometimes extreme dieting or eating disorders to just television usage, but has found television as a strong indicator of eating disorders (2004). Ultimately, television affects how young women perceive themselves. Seeing the “thin-ideal” portrayed time and again on the screen can lead teenage girls to decrease in self-esteem and develop

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eating disorders, resulting in a loss of identity.

Conclusion

The media is an outlet that must be used with caution. It is crucial to be educated in all the possible risks inherent in a life of consistent media intake. However, media users must be cautious and aware that sometimes, these forms of media can bring down self-esteem, cause jealousy and alter views about healthy sexual relationships.

Some steps to take that will decrease the negative effects of media for adolescents include parental involvement. Heightening parental involvement with adolescent's media intake can greatly decrease the output of negative sexual behaviors and low self-esteem (Schooler, Kim & Sorsoli, 2006). Having a healthy belief that the bodies used in magazine images are digitally altered can help to lessen body dissatisfaction. Recognizing that the scenarios depicted in television shows or music videos are not accurate portrayals of daily life for the common person can help viewers to avoid false perceptions of reality. Time restraints may not be a useful solution because, as stated above, it only takes 3-4 minutes for a sexualized image to be seen in a music video, or 10 minutes of Facebook use for a

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mood to turn negative.

This research does not definitively answer the question of how much the media can affect its audiences; each study has its limitations. Research still cannot definitively find which of all the media platforms can be known to produce the most harmful effects. It even still cannot answer the question of how much can each person spend using different types of media before it can become harmful. For each person, thresholds and limits are different. For example, some people may spend their 6.75 hours of television time watching educational programs or historical documents. Surely these types of shows will not have the same effects that perhaps watching a sexualized show will bring. At this point, research cannot give definite solutions to the questions that have been posed in this paper. However, one thing is certain: media is all around us, and it is up to the individual to recognize the warning signs of a behavior that decreases self-esteem or heightens negative sexual behaviors.

References

- Ayala, G. X., Mickens, L., Galindo, P., & Elder, J. P. (2007). Acculturation and body image perception among Latino youth. *Ethnicity and Health, 12*(1), 21-41.
- Baker, J. H., Maes, H. H., Lissner, L., Aggen, S. H., Lichtenstein, P., & Kendler, K. S. (2009). Genetic risk factors for disordered eating in adolescent males and females. *Journal of abnormal*

EFFECTS OF DAILY MEDIA CONSUMPTION

- psychology, 118(3), 576.
- Becker, A. E. (2004). Television, disordered eating, and young women in Fiji: Negotiating body image and identity during rapid social change. *Culture, medicine and psychiatry*, 28(4), 533-559.
- Burgess, M., & Burpo, S. (2012). The effect of music videos on college students' perceptions of rape. *College Student Journal*, 46(4), 748-763.
- Cameron, E. M., & Ferraro, F. R. (2004) Body satisfaction in college women are brief exposure to magazine images 1. Perceptual and motor skills, 98(3), 1093-1099.
- Chia, S. C., & Gunther, A. C. (2006). How media contribute to misperceptions of social norms about sex. *Mass Communication & Society*, 9(3), 301-320.
- Culbert, K. M., Burt, S. A., McGue, M., Iacono, W. G., & Klump, K. L. (2009). Puberty and the genetic diathesis of disordered eating attitudes and behaviors. *Journal of abnormal psychology*, 118(4), 788.
- DuRant, R. H., Rich, M., Emans, S. J., Rome, E. S., Allred, E., & Woods, E. R. (1997). Violence and weapon carrying in music videos: A content analysis. *Archives of pediatrics & adolescent medicine*, 151(5), 443-448.
- Eliot, A. O. (2004). A concept of self in eating-disordered adolescent girls: A consideration of genetic factors. *Annals of the American Psychotherapy Association*, 7(1), 14-24.
- Fardouly, J., Diedrichs, P. C., Vartanian, L. R., & Halliwell, E. (2015). Social comparisons on social media: The impact of Facebook on young women's body image concerns and mood. *Body Image*, 13, 38-45.
- Frisby, C. M., & Aubrey, J. S. (2012). Race and genre in the use of sexual objectification in female artists' music videos. *Howard Journal of Communications*, 23, 66-87. doi:10.1080/10646175.2012.641880
- Frisson, E., & Eggermont, S. (2015). Exploring the relationships between different types of Facebook use, perceived online social support, and adolescents' depressed mood. *Social Science*

EFFECTS OF DAILY MEDIA CONSUMPTION

Computer Review, 0894439314567449.

Helfgott, J. B. (2015). Criminal behavior and the copycat effect:

Literature review and theoretical framework for empirical investigation. *Aggression and violent behavior*, 22, 46-64.

Kross, E., Verduyn, P., Demiralp, E., Park, J., Lee, D. S., Lin, N., ... & Ybarra, O. (2013). Facebook use predicts declines in subjective well-being in young adults. *PloS one*, 8(8), e69841.

Mabe, A. G., Forney, K. J., & Keel, P. L. (2014). Do you 'like' my photo? Facebook use maintains eating disorder risk. *International Journal Of Eating Disorders*, 47(5). 516-523. doi:10.1002/eat.22254

Mayer, W. G. (1993). Poll trends: Trends in media usage. *The Public Opinion Quarterly*, 57(4), 593-611.

McAndrew, F. T., & Jeong, H. S. (2012). Who does what on Facebook? Age, sex, and relationship status as predictors of Facebook use. *Computers in Human Behavior*, 28(6), 2359-2365.

McCloskey, W., Iwanicki, S., Lauterbach, D., Giammittorio, D. M., & Maxwell, K. (2015). Are Facebook "friends" helpful? Development of a Facebook-based measure of social support and examination of relationships among depression, quality of life, and social support. *Cyberpsychology, Behavior, and Social Networking*, 18(9), 499-505.

Meier, E. P., & Gray, J. (2014). Facebook photo activity associated with body image disturbance in adolescent girls. *Cyberpsychology, Behavior, and Social Networking*, 17(4), 199-206.

Muise, A., Christofides, E., & Desmarais, S. (2009). More information than you ever wanted: Does Facebook bring out the green-eyed monster of jealousy?. *CyberPsychology & behavior*, 12(4), 441-444.

Nesi, J., & Prinstein, M. J. (2015). Using social media for social comparison and feedback-seeking: gender and popularity moderate associations with depressive symptoms. *Journal of abnormal child psychology*, 43(8), 1427-1438.

Orbach, S. (2011). Losing bodies. *Social Research: An Interna-*

EFFECTS OF DAILY MEDIA CONSUMPTION

- tional Quarterly, 78(2), 387-394.
- Peat, C. M., Von Holle, A., Watson, H., Huang, L., Thornton, L. M., Zhang, B., ... & Bulik, C. M. (2015). The association between internet and television access and disordered eating in a Chinese sample. *International Journal of Eating Disorders*, 48(6), 663-669.
- Peter, J., & Valkenburg, P. M. (2007). Adolescents' exposure to a sexualized media environment and their notions of women as sex objects. *Sex roles*, 56(5-6), 381-395.
- Peterson, S. H., Wingood, G. M., DiClemente, R. J., Harrington, K., & Davies, S. (2007). Images of sexual stereotypes in rap videos and the health of African American female adolescents. *Journal of Women's Health*, 16(8), 1157-1164
- Reizer, A., & Hetsroni, A. (2014). Media exposure and romantic relationship quality: a slippery slope?. *Psychological reports*, 114(1).
- Roberts, D. F. (2000). Media and youth: Access, exposure, and privatization. *Journal of adolescent health*, 27(2), 8-14
- Sagioglou, C., & Greitemeyer, T. (2014). Facebook's emotional consequences: Why Facebook causes a decrease in mood and why people still use it. *Computers in Human Behavior*, 35, 359-363.
- Satici, S. A., & Uysal, R. (2015). Well-being and problematic Facebook use. *Computers in Human Behavior*, 49, 185-190.
- Schooler, D., Kim, J. L., & Sorsoli, L. (2006). Setting rules or sitting down: Parental mediation of television consumption and adolescent self-esteem, body image, and sexuality. *Sexuality Research & Social Policy*, 3(4), 49-62.
- Shaw, J. (1995). Effects of fashion magazines on body dissatisfaction and eating psychopathology in adolescent and adult females. *European Eating Disorders Review*, 3(1), 15-23.
- Stice, E., Spangler, D., & Agras, W. S. (2001). Exposure to media-portrayed thin-ideal images adversely affects vulnerable girls: A longitudinal experiment. *Journal of Social and Clinical Psychology*, 20(3), 270.
- van Oosten, J. M., Peter, J., & Valkenburg, P. M. (2015). The

EFFECTS OF DAILY MEDIA CONSUMPTION

influence of sexual music videos on adolescents' misogynistic beliefs: The role of video content, gender, and affective engagement. *Communication Research*, 42(7), 986-1008.

Wiseman, C. V., Sunday, S. R., & Becker, A. E. (2005). Impact of the media on adolescent body image. *Child and adolescent psychiatric clinics of North America*, 14(3), 453-471.

Wright, P. J. (2009). Sexual socialization messages in mainstream entertainment mass media: A review and synthesis. *Sexuality & Culture*, 13(4), 181-200.

Young, S. D., & Jordan, A. H. (2013). The influence of social networking photos on social norms and sexual health behaviors. *Cyberpsychology, behavior, and social networking*, 16(4), 243-247.

Zuckerman, N. F. (2003). The Correlation Between Reading Women's Magazines and Adolescent Girls' Body Image. *Dissertation Abstracts International*, 64, 1545.

Differences in Disorders: Secondary Disabilities in the Diagnosis of ADHD and FASD

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Abstract:

Fetal alcohol syndrome disorder (FASD) is a syndrome affecting some children whose mothers consumed alcohol while pregnant. The effects of FASD are based on genetic predisposition, level of maternal alcohol consumption, fetal age during alcohol consumption and the overall health of the mother and fetus. Psychologists have compared FASD with attention-deficit/hyperactivity disorder (ADHD) and found that they differ in two major areas: motor skills and cognitive performance. Without recognizing differences and diagnosing the disorders correctly, doctors may allow symptoms to go untreated. These untreated symptoms may lead to secondary disabilities and result in incorrectly prescribed medications. With more research, doctors may not prescribe ADHD medication for children diagnosed with FASD because they may recognize differences between the disorders and understand how ADHD medication negatively affects them. An accurate diagnosis could lead to better use of ADHD medications as doctors may recognize differences between FASD and ADHD.

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A family pediatrician examined a recently adopted four-year-old boy and diagnosed him with attention-deficit/hyperactivity disorder (ADHD). The pediatrician prescribed ADHD medications to help regulate his behavior. After researching the possible negative effects of medications the physician had prescribed, the boy's parents took their son to a pediatric neuropsychologist. After extensive testing and analysis, the psychologist concluded that the boy actually had fetal alcohol syndrome disorder (FASD). She explained that the physical and cognitive results of his testing that were linked to the syndrome and described some of the implications of the new diagnosis. This led to a completely different treatment plan. Real stories, like this one, demonstrate the importance of FASD research.

Psychologists have researched the impacts of FASD on children, including developmental delays and behavioral issues and have sought to educate expectant mothers about the disorder. For example, Ware et al. (2014) concluded that prenatal alcohol exposure is one of the most common preventable causes of mental retardation and developmental disorders. Although this research has demonstrated how to prevent future cases of FASD, but does nothing to educate caregivers and parents as to how best to help children diagnosed with FASD, prevention re-

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search cannot reverse the effects of the disorder in those already struggling with it. Researchers have not focused sufficiently on ways to help children who already have FASD. Caretakers should know how to help individuals currently struggling with this disorder because sufficient research on how to prevent FASD has not been done.

By understanding FASD, caretakers may be able to provide proper interventions (Streissguth, Barr, Kogan & Bookstein, 1997). FASD can have an array of effects, based on genetic predisposition, the level of maternal alcohol consumption, and fetal age when consumption occurs, among other variables. Variations in these factors can lead to a range of effects including facial abnormalities, growth delays, and irregularities in the central nervous system. The evaluation of these and other effects are the basis for a medical diagnosis on the FASD spectrum and the subsequent prescription of specific treatments and therapies.

This diagnosis seems straightforward, but too many doctors do not know many of the symptoms of FASD (Benz, Rasmussen, & Andrew, 2009). During a doctor's visit, alcohol consumption during pregnancy is factor that should be discussed more frequently (Rojmahamongkol, Weitzman, Sentur-

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ias, & Augustyn, 2014). Instead of asking these personal questions, doctors may resort to diagnosing the child with a more common disorder—ADHD. FASD and ADHD can be similar in their symptomologies as shown by the statistic that about 73% of children diagnosed with FASD may also have ADHD (Lane, Stewart, Fernandes, Russo, Enns, & Burack, 2014; Doig, McLennan & Gibbard, 2008). Even though there is overlap between the two disorders (which may be caused by inaccurate diagnoses of FASD) there are notable behaviors and symptoms that are unique to FASD (Frankel, Paley, Marquardt & O'Connor, 2006). When children are diagnosed with ADHD, doctors are able to prescribe specific treatments and medications to help them. If a child has FASD but is misdiagnosed with ADHD, he or she may not receive the proper treatment needed.

The notable differences between FASD and ADHD make the medications unique for these disorders. While neuropsychological testing can differentiate between FASD and ADHD, doctors may still diagnose individuals with only ADHD and fail to utilize the more accurate neuropsychological tests because the symptomologies are so similar. The inaccurate diagnosis of FASD may lead doctors to relieve some symptoms, but other symptoms may go untreated. Ultimately, inappropriate

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ate treatment may lead to secondary disabilities.

Differences between FASD and ADHD

The differences between FASD and ADHD, especially in terms of behavior, may be so small that physicians cannot differentiate between the two disorders during a routine exam. To determine whether a child has FASD, the medical interview is used to determine whether the mother used alcohol during pregnancy and, if so, when she used it. The child may also be referred for neuropsychological testing. In the absence of a comprehensive testing and a thorough analysis of the results, a child may well be misdiagnosed as having only ADHD. Consequently, the prescribed treatment may be inadequate because ADHD and FASD affect motor skills and cognitive performance differently. The health and development of the child requires a proper diagnoses of ADHD or FASD.

Motor Skills

Children diagnosed with ADHD and FASD display a similar lack of fine motor skills. Researchers have shown that some children diagnosed with ADHD have severely impaired motor and postural skills (Kooistra et al., 2009). Research has also

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shown that some children diagnosed with FASD had no more disruption in their learning, including during therapy, than children diagnosed with ADHD (Ware et al., 2015). Thus the results of tests of gross motor skills should be included in the decision making that results in the FASD diagnosis (Lucas et al., 2014). When children are tested for ADHD, doctors should analyze whether the motor results of those being tested are in line with control group results or if they are significantly impaired. They can then also refer children to neuropsychological testing to make sure the children do not have FASD. Using this simple technique, doctors can obtain a more accurate diagnosis than is possible if they just quickly diagnose ADHD.

Cognitive Performance

Another difference between FASD and ADHD is cognitive performance. Children diagnosed with both FASD and ADHD perform worse cognitively than those diagnosed with ADHD only. These children exhibit impaired working-memory processes, verbal abilities, perceptual reasoning skills, processing speeds, and overall adaptive skills (Boseck, Davis, Cassady, Finch, & Gelder, 2015; Glass et al., 2013). Children diagnosed with ADHD who were exposed to alcohol prenatally but are

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not diagnosed with FASD nonetheless score poorly on tests of visual recognition and struggle to encode verbal information compared to controls (Crocker, Vaurio, Riley, & Mattson, 2011). Children diagnosed only with ADHD perform better at learning verbal information than those with additional prenatal alcohol exposure. There is a clear difference in cognitive abilities of children diagnosed with ADHD only and those who have been prenatally exposed and ADHD, specifically attentional control and executive functioning. Overall, children with both prenatal alcohol exposure and ADHD have much lower cognitive performance than children who just have ADHD.

Attentional control. Children diagnosed with FASD but who do not have ADHD struggle to switch their attention between alternatives (Lane et al., 2014; Kooistra, Crawford, Gibbard, Ramage, & Kaplan, 2010; Lane et al., 2014). Children diagnosed with both FASD and ADHD become less focused when they are under-stimulated. They also demonstrate little motivation to concentrate their attention on what is most important in a stimulus field. However, children only diagnosed with FASD and who do not have ADHD may have problems concentrating their attention when there are multiple stimuli (Kooistra et al., 2010). For example, children with prenatal al-

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cohol exposure are more likely to be hyperactive and daydream more often than those without alcohol-exposure (Graham et al., 2013). These children may daydream because they are trying to avoid over-stimulation—instead of over-stimulation from a school lesson; they distract their minds with daydreams. Because children diagnosed with ADHD show these same signs, doctors misdiagnose children diagnosed with FASD or ADHD. However, the underlying causes of these symptoms come from opposite ends of the stimulation spectrum. Children diagnosed with ADHD daydream because they are under-stimulated and kids with FASD daydream because they are over-stimulated. This is an important defining difference between ADHD and FASD that doctors cannot detect immediately.

Executive functioning. Children who have been diagnosed only with FASD, as well as those diagnosed with both ADHD and FASD show executive function deficits (Kingdon, Cardoso, & McGrath, 2016; Kooistra, Crawford, Gibbard, Kaplan, & Fan, 2011). Alerting, orientating and executive control are three indistinguishable functions of those children compared to those who do not have either disorder (Kooistra et al., 2011). Researchers need more data to see how FASD and ADHD differ from one another in terms of executive func-

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tioning. Although not many over-arching conclusions can be drawn about specific defining parts of executive functioning in children from these studies, it is possible that under- and over-stimulation are another significant difference between FASD and ADHD.

By understanding these differences better, doctors may be able to provide more useful treatments and intervention and allow some currently treated symptoms to be treated.

Secondary Disabilities

Primary disabilities in children diagnosed with FASD are abnormalities in the central nervous system. Deficits caused by negative interactions between primary disabilities and the environment are called secondary disabilities (Streissguth et al., 1997). They may result from untreated symptoms from differences between ADHD and FASD. Because of the misdiagnoses between the two, children may face primary disability-environment interaction. Secondary disabilities may include complications like social rejection, inappropriate expectations, and misuse of medications.

Social Rejection

The secondary disability of social rejection may lead to a child's poor social judgment, the inability to read social cues

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and predict consequences, inappropriate social behaviors, and communication issues, which may prevent the development of positive peer relationships (Frankel et al., 2006; Peadon & Elliott, 2010; Streissguth et al., 1997). For example, some children diagnosed with FASD have receptive-expressive language disorder, which affects social cognition and social communications adversely (Crocker et al., 2011; O'Malley & Nanson, 2002). They struggle to find ways to connect with peers, which may only intensify social rejection. Because of these issues, children diagnosed with FASD can struggle to find positive social interaction (Frankel et al., 2006). These children may have a difficult time fitting in with their peers.

Even without essential socializing skills, most children can quietly copy the actions of their peers to blend. On the other hand, children with prenatal alcohol exposure perform daily living skills significantly worse than those in the ADHD and the normally developing groups (Peadon & Elliott, 2010). Children may not be able to grasp these skills because of the neurocognitive and behavioral effects of FASD (Frankel et al., 2006). Even with repeated practice of these daily living skills, children diagnosed with FASD cannot perform these tasks well enough to fit in with their peers. Even to complete other tasks

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that require less repetition, children may not be able to blend in either. For example, learning to put on shoes is a task that does not require much repetition. However, children diagnosed with FASD may take more repetition to learn the skill or may not perform the skill as smoothly as children without FASD. This inability to perform tasks like their peers may also lead to social rejection.

Disrupted School Experience and Inappropriate Expectations

Teachers' erroneous expectations of a student's academic success may result from the latter's secondary disabilities. More than half of the individuals in one study who were prenatally exposed to alcohol either dropped out of school, were suspended, or were expelled (Streissguth et al., 1997). This disrupted school experience is another example of a secondary disability. There are no specific reasons shown in the research explaining why individuals with FASD have disrupted school experiences, it could be from the lack of positive social interaction experienced by them, but it could also be the lack of appropriate expectations from authority figures. For example, teachers of children diagnosed with FASD may be unfamiliar with its symptoms and may have similar expectations of such students

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as for their peers. This may increase the frustration experienced by those with FASD, frustration that teachers may also fail to comprehend.

Adding to the lack of understanding, children diagnosed with FASD lack cognitive understanding and may talk at inappropriate times, and exhibit oppositional defiance (O'Malley & Nanson, 2002). Their verbal responses to questions may not make sense, but because of their expressible vocabulary, teachers may believe that these children diagnosed with FASD are capable of completing more than they actually are. Because of a lack of knowledge about FASD, teachers may not understand that children diagnosed with FASD need specific to achieve the expectations set for most children (Peadon & Elliott, 2010). The interventions needed are different from those needed for students with ADHD or other disorders.

ADHD Medications

Treating children diagnosed with FASD using medications for ADHD can have mixed results because they include stimulants such as dexamphetamine and methylphenidate (Peadon & Elliott, 2010). These medications are used to stimulate the central nervous system by inhibiting dopamine, norepinephrine

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and serotonin. This may help ADHD individuals to become hyper-aware and focus on what is salient. However, individuals with FASD have a different central nervous system structure which may cause them to react differently to these medications (Peadon & Elliott, 2010). Their unique brain structure and addiction tendencies cause the stimulants to overwhelm the autonomic nervous systems of these individuals with FASD (Kooistra et al., 2010). Consequently, using ADHD medications may hinder their performances.

Unique brain structure. Because individuals with FASD have unique brain structures with unexpected reactions to ADHD medications, they may develop increased impulsiveness and aggressiveness (O'Malley & Nanson, 2002). These issues may lead to more secondary disabilities such as trouble making friends. Prenatal alcohol exposure affects the dopamine and norepinephrine neurotransmitters of the fetus. The negative effects of medication often stem from hypersensitivity of individuals with FASD, especially in the prefrontal and striatal brain regions (Peadon & Elliott, 2010; Ware et al., 2015).

Stimulants are used to inhibit dopamine and norepinephrine so those neurotransmitters cannot leave the brain. Altering these neurotransmitters may influence attention,

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impulsivity and behavior inhibition (Peadon & Elliott, 2010). Although these effects may seem to improve behavioral issues of FASD, they do not help as well as other medications might. For example, neuroleptic medication is shown to be helpful in improving behavior more than other medicines. Neuroleptic medicines depress nerve functions, and therefore give better outcomes for children diagnosed with FASD than stimulants (Frankel et al., 2006). In one experiment, parents and teachers reported greater improvement of behavior with neuroleptics while stimulant medications had no significant difference or resulted in worse behaviors (Frankel et al., 2006).

Another study shows contrasting research that impulsivity, inattentiveness, and hyperactivity improved in 63% of individuals with FASD when a stimulant was prescribed (Doig et al., 2008). This contradicts the other research, which was inconclusive. One avenue of study may be to explore the optimal dosages of neuroleptics and how they affect unique brain structures (Frankel et al., 2006). Even though the research is not yet completely conclusive (reorder words), researchers, caregivers and physicians can help affected children improve their secondary disabilities. Finding how medications affect the unique brain structures of children diagnosed with FASD may decrease

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the impact of secondary disabilities.

Addiction tendencies. Children diagnosed with FASD often have addiction tendencies, a symptom that ADHD medications do not treat well. Children with prenatal alcohol exposure are more likely to become addicted to substances because of the structural brain changes that exposure to alcohol may cause (Uban, Comeau, Ellis, Galea, & Weinberg 2013). Because children with prenatal alcohol exposure may be more addiction-prone, exposing them to ADHD medications may increase their chances of becoming drug addicts since ADHD treatments increase dopamine levels (Peadon & Elliott, 2010). In a study by Streissguth (1997), a pioneering FASD researcher, 30% of the patients with FASD (12 years old and over) had alcohol/drug problems.

Most factors influencing FASD are uncontrollable after prenatal alcohol consumption occurs. However, secondary disabilities are one of the few pieces of FASD that can be manipulated once the child is born. Secondary disabilities may increase with negative experiences, specifically social rejection, inappropriate expectations and misuse of medications—these are all factors that parents, teachers and physicians can monitor and change. Doctors may recognize primary disabilities of

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children diagnosed with FASD (deleted “the”) and then suggest appropriate interventions before the secondary disabilities begin affecting the child’s life.

Conclusion

Physicians may misdiagnose children who have FASD as having ADHD instead and may therefore prescribe ADHD medications. As a result, such children suffer additionally from secondary disabilities, such as social rejection. Prescribing appropriate treatment can help these secondary disabilities. However, appropriate treatment cannot be given unless the doctor diagnoses the individual’s disorder correctly. For this reason, I have argued that it is essential that physicians reliably and validly differentiate between the symptoms of ADHD and those of FASD.

There are limitations in research in this field of study; the specific results of FASD have not been thoroughly researched. Because diagnoses of FASD are so rare, it is difficult to find large groups of subjects. Also, researchers cannot control numerous, life-defining variables of a child with FASD, such as the amount of alcohol a pregnant mother consumes. There are other parts of the environment that are in the past and cannot be changed like peers’ interactions, teachers’ expectations and

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medicine prescribed to individuals. Although these factors cannot be individually controlled, analyzing combinations of them can help psychologists draw useful conclusions.

Some research regarding the effects of FASD and certain factors within the environment has already been done. This literature review combines information from these limited sources of research to demonstrate the importance of correct diagnosis of FASD. The differences between ADHD and FASD may lead to more secondary disabilities, and these secondary disabilities are hindered even more by social rejection, frustrating expectations and ADHD medications. The factors discussed are in the environment, and can be monitored, controlled, and improved. Without improvement, individuals may suffer their entire lives trying to fix their symptoms using incorrect methods like ADHD medications. Further research may identify productive steps for parents, and other caregivers, physicians, teachers, and psychologists to take separately and collectively to provide better treatment, through better diagnosis, for children diagnosed with FASD, or both FASD and ADHD.

References

Benz, J., Rasmussen, C., & Andrew, G. (2009). Diagnosing fetal

DIAGNOSIS OF FASD AND ADHD

- alcohol spectrum disorder: History, challenges and future directions. *Paediatrics & Child Health*, 14(4), 231–237.
- Boseck, J. J., Davis, A. S., Cassady, J. C., Finch, W. H., & Gelder, B. C. (2015). Cognitive and adaptive skill profile differences in children with attention-deficit hyperactivity disorder with and without comorbid fetal alcohol spectrum disorder. *Applied Neuropsychology: Child*, 4(4), 230-236. doi:10.1080/21622965.2013.877392
- Crocker, N., Vaurio, L., Riley, E. P., & Mattson, S. N. (2011). Comparison of verbal learning and memory in children with heavy prenatal alcohol exposure or attention deficit/hyperactivity disorder. *Alcoholism: Clinical and Experimental Research*, 35(6), 1114-1121. doi:10.1111/j.1530-0277.2011.01444.x
- Doig, J., McLennan, J. D., & Gibbard, W. B. (2008). Medication effects on symptoms of attention-deficit/hyperactivity disorder in children with fetal alcohol spectrum disorder. *Journal of Child and Adolescent Psychopharmacology*, 18(4), 365-371. doi:10.1089/cap.2007.0121
- Frankel, F., Paley, B., Marquardt, R., & O'Connor, M. (2006). Stimulants, neuroleptics, and children's friendship training for children with fetal alcohol spectrum disorders. *Journal of Child and Adolescent Psychopharmacology*, 16(6), 777-789. doi:10.1089/cap.2006.16.777
- Glass, L., Ware, A. L., Crocker, N., Deweese, B. N., Coles, C. D., Kable, J. A., & ... Mattson, S.N. (2013). Neuropsychological deficits associated with heavy prenatal alcohol exposure are not exacerbated by ADHD. *Neuropsychology*, 27(6), 713-724. doi:10.1037/a0033994
- Graham, D. M., Crocker, N., Deweese, B. N., Roesch, S. C., Coles, C. D., Kable, J. A., & ...Mattson, S. N. (2013). Prenatal alcohol exposure, attention-deficit/hyperactivity disorder, and sluggish cognitive tempo. *Alcoholism: Clinical and Experimental Research*, 37(Suppl 1), E338-E346.
- Infante, M. A., Moore, E. M., Nguyen, T. T., Fourligas, N.,

DIAGNOSIS OF FASD AND ADHD

- Mattson, S. N., & Riley, E. P. (2015). Objective assessment of ADHD core symptoms in children with heavy prenatal alcohol exposure. *Physiology & Behavior*, 14(8), 45-50.
doi:10.1016/j.physbeh.2014.10.014
- Kingdon, D., Cardoso, C., & McGrath, J. J. (2016). Research review: Executive function deficits in fetal alcohol spectrum disorders and attention-deficit/hyperactivity disorder—a meta analysis. *Journal of Child Psychology and Psychiatry*, 57(2), 116-131. doi:10.1111/jcpp.12451
- Kooistra, L., Ramage, B., Crawford, S., Cantell, M., Wormsbecker, S., Gibbard, B., & Kaplan, B. J. (2009). Can attention deficit hyperactivity disorder and fetal alcohol spectrum disorder be differentiated by motor and balance deficits? *Human Movement Science*, 28(4), 529-542. doi:10.1016/j.humov.2009.01.007
- Kooistra, L., Crawford, S., Gibbard, B., Kaplan, B. J., & Fan, J. (2011). Comparing attentional networks in fetal alcohol spectrum disorder and the inattentive and combined subtypes of attention deficit hyperactivity disorder. *Developmental Neuropsychology*, 36(5), 566-577. doi:10.1080/87565641.2010.549978
- Kooistra, L., Crawford, S., Gibbard, B., Ramage, B., & Kaplan, B. J. (2010). Differentiating attention deficits in children with fetal alcohol spectrum disorder or attention-deficit hyperactivity disorder. *Developmental Medicine & Child Neurology*, 52(2), 205-211. doi:10.1111/j.1469-8749.2009.03352.x
- Lane, K. A., Stewart, J., Fernandes, T., Russo, N., Enns, J., & Burack, J. A. (2014). Complexities in understanding attentional functioning among children with fetal alcohol spectrum disorder. *Frontiers in Human Neuroscience*, 8(119). doi:10.3389/fnhum.2014.00119
- Lucas, B. R., Latimer, J., Pinto, R. Z., Ferreira, M. L., Doney, R., Lau, M., & ... Elliott, E. J. (2014). Gross motor deficits in children prenatally exposed to alcohol: A meta-analysis.

DIAGNOSIS OF FASD AND ADHD

- Pediatrics, 134(1), e192-e209. doi:10.1542/peds.2013-3733
- O'Malley, K. D., & Nanson, J. (2002). Clinical implications of a link between fetal alcohol spectrum disorder and attention-deficit hyperactivity disorder. *Canadian Journal of Psychiatry/La Revue Canadienne De Psychiatrie*, 47(4), 349-354.
- Peadon, E., & Elliott, E. J. (2010). Distinguishing between attention-deficit hyperactivity and fetal alcohol spectrum disorders in children: Clinical guidelines. *Neuropsychiatric Disease and Treatment*, 6, 509-515. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2938300/>
- Rojmahamongkol, P., Weitzman, C., Senturias, Y., & Augustyn, M. (2014). Attention deficit hyperactivity, fetal alcohol spectrum disorder, or something else: The broad differential of kindergarten suspension. *Journal of Developmental and Behavioral Pediatrics*, 35(5), 344-346. doi:10.1097/DBP.0000000000000066
- Streissguth, A., Barr, H., Kogan, J., & Bookstein, F. (1997). Primary and secondary disabilities in Fetal Alcohol Syndrome. In A. Streissguth, J. Kanter, A. Streissguth, & J. Kanter (Eds.), *The challenge of Fetal Alcohol Syndrome: Overcoming secondary disabilities* (pp. 25-39). Seattle, WA: University of Washington Press.
- Uban, K. A., Comeau, W. L., Ellis, L. A., Galea, L. M., & Weinberg, J. (2013). Basal regulation of HPA and dopamine systems is altered differentially in males and females by prenatal alcohol exposure and chronic variable stress. *Psychoneuroendocrinology*, 38(10), 1953-1966. doi:10.1016/j.psyneuen.2013.02.017
- Ware, A. L., Glass, L., Crocker, N., Dewese, B. N., Coles, C. D., Kable, J. A., & ... Mattson, S.N. (2014). Effects of prenatal alcohol exposure and attention-deficit/hyperactivity disorder on adaptive functioning. *Alcoholism: Clinical and Experimental Research*, 38(5), 1439-1447. doi:10.1111/acer.12376
- Ware, A. L., Infante, M. A., O'Brien, J. W., Tapert, S. F., Jones, K.

DIAGNOSIS OF FASD AND ADHD

L., Riley, E. P., & Mattson, S. N. (2015). An fMRI study of behavioral response inhibition in adolescents with and without histories of heavy prenatal alcohol exposure. *Behavioural Brain Research*, 27(8), 137-146. doi:10.1016/j.bbr.2014.09.037

Adolescent OCD: Healing Through Parent Integration

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Abstract:

Adolescent obsessive compulsive disorder (OCD) is often misdiagnosed and not effectively treated due to a lack of knowledge and resources. One of the main factors that contributes to these misdiagnoses is that there are a limited number of trained clinicians who specialize in adolescent treatment. Comorbidity among the diagnosis of OCD in adolescents also adds to the lack of effective treatment specific to OCD. Often OCD symptoms can remain hidden as these symptoms often manifest as heightened versions of normal behavior in response to normal thoughts and feelings, which may increase during puberty. Effective treatment of adolescent OCD decreases when parents reinforce maladaptive coping behavior such as asking questions, washing, and checking. Current effective treatments include cognitive behavior therapy (CBT), exposure and response prevention (ERP), and medication, all performed under the supervision of a clinician. To improve treatment availability for OCD, the development of a parent-based program may be the most practical option. This review compares successful common factors present in each type of treatment and investigates the possibility of adaptation within an environment that leads to a parent-based treatment program.

Key words: Obsessive Compulsive Disorder, Cognitive Behavior Therapy, Exposure and Response Prevention, Supportive Parenting for Anxious Childhood Emotions Program, adolescents, parents

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The phrase “I am just a little OCD” is often used by many to describe their desire to be neat, and this usage leads to the misconception that OCD is just another personality quirk. However, Obsessive Compulsive Disorder (OCD) is a general term for a more extensive disorder made up of unreasonable thoughts or fears that lead to habitual actions. This disorder may include involuntary impulses to confess, have dark thoughts, inflict self-injury, or perform ritual religious acts like praying compulsions (Geller et al., 1998). When exhibited among children, this disorder may be mistaken for personality, puberty, or depression. However, Walitza et al. (2011) reveals, “OCD is one of the more common mental illnesses of children and adolescents, with prevalence of 1% to 3%” (p. 174).” Because of the relatively common occurrence of OCD, parents need to be aware of the many facets of the disorder and possible treatments available. OCD has been the subject of continued research, and a number of studies have focused on the effects of various treatments of the disorder on adolescents. Most research on treatment for OCD has shown that the preferred methods include cognitive behavior therapy (CBT) and serotonin-based medications (Walitza et al., 2011). Indeed, Wagner (2003) suggests that even though CBT may be the most effective treatment for OCD,

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many adolescents fail to complete a course of CBT since few clinicians are specifically trained to work with adolescents. This lack of training and the prevalence of OCD combined contribute to the struggle that many adolescents face as they try to understand and work through compulsive behaviors.

In addition to the varying treatments mentioned above, specialized attention from parents may create an effective treatment for children with OCD (Lebowitz, 2013). Parents, having insights gained by being in the home with their child that only a limited number of clinicians gain through specialized training, may be the best aids in their child's treatment. Due to the fact, that parents are generally present in the home, they have the opportunity to build a relationship of trust and confidence, allowing them to deliver treatment in a fair and consistent environment. Notably, adolescents rarely have the awareness or motivation required to change their behavior on their own and need the assistance of a parent (Labouliere, Arnold, Storch, & Lewin, 2013). Using parents as a new source of treatment would enable more adolescents to receive the assistance they require (Lebowitz, 2013).

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Misunderstanding of OCD Leads to Underestimating the Symptoms

OCD is commonly overgeneralized in our society as a personality trait rather than a disorder, and this belief may make those with the disorder less likely to receive treatment. Furthermore, the limited specialized professional help compounds the lack of treatment for adolescents with OCD (Wagner, 2003). Besides these concerns, symptoms of OCD can also be obscured by puberty or comorbid conditions like depression and general anxiety (Brown, Lester, Jassi, Heyman, & Krebs, 2015). Consequently, parents can help prevent or resolve comorbidity-caused misdiagnoses with an increased awareness of the diagnosis criteria that identify the distinct differences between OCD and similar disorders like anxiety or depression as found in Diagnostic and Statistical Manual of Mental Disorders (DSM-V, 2013). First, those with OCD generally have obsessions (recurrent and persistent thoughts) and compulsions (repetitive behaviors). Second, these obsessive symptoms are time consuming (e.g. more than an hour a day) are time consuming, may interfere with regular activities, and must be a source of distress. Third, the symptoms cannot be attributed to another medical condition or the effects of a substance. Finally, the dis-

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turbance cannot be better explained by the symptoms of another mental disorder (American Psychiatric Association, 2013). DSM-V clarifies that children who may not understand the inappropriateness of their impulses can still be diagnosed with OCD, even if they don't show any resistance to their compulsions (American Psychiatric Association, 2013). Any combination of the above behaviors or resulting compulsions serve as a warning sign and should prompt closer observation by a parent.

The “Hidden” Aspects of OCD

Along with understanding basic symptoms, knowledge of scientific findings about OCD enable those affected and those observing to grasp how OCD continues to be hidden and misunderstood. Salkovskis (1985) argues that metacognitive-behavioral models show that OCD is a person's overactive response to normal intrusive or negative thoughts. For example, a “non-affected” mind might have an intrusive thought of germs covering a door knob. The person with the “normal” mind would then be able to process that there are probably germs on the door knob but the worst that might happen from touching the knob is getting a cold. An individual with OCD may have the same thought, yet believe that they might become seriously

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ill or even die from what might be on the door knob. Afraid of what they have contracted and how it may affect others around them, the affected person may withdraw from everyone around them. Due to dysfunctional interpretive patterns, the ensuing thoughts are often seen as increased perceptions of danger and self-responsibility. This in turn may lead to compulsions and attempts to avoid intrusive thoughts through particular coping behaviors (severe avoidance, for example) and cycling feelings of relief and tension (Salkovskis, 1985).

An understanding of neurological chemical changes is critical in understanding OCD in adolescents. For instance, Rutter and Rutter (1993) explains that in adolescents, the mind is going through chemical changes that result in alterations to identity (how an individual perceives their place in the world; e.g. popular or a listener), alterations to identity, increases in self-consciousness, and changes in cognitive flexibility. (as cited in Blakemore, 2006). Blakemore (2006) proposes that adolescents' minds go through a qualitative shift and become more self-aware and self-reflective. The preceding information sheds light on why twenty percent of all OCD cases are manifested in adolescents ages 10 or younger with a median age of 11 (Kessler et al., 2005). Although most OCD cases manifest by age 11, the

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average age of treatment is 13. This delay in treatment can be attributed to symptoms being hidden by the one affected (Walitza et al., 2008). However, an affected individual's tendency to hide symptoms isn't the only reason why treatment is often delayed as discussed later.

Unidentified parent aspect: Enabling

A closer look at the progression and development of OCD reveals that an observer (a parent in an adolescent's case) can actually perpetuate the compulsive behavior, instead of identifying compulsions and dealing with them in a proactive way. Often, this occurs in the form of allowing behaviors to continue without resistance. One such way of enabling negative behaviors is by answering checking compulsions; for example, parents may constantly reassure a child that they (the parents) are not leaving the house if he or she has a fear of being alone (Walitza et al., 2011). Researchers conclude that this behavior is indulged or tolerated by parents in order to avoid aggressive outbursts from the adolescent (Walitza et al., 2011). Thus, while increased attention regarding behavior and symptoms is needed to help diagnose more children, increased attention can also prove detrimental and must be exercised with caution. For example, Wal-

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Walitza et al. (2011) describes a 10-year-old girl who began blowing large puffs of air after her grandfather passed away. She did not want to think about family when she was away from home. Furthermore, she had to wash her hands when she touched someone outside the family she did not like (Walitza et al., 2011). In this case, parents encouraged the behavior by allowing certain thought processes to continue outside the home without trying to understand or educate her on her false processing. While the results in this case study caused by the parent's behavior were unintentional it is clear how the results were still damaging. Furthermore, parents can use the principles outlined below, to become informed on how to combat these types of behaviors, and healing can occur in the home through parent's efforts and using adapted CBT tools.

Escaping the Prison: Treatment

The three most widely recognized treatments for OCD include CBT, exposure and response prevention (ERP) and medication. However, there is still a continuing discussion on the most effective treatment for the disorder. Walitza et al. (2011) concludes that CBT yields the best outcome for treatment due to the support built by the therapeutic relationship and positive

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long-term prevalence. However, Barrett, Farrell, Pina, Peris, and Piacentini (2008) asserts that ERP is the cornerstone of effective treatment based on its significant remission rates of forty to eighty-five percent. Despite the proven effectiveness of a combination of medication and a therapy program, the fact that it cannot be duplicated in the home by parents without the help of a therapist makes this a non-viable option for self-implemented treatment (Walitza et al., 2011). It is also important to note that many of the treatments, diagnostic categories, and practices now used by clinicians were initially created for adults and therefore must be adapted to children (Steinberger & Schuch, 2002).

Comparing Effective Treatments for OCD: CBT vs. ERP

Once a parent begins to understand how each type of therapy affects OCD behavior, a program could be developed to focus on their child's specific negative coping behavior. CBT uses both exposure and cognitive restructuring in the form of changing current thought processes to deter negative coping behavior (Barrett, Farrell, Pina, Peris, & Piacentini, 2008). This is done through a three-part system (Kramer, Bernstein, & Phares, 2014). First, the maladaptive thoughts must be identi-

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fied as they occur. Second, individuals must refute or challenge the thoughts when they occur. Third, doctors should give the individual the skills to replace the maladaptive thought with more accurate or adaptive thoughts (Kramer, Bernstein, & Phares, 2014). On the other hand, ERP uses exposure to obsessive fear stimuli to build up resistance and diminish the need for coping behaviors (Foa & Kozak, 1986). The main difference between these therapies is that CBT is designed to address the behavior and cognitive portion of the disorder directly, while ERP addresses the causes of OCD coping behaviors, and other aspects (like cognitive processes) are naturally treated.

Certainly, one of the most compelling aspects of CBT is that it addresses one of the core problems of OCD—the hyper-reaction to normal stimuli (Salkovskis, 1985). Salkovskis (1996) explains that the cognitive portion of CBT helps restructure an individual's thoughts to challenge the unrealistic reactions the mind initially presents such as taking responsibility for harm or constant self-doubt (as cited in Chu et al., 2015). One such example of unrealistic reactions might be avoiding other people in fear of getting them sick because of touching a doorknob as described earlier. However, despite the general success of CBT, Benito, Conelea, Garcia, and Freeman (2012)

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report that the extensive use of a CBT therapy can lead to higher anxiety during mid-treatment. Furthermore, Hedtke, Kendall, and Tiwari (2009) argue that “safety behaviors” or “crutch behaviors” that occur because of heightened anxiety are associated with a lower treatment success rate. For the program to be successful for adolescents, a parent must be aware of anxiety levels in their child and be prepared for subsequent behaviors.

ERP is similar to CBT, though it has a few vital differences. ERP is normally preferred by most therapists because it has a higher success rate over time (Craske et al., 2008). However, because ERP produces higher anxiety rates in the short term, parents may have a harder time managing a consistent program on their own. Those who practice ERP believe that through repeated exposures, coping behaviors will decrease in response to emotional processing or desensitization (Chu et al., 2015). If parents can react appropriately to the heightened levels of short-term anxiety then ERP will likely be more successful overall. Lebowitz (2013) asserts that ERP “encourages independent coping and confrontation of avoided triggers” (p. 425). Unlike CBT, ERP does not usually lead to an escalation of coping behaviors with the increased anxiety because the individual is focused on the immediate exposure task (Chu et al., 2015).

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Therefore, by increasing anxiety in the short term through ERP, responsiveness and long-term results will improve.

Identifying the True Independent Variable in Each

Treatment: The Parents

The continuing analysis of these treatments in studies focuses on the effectiveness of treatment in treating OCD. These varying studies often conclude that the success rates are dependent on the type of treatment. However, Ginsburg, Kingery, Drake, and Grados (2008) identify that the only common factor of poorer responses to CBT were the severity of symptoms and the presence of a disjointed family environment. In addition, Garcia et al. (2010) demonstrate that increased family adjustment introduced in the home, and comorbid conditions present within the subject decrease CBT effectiveness. A better hypothesis based on these findings might be that parent accommodation has an equal or greater influence on anxiety reduction than the type of treatment.

It is important to know the types of treatments as well as the common structure and possible hindrances to these programs (Brown, Lester, Jassi, Heyman, & Krebs, 2015). There are other factors that can have an impact on the effectiveness

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of treatment for OCD, some of which cannot be controlled. For instance, the severity of symptoms, other comorbid conditions, and how an individual cognitively interprets various stimuli are all likely to impact the effectiveness of treatment, but cannot be controlled by either parents or therapists (Storch et al., 2008). Most notably, what can be controlled is the parent's verbal response and accommodation level toward the compulsive behavior. The more a parent can prevent negative coping behaviors, the more effective both CBT and ERP will be (Storch et al., 2007). Therefore, it is crucial that parents, as well as those diagnosed with OCD, take active participation in changing adaptation behaviors and in therapy.

Discussion

As discussed above, effective OCD treatments have already been developed; multiple studies have supported the validity of ERP, CBT, and medication. However, the limited amount of trained professionals limits treatment options (Wagner, 2003), especially since most programs need a trained professional to adapt them for an adolescent (Steinberger & Schuch, 2002). During most treatments, parent accommodation to compulsions is rarely addressed, giving adolescents a major disad-

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vantage. Without the influence of properly instructed parents, children are likely to grow up without knowing how to manage their symptoms. Active, helpful parents may lead to adolescents diagnosed with OCD becoming better-adjusted adults and lower the need for treatment and medication in this population of adults

Forging the Parent/Child Alliance

Families adjusting their lifestyle in an effort to ease a child's anxiety is a common occurrence (Lebowitz et al., 2013). As discussed above, it is common for families to become their adolescent's primary enablers, which only increases the length and severity of OCD related troubles (Storch et al., 2007). This may decrease a child's willingness to participate in any treatment at all (Lebowitz, 2013). However, through changing parenting behaviors, outcomes can be improved.

Many studies have been done to evaluate parenting in regards to OCD treatment. Family dynamic studies focus on modifying multiple problems such as accommodation, conflict, and communication (Lebowitz, 2013); ultimately, they show that the main concern when treating OCD is accommodating behavior. One way parents can avoid accommodating behavior

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is by replacing it with non-violent resistance (NVR). Lebowitz (2013) states that NVR is “uniquely suited to coping with children’s deregulated reactions without fanning the fire” (p. 426). During NVR treatment, parents accept that they have a limited ability to control or change the behavior of their child and instead focus on aligning their own behavior with a desired belief or path (Lebowitz, 2013). NVR effectively provides parents with a plan to use alternative behaviors in place of the previous destructive helping behaviors. Parents are undoubtedly terrified at the prospect of having a seriously mentally ill child; however, it’s imperative that boundaries be observed in order to provide a stable and consistent environment to support the healing process (Labouliere et al., 2013).

Rescuing May: Utilizing SPACE.

NVR is an effective tool for parents when helping their adolescent with OCD. Many programs utilize NVR as the basis of their treatment; one such program is called the Supportive Parenting for Anxious Childhood Emotions Program (SPACE) created by Lebowitz and Omer (as cited in Lebowitz, 2013, p. 426). This program specializes in reducing accommodation behaviors and reducing a child’s symptoms through steps that

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retrain parents as they aid their child. SPACE has six steps. First is parental introduction and education; SPACE teaches the difference between protective, short-term alleviation and supportive behavior. Second, parents must monitor and document all accommodating behaviors. Third, parents create a plan and write the plan out to present to the child. Fourth, parents must establish cooperation between one another and present a unified front. Fifth, parents should find a trusted friend or family member outside the home that can provide social support. Sixth, parents must deal with aggressive outbursts that may have triggered accommodating behavior previously. When implemented correctly, SPACE can allow parents to successfully help their adolescent.

The following SPACE case study involves 13-year-old May, her parents, and a therapist. From the ages of nine to thirteen May had fears of germ contamination, which led her to fear exposure to harmful chemicals, radiation, asbestos, and other environmental hazards. Her family accommodated her intrusive thoughts by leaving all windows closed, cleaning everything with only plain water, and answering questions about their possible exposure to various things while outside the home (Lebowitz, 2013). Despite her family seeking profession-

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al help, May “admitted her worries may be inflated, but stated that if this were the case, it was because her parents and siblings were ‘grossly irresponsible’ and therefore she needed to be extra careful” (Lebowitz, 2013, p. 429). This illustrates the destructive pattern that accommodation can have on the individual and the family.

Recognizing that May’s symptoms had to be properly treated, her parents implemented the SPACE program. First, the family successfully addressed only her open window fear. After diminishing her response to open windows, they dealt with her compulsion to ask questions. In response, May retaliated by destroying her parents’ bedroom. The supporting therapist instructed them to leave it as it was and contact one of the supporters to express an understanding of her distress, but explain how her behavior was unacceptable (Lebowitz, 2013). Understandably, it is tempting for parents to return to accommodating behavior during setback, yet a review of May’s earlier behavior will serve as a reminder of the continuous cycle. Eventually, May became more compliant to the implementation of each new stage and began individual treatment (Lebowitz, 2013). It became clear that as May’s parents changed their behavior, May was able to focus on her symptoms and take an active part in

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her own recovery.

Moving Forward: A Conclusion

Ultimately, it is imperative that parents adapt their behavior and become a solid example and voice of reason for their children.

The hardest part of this disorder for adolescents is that they don't have enough life experience to know what is normal in terms of their overactive responses. An adolescent with OCD has to deal with growing up fighting their own thoughts and attempting to fit into society (Salkovskis, 1985). The plan to alter a parent's behavior stems from the logical assumption that children will learn new behaviors while their parents are also learning. While a parental intervention program may create more anxiety and stress in the short term, in the long run it will benefit the whole family (Chu et al., 2015). Parent-based therapy has the potential to aid children who are not receiving treatment or refuse treatment, ultimately helping adolescents live out a more normal childhood and become well-adjusted adults.

References

American Psychiatric Association. Diagnostic and statistical manual of mental disorders (5th ed.). Washington DC: Amer-

ADOLESCENT OCD AND PARENTS

ican Psychiatric Association, 2013.

- Barrett, P. M., Farrell, L., Pina, A. A., Peris, T. S., & Piacentini, J. (2008). Evidence-based psychosocial treatments for child and adolescent obsessive-compulsive disorder. *Journal of Clinical Child and Adolescent Psychology, 37*(1), 131–55. <http://doi.org/10.1080/15374410701817956>
- Benito, K. G., Conelea, C., Garcia, A. M., & Freeman, J. B. (2012). CBT specific process in exposure-based treatments: Initial examination in a pediatric ocd sample. *Journal of Obsessive-Compulsive and Related Disorders, 1*(2), 77–84. <http://doi.org/10.1016/j.jocrd.2012.01.001>
- Blakemore Suparna, S.-J. (2006). Development of the adolescent brain: Implications for executive function and social cognition. *Journal of Child Psychology & Psychiatry, 47*(3/4), 296–312. Retrieved from 10.1111/j.1469-7610.2006.01611.x
- Brown, H. M., Lester, K. J., Jassi, A., Heyman, I., & Krebs, G. (2015). Paediatric obsessive-compulsive disorder and depressive symptoms: Clinical correlates and CBT treatment outcomes. *Journal of Abnormal Child Psychology, 43*(5), 933–942. <http://doi.org/10.1007/s10802-014-9943-0>
- Chu, B. C., Colognori, D. B., Yang, G., Xie, M., Bergman, R. L., & Piacentini, J. (2015). Mediators of exposure therapy for youth obsessive-compulsive disorder: Specificity and temporal sequence of client and treatment factors. *Behavior Therapy, 46*(3), 395–408. <http://doi.org/10.1016/j.beth.2015.01.003>
- Craske, M. G., Kircanski, K., Zelikowsky, M., Mystkowski, J., Chowdhury, N., & Baker, A. (2008). Optimizing inhibitory learning during exposure therapy. *Behaviour Research and Therapy, 46*(1), 5–27. <http://doi.org/10.1016/j.brat.2007.10.003>
- Foa, E. B., & Kozak, M. J. (1986). Emotional processing of fear: Exposure to corrective information. *Psychological Bulletin, 99*(1), 20–35. <http://doi.org/10.1037/0033-2909.99.1.20>
- Garcia, A. M., Sapyta, J. J., Moore, P. S., Freeman, J. B., Franklin, M. E., March, J. S., & Foa, E. B. (2010). Predictors and moderators of treatment outcome in the Pediatric Obsessive

ADOLESCENT OCD AND PARENTS

- Compulsive Treatment Study (POTS I). *Journal of the American Academy of Child and Adolescent Psychiatry*, 49(10), 1024–33; quiz 1086. <http://doi.org/10.1016/j.jaac.2010.06.013>
- Geller, D. A., Biederman, J., Jones, J., Shapiro, S., Schwartz, S., & Park, K. S. (1998). Obsessive-compulsive disorder in children and adolescents: A review. *Harvard Review of Psychiatry*, 5(5), 260–273.
- Ginsburg, G. S., Kingery, J. N., Drake, K. L., & Grados, M. A. (2008). Predictors of treatment response in pediatric obsessive-compulsive disorder. *Journal of the American Academy of Child and Adolescent Psychiatry*, 47(8), 868–78. <http://doi.org/10.1097/CHI.0b013e3181799ebd>
- Hedtke, K. A., Kendall, P. C., & Tiwari, S. (2009). Safety-seeking and coping behavior during exposure tasks with anxious youth. *Journal of Clinical Child and Adolescent Psychology : The Official Journal for the Society of Clinical Child and Adolescent Psychology*, American Psychological Association, Division 53, 38(1), 1–15. <http://doi.org/10.1080/15374410802581055>
- Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, 62(6), 593–602. <http://doi.org/10.1001/archpsyc.62.6.593>
- Kramer, G. P., Bernstein, D. A., & Phares, V. (2014). Behavioral and cognitive-behavior psychotherapies. (8th ed.), Introduction to clinical psychology (108-235). Upper Saddle River, NJ: Prentice-Hall.
- Labouliere, C. D., Arnold, E. B., Storch, E. A., & Lewin, A. B. (2013). Family-based cognitive-behavioral treatment for a preschooler with obsessive-compulsive disorder. *Clinical Case Studies*, 13(1), 37–51. <http://doi.org/10.1177/1534650113504985>
- Lebowitz, E. R. (2013). Parent-based treatment for childhood and adolescent OCD. *Journal of Obsessive-Compulsive and Related Disorders*, 2(4), 425–431. <http://doi.org/10.1016/j>

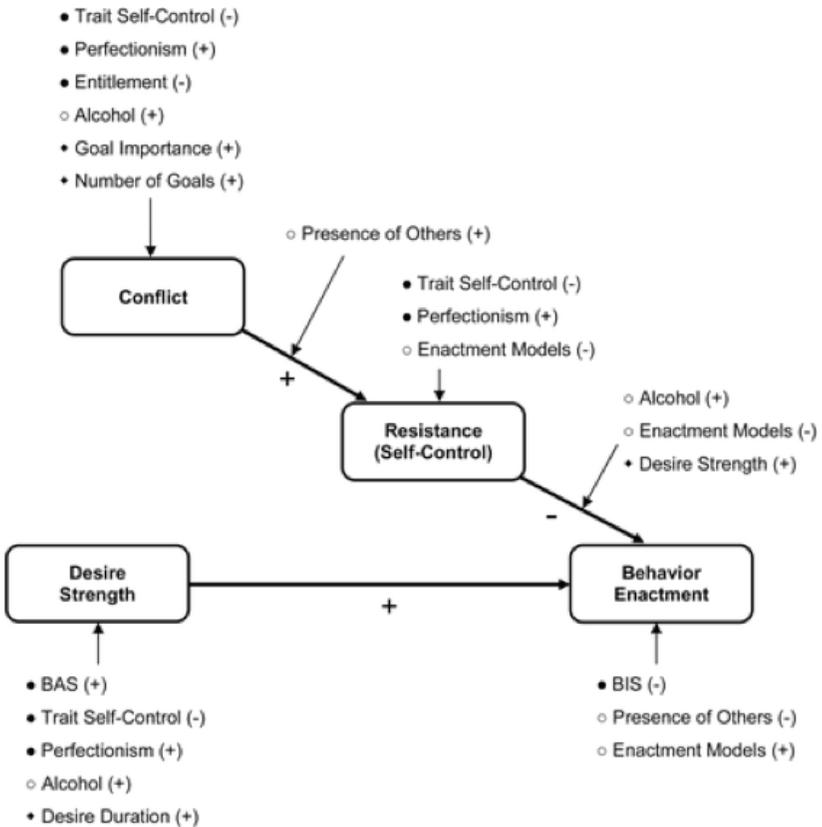
ADOLESCENT OCD AND PARENTS

jocrd.2013.08.004

- Lebowitz, E. R., Woolston, J., Bar-Haim, Y., Calvocoressi, L., Dauser, C., Warnick, E., ... Leckman, J. F. (2013). Family accommodation in pediatric anxiety disorders. *Depression and Anxiety, 30*(1), 47–54. <http://doi.org/10.1002/da.21998>
- Rutter, M., & Rutter, M. (1993). *Developing minds*. London: Penguin.
- Salkovskis, P. M. (1985). Obsessional-compulsive problems: A cognitive-behavioural analysis. *Behaviour Research and Therapy, 23*(5), 571–583.
- Steinberger, K., & Schuch, B. (2002). Classification of obsessive-compulsive disorder in childhood and adolescence. *Acta Psychiatrica Scandinavica, 106*(2), 97–102. <http://doi.org/10.1034/j.1600-0447.2002.02220.x>
- Storch, E. a, Geffken, G. R., Merlo, L. J., Jacob, M. L., Murphy, T. K., Goodman, W. K., ... Grabill, K. (2007). Family accommodation in pediatric obsessive-compulsive disorder family. *Journal of Clinical Child & Adolescent Psychology, 36*(2), 207–216. <http://doi.org/10.1080/15374410701277929>
- Storch, E. A., Merlo, L. J., Larson, M. J., Geffken, G. R., Lehmkuhl, H. D., Jacob, M. L., ... Goodman, W. K. (2008). Impact of comorbidity on cognitive-behavioral therapy response in pediatric obsessive-compulsive disorder. *Journal of the American Academy of Child and Adolescent Psychiatry, 47*(5), 583–92. <http://doi.org/10.1097/CHI.0b013e31816774b1>
- Wagner, A. P. (2003). Cognitive-Behavioral therapy for children and adolescents with obsessive-compulsive disorder. *Brief Treatment and Crisis Intervention, 3*(3), 291–306. <http://doi.org/10.1093/brief-treatment/mhg022>
- Walitza, S., Melfsen, S., Jans, T., Zellmann, H., Wewetzer, C., Warnke, A., & Taub, E. (2011). Obsessive-compulsive disorder in children and adolescents. *Deutsches Ärzteblatt International, 108*(11), 173–179. Retrieved from <https://www.lib.byu.edu/cgi-bin/remoteauth.pl?url=http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2011-14000-001&site=ehost-live&scope=site>

ADOLESCENT OCD AND PARENTS

Walitza, S., Scherag, A., Renner, T. J., Hinney, A., Remschmidt, H., Herpertz-Dahlmann, B., ... Gerlach, M. (2008). Transmission disequilibrium studies in early onset of obsessive-compulsive disorder for polymorphisms in genes of the dopaminergic system. *Journal of Neural Transmission* (Vienna, Austria : 1996), 115(7), 1071–1078. <http://doi.org/10.1007/s00702-008-0051-6>



Family Therapy: An Early Intervention in Mitigating PAS

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Abstract:

Children with Parental Alienation Syndrome (PAS) potentially suffer from negative indoctrination from at least one parent. This results in damaging the bond between the targeted parent and child and in the creation of an emotionally taxing environment for the child. This clinical challenge calls for a review on the dynamics of PAS and the child caught in the crossfire between parents. PAS is difficult to treat because alienated parents don't realize the harm they are causing to their child. Hence, it is difficult for the alienating parent to change their approach and negative feeding of the rival parent. Thus, court-ordered family therapy sessions should be considered by some psychologists and legal authorities, so that therapists can have the power of identifying examples of PAS occurring within a family. This review will investigate family therapy as a possible intervention to mitigate the effects of PAS.

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Evaluators, attorneys, and judges play fundamental roles in child custody decisions during marital discord and divorce (Lamminen, 2013). Yet despite their efforts, there are three underlying realities that are often dismissed in many toxic divorce cases. First is the child's hatred towards the rival parent—a product of negative indoctrination of one parent about the other. This ultimately leads a child to form “his or her own vilification of the alienated parent” (Baker & Darnall, 2007, p. 254). Second, the child's fabrication of stories of the rival parent has potential to damage the bond with that parent. And third is the emotionally taxing environment a child becomes exposed to (Lamminen, 2013). This alienation phenomenon has potential to psychologically harm the child. A better understanding of Parental Alienation Syndrome (PAS) during custody battles should be taken into account by clinicians and other legal professionals (Lamminen, 2013). Psychologists and legal authorities have yet to accept an examination of parental conflict—unconsciously or consciously alienating the child from the other parent— in child custody cases (Bruch, 2001). Ultimately, accepting such a condition could help build healthy relationships between the child and the alienated parent.

Considering the alienation that occurs in the aforemen-

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tioned three steps, it is of little wonder that PAS is attributed to the increase of child custody disputes—especially since the child can become a parent’s most important ally during a relationship conflict or divorce (Lee & Hunsley, 2001; Wallerstein & Kelly, 1976). Gardner’s (1998) research has shown that mothers are usually the allegedly “loved” parent denigrating the “hated” parent, which is generally the father. Furthermore, PAS can result in serious sex-abuse accusations. In such incidents, serious consideration must be taken to evaluate if accusations are true or just a derivative of PAS. PAS has damaging consequence for the child’s futures as well, especially when the child has learned to loathe one parent without remorse and love the other.

In view of these underlying realities of PAS, this paper will offer awareness in recognizing this syndrome as more than a phenomenon. PAS must be considered a diagnosable disorder rather than a situation that is observed to exist or questioned by legal authorities. This paper suggests family therapy as an early intervention (Baker, 2007). Once more people recognize PAS as a potential diagnosable disorder, the parents and other legal authorities can realize the serious implications that must be considered during child custody disputes. If this phenomenon were dealt with in family and marital therapy, the degree of neg-

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ative implications may be mitigated (Baker, 2007). This would provide the best results for the parents, and most importantly, the child.

Understanding the Manifestation of Negative Indoctrination

Often, divorce troubles comes from trying to reconcile two different perspectives: one party wants x; whereas, the other wants y. This psychological and physiological difference in mindset can lead one parent to be vindictive. This malice creates a higher risk for PAS since one parent pathologically contaminates the relationship of the child with the rival parent (Viljoen & van Resenburg, 2014). The alienating parent (often the one opposed to the divorce), may alienate their child subconsciously (Viljoen & van Rensburg, 2014). It is imperative that parents be aware of how they may be affecting their child—consciously or subconsciously.

There's a power alienating parents hold over their child that makes the child want to love the alienating parent and loathe the other. Child attachment to the alienating parent shows the pathological bind that causes a child to be hostile to the targeted parent. Steinberger's (2006) research discusses a story of 5-year-old Sally, a victim of PAS. Sally would want to

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call her father to tell him about her fun-filled day, yet her mother would respond in only one way: “sullen anger” (Meier, 2009); this anger and dissatisfaction led to the mother being “too tired” to read her a bedtime story later that night. The alienating mother showed her child that displaying the same affection to both parents is inappropriate behavior. Thus, Sally learned that she should not share the same experiences with both parents—she must learn to choose one. The child will then learn to cave to meeting the alienating parent’s needs (Baker, 2006). These actions have the potential to become vengeful as they occur over a period of time. The reoccurrence of the alienating parent’s reaction to the rival parent may vary in degrees of intensity, but will always be a powerful motivator to the child (Steinberger, 2006). The alienating parent sees the rival parent as a threat and will cause their child to remove themselves from that parent (Meier, 2009). Therefore, the strategies developed among PAS children are the cultivation of dependency or threat of rejection and a creation of obligation/guilt for the alienated parent (Baker, 2006). This may then cause in the child a manifestation of an unhealthy reliance on acceptance and approval (Baker, 2005). Unfortunately, the cycle seems to perpetuate.

Furthermore, as the alienated parent feels vexed, the

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child becomes emotionally cut off from the alienating parent (Baker, 2006). The child's attachment to the parent, makes the child want to fix their emotional needs by being hostile to the rival parent as a form of reassurance and comfort, as well as revenge for the alienated parent (Baker, 2006). The longing for parental love makes PAS hard to disentangle (Golumb, 1992, as cited by in Baker, 2006). The child-attachment present between the child and alienated parent is a strong bond that the child needs secured.

The child's emotionally taxing environment

Another problematic effect of PAS is the child's response to the taxing environment. The child's environment is shaped by the alienator's perception of the rival parent (Baker & Sauber, 2013). In order to manipulate the situation and environment, the alienator ensures that the child has no actual positive experiences with the targeted parent. Children may also partake in "parrot-like echolalia" behavior, meaning that they mimic the language of the alienating parent—which often isn't very generous or kind (Waldron & Joanis, 1996). The affected child may start to use blended pronouns referring to him- or herself and the alienator as "we" or "us", displaying that their mind is pro-

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grammed to protect the alienating parent (Waldron & Joanis, 1996). These behaviors demonstrate that the child is claiming to have their own thoughts, but in reality they are just mirroring the alienating parent's thoughts (Waldron & Joanis, 1996). The child's lack of control for their own emotions affects their developmental environment.

Consequences to the Child's Development

Furthermore, this emotionally taxing environment may create "poor interpersonal relationships, depression/anxiety, difficulty trusting others, and low self-esteem" in the child's adulthood (Baker & Sauber, 2013, p. 6). The child will then grow to perceive that parental love and acceptance is conditional. They have based their individual expectations, behaviors, and beliefs off of meeting the alienating parent's needs (Baker, 2007). The consequences of PAS indicate "they lack parental support, encouragement, and responsiveness" which in turn "negatively influence the autonomy, competence, and relatedness" of the child (Borstlap, 2014). Parenting structure becomes neglected, disrupting the child's development, since they are not experiencing healthy family relationships (Baker & Verrocchio, 2013; Campana, Henderson, Stolberg, & Schum, 2008). Unfortunate-

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ly, these effects can continue into adulthood.

Another child development consequence is perceiving children as being cognitively immature when in reality their problems are due to PAS (Gardner, 1998). Children with PAS learn to behave negatively toward the alienated parent without any remorse, often seeing their relationship with the alienated parent as insignificant and feeling no shame in “exploiting the goodness of the targeted parent for their personal gain” (Wakeford, 2001, as cited by Raso, 2004, p. 37). Because of this manipulation, the child views the alienating parent as either a weak victim or a perfect superior being in comparison to the rival parent (Cartwright, 1993). For example, an alienating mother may tell the child that the father never pays child support. The child will believe that the checks are “fraudulent and not that his mother is lying” (Warshack, 2000, p. 37) even if the father shows the child proof of payment. Thus, the child’s environment consists of negative indoctrination by the alienating parent, altering the child’s reality-testing ability.

The extreme allegations of PAS

Although parental alienation syndrome is a form of emotional abuse (Gardner, 1999), it must be noted that PAS is different

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from physical abuse and sexual abuse. Occasionally, a case of PAS gets so bad that the child falsely accuses a parent of one of society's worst crimes: physical and/or sexual abuse. These allegations are formed when the alienating parent manipulates the child into believing the targeted parent is unloving, unsafe, or unavailable (Garber, 2004). Now for psychologists and other legal authorities, these extreme allegations can become dangerous. Some psychologists or legal authority may become convinced by the compelling stories told by children of PAS (Baker & Sauber, 2013). For the targeted parent, abusive allegations become an instance of frustration and a demoralizing process (Baker & Sauber, 2013, p. 4) as authorities try to evaluate the extreme allegations. Ultimately, it is best for the authorities to get to the truth in order to protect both the child and the parent. In such incidents, serious consideration must be taken to evaluate accusation as a derivative of PAS or an actual assault.

Distinguishing between bona fide abuse and PAS

In majority of cases, the accusation of sexual abuse is not just PAS, but a reality. Abuse is a common occurrence and it is vital to understand that PAS is not a term for abusers to hide behind. Legal authorities need to be able to distinguish between sexual

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abuse and PAS in order to prevent abusers from falsely proclaiming innocence through PAS. A child with PAS will exhibit the eight primary symptoms of PAS “campaign of denigration; weak, frivolous, or absurd rationalizations for the deprecation; lack of ambivalence; the ‘independent thinker’ phenomenon; reflexive support of the alienating parent in the parental conflict; absence of guilt over cruelty to and/or exploitation of the alienated parent; presence of borrowed scenarios; spread of animosity to the friends and/or extended family of the alienated parent” (Gardner, 1999, p. 98). Whereas, abused children will exhibit primary symptoms found in post-traumatic stress disorder (DSM-5; 1). A child of PAS will rarely ever exhibit these symptoms. Some children with PAS “represent rational responses to abusive parenting . . . that are outside the scope of manipulation of the favored parent” (Baker & Sauber, 2013, p. 2). Therefore, references to the aforementioned symptoms can help distinguish between PAS and bona fide abuse.

It is also important to examine the parents being accused of abuse, too. A parent who is guilty of the accusation is more likely to be uncooperative with legal authorities. Whereas, a PAS victim will be cooperative and will reach out to professionals and legal authorities to prove their innocence.

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Investigating family therapy

Just by analyzing the research on PAS, it is clear that the syndrome is complex. PAS becomes difficult to treat because the alienating parent fails to realize the harm they are inducing in their child. This makes it difficult for them to change their approaches and stop the negative indoctrination of the rival parent to their child. With the solution of court-ordered family therapy sessions, a therapist may have the power to point out examples of PAS occurring within the family. With family therapy, mood disorders could also possibly be detected. Narcissistic characteristics may be identified in some alienating parents (Viljoen & van Resenburg, 2014). Garber's (2004) research concluded that children of highly conflicted parents are "among those most in need of psychotherapeutic support" (Viljoen & van Resenburg, 2014, p. 270). If these children are in most need, one must wonder why courts aren't mandating more family therapy.

Family therapy may be a challenging approach as it's usually one parent that seeks therapeutic interventions (Lamminen, 2013). As well, PAS may cause a child to be guarded during the family therapy sessions in order to protect their alienated parent (Lamminen, 2013). Or the alienating parent

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might feel as though the therapy intervenes with their goals to undermine the other parent, resulting in blaming the therapist. Parents with narcissistic tendencies can be arrogant, disregarding the therapist's suggestions. As well, psychologists working with the syndrome, can be tainted with frustration and stress due to the complex cases of PAS (Viljoen & van Resenburg, 2014). Thus, more research on PAS is necessary in order to find solutions for a better family therapy approach.

Mandating Family Therapy

Because family therapy can be successful, many families with PAS effects should seek the help. However, family therapy is a system that needs all individuals involved in order for the family to be restored (Waldron & Joanis, 1996). A mandated family counseling session for those in toxic divorce cases should be enforced in order to help children maintain healthy relationships with both parents.

Furthermore, attending family therapy can lead to a diagnosis of PAS effects in toxic divorce cases (Meier, 2009). Conscientious child-centered mental health professional should screen every child referral from the first contact in order to minimize the risk of therapist alienation (Baker, 2007). Family therapy allows for PAS to represent the dysfunction family dy-

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namic and then address the family subsystems (family members involved) (Baker, 2007). The child can learn to identify behavior that may lead to mistreating the targeted parent. This allows the therapist to detect and fix problems within the family.

Overall, family therapy will allow the family (alienator, target, and victim) to reestablish positive relationships by allowing them to develop healthy relationships with one another during marital discord (Baker, 2007, p. 258). The therapist can create a treatment plan for families. Due to PAS having yet to be universally accepted, few legal authorities have the foresight to order this kind of intervention. Yet, by understanding the dynamics of parental alienation syndrome, legal professionals may realize that family therapy may mitigate the effects of PAS with the goal of rebuilding a healthy family dynamic.

Discussion

Parental alienation syndrome is a rising problem for high conflict divorce cases due to the syndromes existence not being recognized. The current problem with PAS is the stance that it is not a diagnosable syndrome; however, it is a very real problem for people who have felt deprived of a child's love. Arguments state that proper authorities are "likely to misunderstand the

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experience . . . minimize the problem (i.e., say that the children will figure it out and come running back in no time) or encourage the targeted parent to take actions that could be quite unhelpful (i.e., taking a ‘wait and see’ attitude)” (Baker & Sauber, 2013, p. 4). An understanding of PAS should embolden the courts and clinicians to go beyond diagnosis routine to apply a parental alienation-informed perspective during litigation (Baker, 2007, p. 259), because such efforts would help mitigate destructive consequences for children caught in the crossfire between parents.

Additionally, it is an unfortunate truth that most people do not know about PAS. When describing PAS to a stranger, clinician, or adult, people will start remembering individuals they know who may have potentially suffered from PAS—it’s that common of an issue. Occasionally people misuse the term PAS, threatening the validity of PAS (Borstlap, 2014). Diagnosing the syndrome is the first step. Once more research is done on a universal PAS diagnosis, faulty logic and poor clinical practice for high conflicted families experiencing PAS will not be as much of a problem. Courts, psychologists, and affected families will be able to minimize the problem and take action in order to improve parent-child relationships during marital discord.

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References

- Baker, A. J. L., (2006). Patterns of parental alienation syndrome: A qualitative study of adults who were alienated from a parent as a child. *The American Journal of Family Therapy*, 34(1), 63-78.
- Baker, A. J. L., (2007). *Adult children of parental alienation syndrome: Breaking the ties that bind*. New York, NY: W. W. Norton & Company.
- Baker, A. J. L., & Darnall, D. C. (2007). A construct study of the eight symptoms of severe parental alienation syndrome: A survey of parental experiences. *Journal of Divorce & Remarriage*, 47(1/2), 55-75. doi: 10.1300/j087v47n01_04
- Baker, A. J. L., & Sauber, S. R. (2013). *Working with alienated children and families: A clinical guidebook*. New York: Routledge.
- Baker, A. J. L., & Verrocchio, M. C. (2013). Italian college student-reported childhood exposure to parental alienation: Correlates with well-being. *Journal of Divorce & Remarriage*, 54 (8), 609-628. DOI:10.1080/10502556.2013.837714
- Bortslap, O. M., (2014). *An exploration on young adults' experiences of childhood parental alienation syndrome*. (Master's Thesis. North-West University). Retrieved from <http://dspace.nwu.ac.za/bitstream/handle/10394/13091/Borstlap>
- Bruch, C. (2001). Parental Alienation Syndrome and Parental Alienation: Getting It Wrong In Child Custody Cases. *Family Law Quarterly*, 35(3), 527-552. Retrieved from <http://heinonline.org/HOL/LandingPage?handle=hein.journals/>
- Campana, K. L., Henderson, S., Stolberg, A. L., & Schum, L. (2008). Paired maternal and paternal parenting styles, child custody and children's emotional adjustment to divorce. *Journal of Divorce & Remarriage*, 48 (3/4), 1-20. DOI: 10.1300/j087v48n03_01
- Cartwright, G. F. (1993). Expanding the parameters of parental alienation syndrome. *The American Journal of Family Therapy*, 21 (3), 205-215. doi: 10.1080/01926189308250919

AN EARLY INTERVENTION TO MITIGATE PAS

- Garber, B. D. (2004). Therapist alienation: Foreseeing and foretelling third party dynamics undermining psychotherapy with children of conflicted caregivers. *Professional Psychology: Research and Practice*, 35(4), 357-363.
- Gardner, R. A. (1998). *The parental alienation syndrome*. 2nd. Cresskill, New Jersey: Creative Therapeutics. 1-5.
- Gardner, R. A. (1999). Differentiating between parental alienation syndrome and bona _____fide abuse-neglect. *American Journal of Family Therapy*, 27(2), 97-107.
- Johnston, J. R. (2003). Parental alignments and rejection: An empirical study of alienation in children of divorce. *Journal of the American Academy of Psychiatry and the Law Online*, 31(2), 158-170. DOI: 10.1177/1359104512444629
- Lamminen, L. (2013). The parental alienation syndrome: A family therapy and collaborative systems approach to amelioration. *Journal of Child and Family Studies*, 22(6), 879-880. DOI: 10.1007/s10826-012-9679-9
- Lee, C. M., & Hunsley, J. (2001). Empirically informed consultation to parents concerning the effects of separation and divorce on their children, *Cognitive and Behavioral Practice*, 51(1), (85-96). DOI:10.1037/a0018282
- Meier, J. S. (2009). A historical perspective on parental alienation syndrome and parental alienation. *Journal of Child Custody*, 6 (3-4), 232-257. DOI:10.1080/15379410903084681.
- Raso, C. (2004). "When the bread goes stale, it's my dad's fault", *The parental alienation syndrome*. (Master's Thesis. Concordia University). Retrieved from: <http://spectrum.library.concordia.ca/7844/>
- Steinberger, C. (2006). Father? What father? Parental alienation and its effect on children. *NY State Bar Association Family Law Review*, 38 (2), 9-19.
- Viljoen, M., & van Rensburg, E. (2014). Exploring the lived experiences of psychologists working with parental alienation syndrome, *Journal of Divorce & Remarriage*, 55 (4), 253-275. DOI: 10.1080/10502556.2014.901833.

AN EARLY INTERVENTION TO MITIGATE PAS

Waldron, K. H., & Joanis, J. D. (1996). Understanding and collaboratively treating parental alienation syndrome. *The American Journal of Family Law*, 10(1), 121-133. Retrieved from: <http://www.fact.on.ca/Info/pas/waldron.htm>

Warshack, R. A. (2000). Remarriage as a trigger for parental alienation syndrome. *The American Journal of Family Therapy*, 28(3), 229-241. DOI: 10.1080/01926180050081667

Wallerstein, J. S., & Kelly, J.B. (1976). The effects of parietal divorce: Experiences of the child in later latency. *American Journal of Orthopsychiatry*, 46(2), 256-269.

Do You Have Internet Addiction?

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Intuition: The BYU Undergraduate Journal of Psychology

Abstract:

The Internet is a readily available tool that can quickly access a vast range of information, resources, and services. Despite the abundance of resources provided by the Internet, it can prove more detrimental than helpful if we do not wisely manage our personal time on and use of the Internet. This lack of personal time management for the Internet has developed a recently new mental disorder called Problematic Internet Use, but more commonly referred to as Internet addiction. Although this disorder is applicable for all ages, it is found to be a common addiction in adolescents. By examining Internet addiction studies from all over the world, this review provides an overview and basic understanding of Internet addiction. I explicitly focus on adolescents and this disorder as well as the comorbidity of Internet addiction and depression often found in adolescents. I, first identify the psychological and physiological signs and symptoms of Internet addiction. Next, I discuss the correlation between depression and Internet addiction and the importance of this correlation. Finally, I address methods of recovery coupled with an appeal for further research to provide additional methods of treatment.

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The Internet is an easily accessible and infinitely extensible tool for finding information, connecting with others, and conducting global business and banking. Because the Internet's possibilities are basically limitless, it has become an essential, even mandatory, means of communication and finding information. In just a little over 10 years, the Internet grew from being available to 1% of the world's population to 97% (Hilbert & López, 2011). With its availability increasing, its usage has grown congruently. Statistics from around the world demonstrate this relationship: in the Middle East and Africa, the user rate increased by 1,300% between the years 2000–2009. In South Korea, 90% of the households have access to high-speed Internet. In the United Kingdom, people spend an average of 45 days per year on the Internet (Aboujaoude, 2010). It has been said that the computer and its Internet functions were designed as a tool for adults to use, and, true to its design, it is (Shapiro & Margolin, 2014). Interestingly however, the adolescent age group (ages ten to nineteen) that lives in a place that has access to the Internet is perhaps the group most influenced, spending an average time of 11 hours a day on the Internet. Contrastingly, adults report spending, on average, 30 minutes a day on social media sites (Shapiro & Margolin, 2014). Because of this

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large difference between adults and adolescents in regards to time spent on the Internet, it is commonly said that the adolescent is the technology expert within the family (Shapiro & Margolin, 2014).

Adolescents use the Internet in intriguing ways. They remarked that they use the Internet not just daily, but multiple times throughout the day (Bélanger, Akre, Berchtold, & Michaud, 2011). Shapiro and Margolin (2014) note that unlike an adult, an adolescent uses the Internet primarily for social purposes. Adolescents are maturing during a time when the Internet has become a commonplace commodity, and they are shaped by the Internet (Shapiro & Margolin, 2014). Because of high adolescent Internet use, adolescents' purposes in using the Internet and the ingrained nature of the Internet into the adolescents' lives, the primary focus of this review will be that of adolescents and how Internet addiction affects them, although Internet addiction is a behavioral condition applicable to all ages. According to Shapiro and Margolin (2014), the biggest source of an adolescents' interest is social media sites such as Facebook, Twitter, and Instagram. In a recent report, it was found that 45% of adolescents use social media sites daily, a percentage which excludes other forms of media such as TV

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shows, videos, and music. Additionally, many youth report at least beginning and ending their day with checking or browsing these sites. (Wartella, Rideout, Montague, Beaudoin-Ryan & Lauricella, 2016). Because of their high exposure to the Internet, adolescents have a risk for developing what is called Problematic Internet Use, or more commonly, Internet addiction. Studies done in the United States, Netherlands, and Korea, have all indicated that Internet addiction is characterized by an exorbitant amount of time spent accessing and perusing all sorts of information, sites, social networking, and activities found on the Internet. With these studies as a foundation, I will define Internet addiction as the following: one's inability to control personal Internet use, an inability which impairs daily functions and activities. Because of this substantial amount of time engaging with a screen rather than face-to-face, Internet addiction has its own distinct byproducts and symptoms.

In an attempt to provide information regarding Internet addiction and its particular impact on adolescents, a review of the current studies around the world regarding this topic will be discussed. First, I will describe the early developmental status of this disorder and the psychological and physiological signs and symptoms of Internet addiction. Second, I will examine

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the proposed link between depressive symptoms in adolescents and Internet addiction. Finally, I will offer suggestions for the treatment of Internet addiction. Throughout each area of interest, I will evaluate the extent of Internet addiction to the degree in which the Internet is used; namely, how international this problematic mental illness relationship is.

Signs and Symptoms of Internet Addiction

Just as there are indicators for the common cold, Internet addiction can be identified through common signs and symptoms associated with this addiction. The signs and symptoms mentioned below are consistent throughout the literature reviewed. Studies mention indicators in both physiological and psychological areas for adolescents specifically. With this overuse of the Internet, adolescents are prone to irregularities in daily routines and habits as well as mental distress. Understanding these signs and symptoms for the mind and the body can help one recognize and begin to self-diagnose the possibility of Internet addiction.

Physiological Signs and Symptoms

Physiological symptoms can occur that impact the growth

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and well-being of adolescents. A major symptom is the lack of or limited amount of sleep. It was found that with increased Internet use, adolescents in the United States reported a decrease in sleep quality, average sleeping time, and a decrease in overall health (Shapiro and Margolin, 2014). In a study conducted in China, adolescents who tested positive to having Internet addiction behaviors were sleeping less than six hours a night. Comparatively, adolescents who responded negative to having Internet addiction averaged more than eight hours of sleep a night (Lam, Zi-wen, Peng, Jin-cheng, Mai, & Jin, 2009; Kawabe, Horiuchi, Ochi, Oka, & Ueno, 2016) In the same study, researchers found that adolescents with Internet addiction also indicated a scarcity of physical activity, and, when asked directly, responded that they did no exercising.

Another physiological sign is the irregularity of eating patterns or skipping of meals altogether (Kim, Park, Kim, Jung, Lim, & Kim, 2010). Shapira et al. (2013) has found a correlation between eating disorders and Internet addiction. Not sleeping, exercising, eating, or any combination of these three suggests a preoccupation, and in these cases, a preoccupation with the Internet. Information regarding physiological symptoms associated with Internet addiction is very limited and categorized

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in broad, basic terms that could apply to a multiplicity of other behavioral and psychological disorders. However, these physiological signs and symptoms are consistently present with those with Internet addiction. Further research regarding additional physiological signs and symptoms as well as consistency throughout the research is needed.

Psychological Signs and Symptoms

The principle psychological symptom of Internet addiction is the failure of the individual to monitor and control her or his Internet usage (Bozoglan et al., 2014; Park et al., 2013; Shapira et al., 2013). Such failure is reflected in scrolling through Facebook or Twitter for a “quick minute” that evolves into hours of time spent on social media sites. Nor is it unusual for adolescents to reopen websites repeatedly, mostly to revisit the same content. In other words, Internet use may become a habit that spirals into an addiction. An addiction can be defined as a condition that results when a substance or behavior initially used to receive pleasure becomes a compulsive need to the degree that it causes distress and impairment in daily life and functioning. Neuroimaging research done in Italy found that those with Internet addiction and those with substance addiction displayed

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similar patterns of activity in the nucleus accumbens and the orbitofrontal cortex of the brain (Cerniglia, Zoratto, Cimino, Laviola, Ammaniti, & Adriani, 2016). These findings suggest that like those who have a substance addiction, those with Internet addiction have the same neurological responses to using the Internet as to those with substance abuse do (Cerniglia et al., 2016; Shapiro & Margolin, 2014). With an addiction, the Internet has become more of a craving to connect or be informed than a tool to use.

The extensive integration of the Internet into the adolescents' lives has dramatically reduced their in-person social interactions, with most social interactions occurring on the Internet instead of occurring face-to-face (Usta, Korkmaz, & Kurt, 2014). Bozoglan's et al. (2014) study in the Netherlands, found that socializing activities such as social media sites and online messaging websites increased Internet addiction. Usta's et al. (2014) study also done in the Netherlands affirmed that adolescents view social interaction in a virtual environment as no different than social interactions with others in a live, non-virtual environment. After all, conversation exists in both settings. However, these adolescents shy away from verbally interacting face-to-face with their peers and adults, and feel

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that it is normal to have relationships with someone via online (Cerniglia et al., 2016 Kawabe et al., 2016; Sanders, Field, Diego, & Kaplan, 2000). Adolescent Internet users are provided with a social scene in which they can quickly highlight what they believe are their good qualities versus a face-to-face interaction, which could yield rejection. It was found that participants were unwilling to share personal and private information about themselves with others in these virtual social scenes (Usta et al., 2014). This online scene becomes safe to be whomever they choose. However, not everything presented through this online social scene is realistic or correct. Additionally, studies done in the United Kingdom and Italy documented that these adolescents also report that they feel lonely despite engaging in what they define as social interactions (Aboujaoude, 2010; Cerniglia et al., 2016). Although there is some form of socializing happening through the Internet, the fundamental elements of social interaction are lost.

Adolescents' use of the Internet is not without a positive side. The Internet brings these adolescents the opportunity to connect with more people from different cultures, backgrounds, and perspectives. Furthermore, adolescents who are shy with in-person settings have the opportunity to create and

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maintain relationships within the comforts of an online social scene. Nevertheless social media relationships have a potential cost. Shapiro and Margolin (2014) and their study with adolescents from the United States found that adolescents do not accurately or fully portray themselves online. Instead bits and pieces are shared, featuring those they consider most important. In the same study it was found that these adolescents are inhibited from creating deeply rooted relationships because the relationships are established through online social scenes, thus encouraging superficial, short-term relationships. These in-person relationships are significant to an adolescent's life, as well as to their growth and development of their opinions, likes and dislikes, behavior, and self-esteem (Cerniglia et al., 2016). Although there is an increase in the amount and types of people one could connect with, the quality and legitimacy of that relationship is influenced and perhaps compromised. Furthermore, face-to-face and in-person relationships are a significant part to an adolescent's life, and those relationships are not developed online. Therefore, while there seems to be a social interaction occurring through some medium, an actual and substantial relationship is lost from a lack of interaction.

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Internet Addiction and the Link to Depression

One of the main comorbid disorders of Internet addiction is clinical depression. According to the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-V) depression is characterized by a presence of an empty, sad, or down mood that persists for an extended period of time. An addiction pre-occupies one's thoughts and actions and often has byproducts that influence your mental state. For Internet addiction, a comorbidity with depression is more common than not (Andreou & Svoli, 2013). It was found in studies done in Spain, China, Qatar, Korea, United States, and the Netherlands that there was a direct correlation between having Internet addiction and developing depression . Moreover, several cross-sectional studies done in Greece found that Internet Addition was more commonly associated with depression in adolescents than any other psychopathological issues (Andreou & Svoli, 2013). These studies found that as use of the Internet increased to an abnormal and excessive level, depressive feelings and an overall state of being depressed simultaneously increased thus developing a cyclical relationship. As an adolescent becomes more depressed, she or he may seek more seclusion and turn increasingly to the Internet for social interaction. This reliance on virtual engage-

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ment, in turn, may amplify the individual's depressive state (Gámez-Guadix, 2014).

The relationship between Internet addiction and depression was found through first identifying if the adolescent participants in each study had Internet addiction, followed by testing for depression. In Park's (2013) study in Korea as well as Bener's and Bhugra's (2013) study in Qatar include the use of Beck's Depression Inventory (BDI) as a self-test and self-report method to measure the severity of the individual's depression. They found that BDI scores were significantly higher for those who were diagnosed with Internet addiction than for those who were not. Lam's et al. (2009) found that, in China, respondents who reported an Internet addiction were almost four times more likely to report clinical depression than those who did not report an Internet addiction. Usta et al. (2014) speculated that the relationship between Internet addiction and depression reflects the withdrawal from traditional, real-world sociality in favor of dependence on online social sites.

Methods of Treatment

According to Gámez-Guadix (2014) who studied adolescents in Spain and Shapiro and Margolin (2014) who studied

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them in the United States, adolescents are most likely to develop Internet addiction compared to other ages groups. Thus, exploring potential methods of recovery can help adolescents receive the assistance they need while still in the early stages of Internet addiction. Because of the lack of a clear and concise definition or method of diagnosis of Internet addiction, there are only a series of self-report questions that are used consistently to diagnose Internet addiction in addition to the signs and symptoms discussed previously (Cerniglia et al., 2016). In 1998, Kimberly Young, the first researcher to report of Internet Addiction Disorder, produced the first set of questions to diagnose Internet addiction. Table 1 displays these questions. Much has changed in the meantime, prompting Cerniglia et al. (2016) to call for new diagnostic methods that better capture the parameters of an Internet addiction.

Cognitive Behavioral Therapy (CBT) has been frequently adopted for the treatment of Internet addiction in the United States, the Netherlands, and China (Aboujaoude, 2010; Bozoglan et al., 2014; Du, Jiang & Vance, 2010). As one method, CBT uses a journal to keep track of the time one spends using the Internet, as well as one's thoughts about Internet use, and time management. Additionally, CBT helps identify when those

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addicted to the Internet rationalize the need to continue browsing. It was found that participants were able to control their impulses and desires to use the Internet for an extended period of time. Shapira's et al. (2013) suggested that Internet addiction be viewed as an impulse control disorder (a disorder associated with a buildup or craving towards an action with a feeling of satisfaction after the action is complete) and be treated accordingly. Treating Internet addiction in views of an impulse control disorder can help separate a thought and action fusion that seems to describe Internet addiction. Medicines such as anti-depressants and mood stabilizers may be effective. Another potential treatment is a form of peer-to-peer offline communication and activities that encourage face-to-face and inter-person interaction and the development of deeper relationships (Cerniglia et al., 2016). Motivational interviews, as well as multi-modal counseling, may also be effective components of this approach.

Conclusion

Internet addiction is becoming a prevalent mental disorder among adolescents. In an attempt to collect and review information from several areas in the world, the literature refer-

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enced has been done in several countries across the globe. As stated before, Internet addiction is a recent development, and information regarding the etiology, prevalence, incidences, and prognosis is being researched but definitely not complete. A few signs and symptoms have been identified in an effort to help individuals recognize a possible Internet addiction. Also, Internet addiction was shown to be a contributor to depression, and is specifically mentioned to help individuals identify a possible source for their feelings or state of depression, namely the Internet. And finally, diagnostic avenues are given through the questionnaire as well as current treatments.

It should be acknowledged that there have been studies and research done on the benefits of Internet use in regards to academia and success in the classroom. However, these studies are done with the Internet being used moderately and as a tool. The studies and literature referenced in this review have focused on an overuse of Internet, self-reported by participants in these studies. Furthermore, it should be stressed that these studies not only focused on the exorbitant amount of time spent on the Internet but also the types of activities pursued by adolescents and the purposes of those Internet activities that fill that long period of time (Bélanger et al., 2011). Thus, these studies are

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aimed at a specific audience of adolescents and seek to observe a direct result between an overuse of the Internet and resulting mental distress.

These studies referenced throughout this review suggest this relationship between Internet use and human behavior: with an increase in Internet use, there is a decrease in psychological balance, a decrease in the fulfillment of basic physiological needs, and a susceptibility to developing depression or depressive thoughts and feelings. Further research, especially longitudinal research, is needed in order to continue to refine the diagnosis and thereby promote more effective forms of treatment.

On-going research is needed to continue to explore the growing problem of Internet addiction, particularly among the adolescent age group, in order to teach them how to properly use the Internet and to be aware of and monitor their time spent on it. Connecting and socializing with a larger, global group is an excellent practice and helps the adolescent group become more socially acceptable of many cultures and practices. However, an online chat room should not become a replacement for socializing face-to-face. The Internet is a great tool, but too much of a good thing can be detrimental. Moderation

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of both use and time is key to using the Internet safely.

Table 1

Young's Diagnostic Questionnaire for Internet addiction

1. Do you feel preoccupied with the Internet (think about previous online activity or anticipate next online session)?
2. Do you feel the need to use the Internet for increasing amounts of time in order to achieve satisfaction?
3. Have you repeatedly made unsuccessful efforts to control, cut back, or stop Internet use?
4. Do you feel restless, moody, depressed, or irritable when attempting to cut down or stop Internet use?
5. Do you stay online longer than originally intended?
6. Have you jeopardized or risked the loss of significant relationship, job, educational or career opportunity because of the Internet?
7. Have you lied to family members, therapist, or others to conceal the extent of involvement with the Internet?
8. Do you use the Internet as a way of escaping from problems or of relieving a dysphoric mood (e.g. feelings of helplessness, guilt, anxiety, depression)?

Note. The questions provided in Table 1 are directly taken from "Internet addiction: The emergence of a new clinical disorder" by Young, diagnosis is considered positive for having Internet addiction when five or more of these questions receive a "yes".

References

- Aboujaoude, E. (2010). Problematic Internet use: An overview. *World Psychiatry*, 9(2), 85–90.
- Andreou, E., & Svoli, H. (2013). The association between Internet user characteristics and dimensions of Internet addiction among Greek adolescents. *International Journal of Mental*

INTERNET ADDICTION

Health and Addiction, 11(2), 139-148. doi:10.1007/s11469-012-9404-3

Bélanger, R. E., Akre, C., Berchtold, A., & Michaud, P. (2011). A U-shaped association between intensity of Internet use and adolescent health. *Pediatrics*, 127(2), e330-e335. doi:10.1542/peds.2010-1235

Bener, A., & Bhugra, D. (2013). Lifestyle and depressive risk factors associated with problematic Internet use in adolescents in an Arabian Gulf culture. *Journal of Addiction Medicine*, 7(4), 236-242. doi: 10.1097/ADM.0b013e3182926b1f

Bozoglan, B., Demirer, V., & Sahin, I. (2014). Problematic Internet use: Functions of use, cognitive absorption, and depression. *Computers in Human Behavior*, 37, 117-123. doi:10.1016/j.chb.2014.04.042

Cerniglia, L., Zoratto, F., Cimino, S., Laviola, G., Ammaniti, M., & Adriani, W. (2016). Internet addiction in adolescence: Neurobiological, psychosocial and clinical issues. *Neuroscience and Biobehavioral Reviews*, doi:10.1016/j.neubiorev.2016.12.024

Du, Y., Jiang, W., & Vance, A. (2010). Longer term effect of randomized, controlled group cognitive behavioral therapy for Internet addiction in adolescent students in Shanghai. *Australian and New Zealand Journal of Psychiatry*, 44(2), 129-134. doi:10.3109/00048670903282725

Gámez-Guadix, M. (2014). Depressive symptoms and problematic Internet use among adolescents: Analysis of the longitudinal relationships from the cognitive-behavioral model. *Cyberpsychology, Behavior, and Social Networking*, 17(11), 714-719.

Hilbert, M., & López, P. (2011). The world's technological capacity to store, communicate, and compute information. *Science*, 332(6025), 60-65.

Kawabe, K., Horiuchi, F., Ochi, M., Oka, Y., & Ueno, S. (2016). Internet addiction: Prevalence and relation with mental states in adolescents. *Psychiatry and Clinical Neurosciences*, 70(9), 405-412. doi:10.1111/pcn.12402

INTERNET ADDICTION

- Kim, Y., Park, J. Y., Kim, S. B., Jung, I.-K., Lim, Y. S., & Kim, J.-H. (2010). The effects of Internet addiction on the life-style and dietary behavior of Korean adolescents. *Nutrition Research and Practice*, 4(1), 51–57. <http://doi.org/10.4162/nrp.2010.4.1.51>
- Lam, L. T., Zi-wen, P., Jin-cheng, M., & Jin, J. (2009). Factors associated with Internet addiction among adolescents. *Cyberpsychology & Behavior*, 12(5), 551-555. doi:10.1089/cpb.2009.0036
- Liu, T. C., Desai, R. A., Krishnan-Sarin, S., Cavallo, D. A., & Potenza, M. N. (2011). Problematic Internet use and health in adolescents: Data from a high school survey in Connecticut. *Journal of Clinical Psychiatry*, 72(6), 836-845. doi:10.4088/JCP.10m06057
- Muusses, L.D., Finkenauer, C., Kerkhof, P., & Billedo, C.J. (2014). A longitudinal association between compulsive Internet use and wellbeing. *Computers in Human Behavior*, 36, 21-28.
- Park, S., Hong, K. M., Park, E. J., Ha, K. S., & Yoo, H. J. (2013). The association between problematic Internet use and depression, suicidal ideation and bipolar disorder symptoms in Korean adolescents. *Australian and New Zealand Journal of Psychiatry*, 47(2), 153-159. doi:10.1177/0004867412463613
- Sanders, C. E., Field, T. M., Diego, M., & Kaplan, M. (2000). The relationship of Internet use to depression and social isolation among adolescents. *Adolescence*, 35(138), 237-242.
- Shapira, N. A., Lessig, M. C., Goldsmith, T. D., Szabo, S. T., Lazoritz, M., Gold, M. S., & Stein, D. J. (2013). Problematic internet use: Proposed classification and diagnostic criteria. *Depression & Anxiety*, 17(4), 207-216. doi:10.1002/da.10094
- Shapiro, L. S., & Margolin, G. (2014). Growing up wired: Social networking sites and adolescent psychosocial development. *Clinical Child and Family Psychology Review*, 17(1), 1-18. doi:10.1007/s10567-013-0135-1
- Usta, E., Korkmaz, Ö., & Kurt, I. (2014). The examination of individuals' virtual loneliness states in Internet addiction and

INTERNET ADDICTION

virtual environments in terms of inter-personal trust levels.

Computers in Human Behavior, 36, 214-224.

Wartella, E., Rideout, V., Montague, H., Beaudoin-Ryan, L., & Lauricella, A. (2016). Teens, health and technology: A national survey. *Media and Communication*, 4(3) doi: <http://dx.doi.org/10.17645/mac.v4i3.515>.

Young, K. S. (1998). Internet addiction: The emergence of a new clinical disorder. *Cyberpsychology & Behavior*, 1(3), 237-244. doi:10.1089/cpb.1998.1.237

Influence of Mothers on the Development of Body Dissatisfaction in Daughters

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Intuition: The BYU Undergraduate Journal of Psychology

Abstract:

Feelings of body dissatisfaction in young women are becoming ever more prevalent. Body Dissatisfaction can lead to shame, hinder personal relationships, and distract women (ranging from pre-adolescence to early adulthood) from educational, career, or creative pursuits. Mothers are some of the biggest influencers in the development of body dissatisfaction in young adult women. A daughter's development of body dissatisfaction can be influenced by their mother through direct interactions, indirect interactions, and the emotional quality of the mother-daughter relationship. Direct mother-daughter interactions can negatively influence daughters' body dissatisfaction through maternal criticism and encouragement to lose weight (Sniezek, 2006; Taniguchi & Aune, 2013). Indirect mother-daughter interactions also negatively influence their daughter's body dissatisfaction through maternal body dissatisfaction and co-rumination. Daughters who perceived their mothers as less caring, more overprotective, and less emotionally close were more likely to struggle with body dissatisfaction (Calam, Waller, Slade, & Newton, 1990; Smith et al., 2016). These combined factors confirm the integral effect of maternal influence on daughters' development of healthy body image. This paper will review existing literature to demonstrate this relationship.

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Amber Knight is a 16-year-old girl who loved to run. She has a caring mother, but suffers from severe body dissatisfaction and Anorexia Nervosa. Amber and her mother, Sheila, have always been known for their athletic ability, especially in long-distance running. Sheila and Amber begin their day by waking at 5:30 a.m. to go on a 3-mile run together. For as long as Amber can remember, she and her mother have maintained a strict low-calorie, low-carb diet to prevent weight gain. Recently Amber was admitted to an inpatient treatment center for Anorexia Nervosa. “I don’t know how it got to this point,” said Amber’s mother. “Her whole life, she’s never been fat, and I’ve always told her she was beautiful. Even now, she is so thin, and I have told her she is skinny so many times. . . I honestly don’t know what else to do.” In an effort to provide her daughter with the help she did not feel she was equipped to provide, the Knights sent Amber to Utah’s Center for Change. “It doesn’t matter what anyone says or if they tell me I am beautiful the way I am,” Amber confessed. “All I see when I look in the mirror is a fat, ugly person” (Adapted from personal communication, names have been changed, 2016). At 5’9” and 100 pounds, she is far from what health professionals would consider overweight. Amber represents millions of American adolescent girls who grapple

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with the often debilitating effects of eating disorders or body dissatisfaction (Gustafson-Larson, 1992).

Although Amber's case is more severe than most others, the issue of body dissatisfaction (a risk factor for the development of eating disorders) is an epidemic that affects millions of women with varying levels of severity (Thompson, Heinberg, Altabe, & Tantleff-Dunn, 1999). It has been estimated that about 6% of women are diagnosed with an eating disorder during their lifetime (Hudson, Hiripi, Pope, & Kessler, 2007). Gustafson-Larson and Terry (1992) found that 46% of 11-year-olds report dieting behaviors, while 81% have family members who report dieting or weight control behaviors. Women who exhibit disordered eating behaviors often strive to reach unrealistic goals, are overly preoccupied with the opinions of others, and have an underdeveloped sense of identity (McGee, Hewitt, Sherry, Parkin, & Flett, 2005). These tendencies negatively affect women's emotional health, hinder interpersonal relationships, and distract them from educational, career, or creative pursuits.

A variety of sociocultural factors contribute to the development of body dissatisfaction in adolescent girls, such as media exposure and interpersonal relationships (Ricciardelli & McCabe, 2001). Media and peer influence can cause adolescent

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girls to internalize messages portraying a thin figure as a body ideal (Knobloch-Westerwick & Crane, 2012). In turn, peer and family influences can reinforce these ideals through actions, comments, or conversations, such as positive compliments or negative criticism (Vincent & McCabe, 2000).

Despite the influence of media, family and peer relationships have been found to have an even stronger impact on the development of body dissatisfaction, as they are more proximal and prevalent in the life of the adolescent (Abraczinskas, Fisak, & Barnes, 2012). The role of mothers in adolescent development is especially important to consider, as they act as models for daughters in the establishment of eating pathology and weight loss behaviors (Vincent & McCabe, 2000). Although the development of adolescent body image is influenced by a wide range of variables, maternal example is arguably the most significant of these factors because of the instrumental role a mother plays during this crucial stage of her daughter's development. Both direct and indirect maternal influence, as well as the emotional quality of the mother-daughter relationship, contribute to development of body dissatisfaction in adolescent girls.

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Direct Maternal Influence

During the time of preadolescence, girls begin to challenge their own concepts of self and compare themselves to those around them (Arroyo & Andersen, 2016). As these cognitive developments occur, the direct influence of mothers can significantly affect the manner in which daughters perceive their bodies. Direct maternal influence, expressed through deliberate, body-related communication, differs from indirect influence, which is passively exerted through parental modeling (Linville, Stice, Gau, & O'Neil, 2011). Research has found that both forms of maternal influence affect the development of body satisfaction in adolescent daughters (Arroyo & Andersen, 2016; Linville et al., 2011). As girls continue to challenge their own self-perceptions, they can also challenge the perception of their own bodies and compare their own physical features to those of their mothers, sisters, peers, and others around them. Direct maternal influence in the form of commentary or criticism from mothers can cause girls to feel insecure and develop a negative perception of their bodies.

Encouraging daughters to lose weight is one way that mothers can exert direct maternal influence on the development of adolescent body dissatisfaction. A study done by Ben-

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edikt, Wertheim, and Love (1997) examined a sample of 89 adolescent Australian girls and their mothers. Using a Likert-type assessment, researchers measured both mothers' and daughters' perceptions of maternal weight loss encouragement, as well as moderate weight-loss behaviors. Results indicated that when mothers encouraged their daughters to lose weight, and when daughters perceived this encouragement, the daughters often lost weight (Benedikt et al., 1998). According to these results, girls who were encouraged to lose weight by their mothers were more likely to act upon those promptings. Although oftentimes intended to promote physical health, this maternal encouragement to lose weight can lead to an unhealthy drive for thinness and prolonged body dissatisfaction.

Another form of direct influence that predicts the development of body dissatisfaction in adolescent girls is maternal criticism. Snizek (2006) conducted a study to test whether perfectionism and eating disorders were predicted by daughters' perceptions of parental criticism in a sample of adolescent girls ages 13-15. Using the Eating Disorders Examination Questionnaire (EDE-Q) and the Adolescents' Perception of Criticism of Attractiveness by Mother Subscale (as measured by the Parental Criticism Questionnaire, PCQA CAM), Snizek (2006) found

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that 20% of the variance of EDE-Q scores was accounted for by the degree to which daughters perceived their mothers as critical of their own appearance. Using the Perfectionism Subscale of the Eating Disorder Inventory (EDI-2), Sniezek (2006) also found that girls who scored higher on the PCQA CAM scored higher on the EDI-2 perfectionism subscale. These results suggest that girls who perceived their mothers to be critical of their appearance were more likely to exhibit behaviors of disordered eating and perfectionism. In addition, Taniguchi and Aune (2013) found perfectionism to be a risk factor in the development of eating disorders. Taken together, these findings suggest that appearance-related maternal criticism may lead to perfectionism which can lead to disordered eating.

Although criticism from both parents has been shown to negatively influence the development of body satisfaction, research has found that criticism from mothers is particularly influential on daughters. A study done by Taniguchi and Aune (2013) sought to understand the effect that parent-child communication has on body dissatisfaction in a sample of 154 adolescent participants. Researchers used the Parent Adolescent Communications Scale (PACS) to measure daughters' perception of negative parent-child communication and the second

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edition of the Eating Disorders Inventory (EDI-2) to measure body dissatisfaction. The results showed that mothers and daughters who frequently criticized one another's appearance exhibited higher levels of body dissatisfaction. Additionally, daughters' perception of maternal criticism was a stronger predictor of body dissatisfaction than their perception of paternal criticism (Taniguchi & Aune, 2013). These findings indicate that mothers' criticism of their daughters' appearance can significantly increase the development of adolescent body dissatisfaction. Perhaps mothers are more critical because they spend more time with daughters than fathers and because they are a same-sex role model.

Research has also found daughters' perceptions of maternal criticism to be more predictive of adolescent body dissatisfaction than the level of maternal criticism reported by mothers themselves (Keery, Eisenberg, Boutelle, Neumark-Sztainer, & Story, 2006; Ogden & Steward, 2000). The previously mentioned study by Snizek (2006), which found adolescent perceptions of maternal criticism to be predictive of body dissatisfaction, also tested whether mothers' self-reported levels of criticism toward their daughters were predictive of adolescent eating disorders. Using the Parental Criticism Questionnaire

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(PCQ GC), Snizek (2006) found no significant relationship between mothers' self-reports and the occurrence of eating disorders based on their daughters' Eating Disorders Examination Questionnaire Global scores. Overall, mothers reported themselves as less critical in comparison to daughters' perceptions of their mothers' criticism. These findings suggest that the amount of maternal criticism, as perceived by the daughter, plays an instrumental role in the development of adolescent body dissatisfaction. Despite the fact that daughters' perceptions of criticism may not be perfectly reflective of reality, even infrequent critical comments made by a mother can cause daughters to perceive higher levels of maternal criticism. These negative perceptions can place daughters at a greater risk for increased body dissatisfaction.

Indirect Maternal Influence

Although direct maternal communications, such as criticism and encouragement to lose weight overtly influence daughters' feelings of body satisfaction, mothers' own personal attitudes and behaviors can also affect their daughters' self-perception in a more discrete and implicit way (Linville et al., 2011).

Throughout daughters' preadolescent to adolescent devel-

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opment, indirect maternal influence can be exerted through attitudes, indirect comments, and example. One influential and highly supported theory of human development is Bandura's (1977) social learning theory. This theory states that learning is a cognitive process which occurs through observation. Children often observe behaviors of same-sex models and replicate those behaviors (Bandura, 1977). Mothers in particular were found to have a significant influence on their daughters as mothers acted as models of behavior (Arroyo & Andersen, 2016). Mothers who personally experience body dissatisfaction can unintentionally model this sense of body dissatisfaction to their daughters.

Mothers can indirectly model body dissatisfaction through what is known as self-objectification. In recent decades, Western culture has increasingly scrutinized the appearance of the female body and its failure to meet unrealistic beauty expectations (Knobloch-Westerwick & Crane, 2012). This scrutiny, known as objectification, treats the female body as an object subject to evaluation. Self-objectification occurs when women evaluate and criticize their own bodies from an external perspective (Fredrickson & Roberts, 1997). A study done by Arroyo and Andersen (2016) examined the relationship levels

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of self-objectification between mothers and daughters. Using an original assessment of self-objectification, researchers measured levels of self-objectification in a sample of 199 women ages 18-25 and their mothers. While the results of the study showed only a small level of correlation, it was significant, indicating that mothers' self-objectification likely negatively influenced daughters' self-objectification, even if it was not the only factor, or even the dominant factor. In accordance with Bandura's social learning theory, daughters actively observe mothers who self-objectify and mimic the behaviors of negative self-evaluation exhibited by their maternal models. This self-objectification causes young girls to compare their own bodies to the socially constructed and often unrealistic idealized thin body expectation which leads to body dissatisfaction. Many women may even feel that this self-evaluation of their bodies is a reflection of their own self-worth. Such evaluations can lead to feelings of shame and distorted perceptions of self.

Mothers can model body dissatisfaction by complaining or co-ruminating with their daughters about the appearance of their own bodies. Co-rumination is the act of sharing or discussing one's own negative feelings with another person (Arroyo & Andersen, 2016). A study done by Lowes and Tig-

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gemann (2003) sought to understand the relationship between parental body dissatisfaction and child body dissatisfaction. In a sample of 135 Australian 5- to 8-year-old boys and girls, researchers found a significant correlation between the incidence of maternal body dissatisfaction and daughter body dissatisfaction, while they found no significant correlation between paternal and daughter body dissatisfaction. Vincent and McCabe (2000) found that girls who frequently engaged in conversations regarding weight loss were more likely to exhibit disordered eating. It may be inferred from these results that mothers can model their own body dissatisfaction to their daughters through the social learning model. Frequent appearance-related complaints or co-rumination act as models of behaviors for daughters and can influence them to feel dissatisfied with their bodies.

Maternal attitudes, when communicated to daughters, can also have a great effect on daughters' attitudes towards their own bodies. Cooley, Toray, Wang, & Valdez (2008) found a very strong positive correlation between the level of a daughter's body dissatisfaction and the level of a mother's dissatisfaction with her daughter's body. Pike and Rodin (1991) also found that mothers who felt more dissatisfied about their own bodies had

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more negative perceptions of their daughters' bodies. Evidently, a daughter's attitude about her own body can be modeled after her mother's attitude. However, social learning occurs based on overt behavior exhibited by a parental model (Bandura, 1977). In accordance with Bandura's (1977) theory, unexpressed parental attitudes alone do not predict body dissatisfaction in daughters. A more accurate predictor of adolescent body dissatisfaction is daughters' perceptions of their mothers' attitudes toward daughters' bodies.

The previous studies suggest that mothers can indirectly affect their daughters' feelings of body dissatisfaction through their own personal habits and behaviors. Mothers act as models for their daughters, who learn by mimicking their mothers' behaviors. Mothers who evaluate their own bodies as if they were objects and complain about their bodies model this behavior to their daughters. Mothers must think and speak positively about their daughters' bodies as well as refrain from co-rumination and self-objectification, in order to help daughters think positively about their bodies. In summary, mothers should celebrate their bodies and model a more body-positive attitude for their daughters.

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Emotional Quality of Mother-Daughter Relationship

Direct and indirect interactions (such as criticism and maternal modeling) are elements of the mother-daughter relationship, yet, research has found that the quality of this relationship itself can influence adolescent body dissatisfaction (Cheng & Mallinckrodt, 2009; Cooley et al., 2008; Pike & Rodin, 1991; Smith et al., 2016). This notion is echoed in Ogden and Steward's (2000) interactive hypothesis. This hypothesis predicts that the mother-daughter relationship, rather than maternal modeling alone, contributes to the development of body dissatisfaction in daughters (Ogden & Steward, 2000). Based on this hypothesis, one may conclude that unhealthy mother-daughter relationships would contribute to body dissatisfaction, while healthy mother-daughter relationships would prevent or protect daughters from body dissatisfaction.

One study found that girls with eating disorders reported that their parents were less caring and more overprotective (Calam et al., 1990). This study, conducted by Calam et al. (1990), used the Parental Bonding Instrument (PBI) to assess the levels of parental care and protection reported by a sample of young adult women with a diagnosed eating disorder and a control sample without a diagnosed eating disorder. Care

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was defined as empathy within the parent-child relationship, while protection was defined as the level of control exerted by parents within the relationship (Calam et al., 1990). Women diagnosed with bulimia and anorexia nervosa were significantly more likely to rate their parents as low in care or high in protectiveness when compared with the control group (Calam et al., 1990). Women with diagnosed eating disorders perceived their parents as less caring, which suggests that a negative perception of parent-child relationships may be predictive of body dissatisfaction. Parents who are overprotective of their daughters limit their autonomy, which can encourage them to engage in disordered eating as an effort to gain a sense of autonomy and control.

Interestingly, a daughter's perception of the quality of the mother-daughter relationship is more predictive of eating pathology and body dissatisfaction than the mother's perception of the relationship (Arroyo & Andersen, 2016; Cooley et al., 2008; Smith et al., 2016; Taniguchi & Aune, 2013). A study done by Smith, et al. (2016) used the interactive hypothesis to better understand how mothers' and daughters' perceptions of the mother-daughter relationship affected childhood body dissatisfaction in a sample of 152 8- to 12-year-old girls and

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their mothers. To determine body dissatisfaction, researchers used the Child Figures Drawings (CFD) assessment, which presented the child with images of female figures which range from thin to heavy. The child then identified the figure which they believed best represents their body type, as well as the figure which they considered to be their ideal body type. The difference between these two figures determined the child's level of body dissatisfaction (CFD score). Researchers also used the Clinical Assessment of Interpersonal Relations (CAIR) to measure the participants' perception of the mother-daughter relationship. The results showed that daughters who scored lower on the CAIR reported higher scores of body dissatisfaction based on the CFD assessments. There was, however, no significant correlation between mothers' perceived mother-daughter relationship and adolescent body dissatisfaction (Smith et al., 2016). The results of this study suggest that daughters who perceive a more positive mother-daughter relationship exhibit lower body dissatisfaction and higher body esteem. Although the participants of this study are pre-adolescent, levels of body dissatisfaction typically increase as girls progress into adolescence (Taniguchi & Aune, 2013). Although significant within a preadolescent sample, the results from this study could even

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be considered under-representative of the body dissatisfaction experienced by the older adolescent population, which might experience even higher rates of body dissatisfaction accounted for by the perceived mother-daughter relationship. These results also correspond with previous studies, which have found that daughters' perceptions of indirect and direct maternal interactions are more predictive of adolescent body dissatisfaction than the reports of their mothers (Keery et al., 2006; Ogden & Steward, 2000; Snizek, 2006; Taniguchi & Aune, 2013).

Conclusion

Many families, such as the previously mentioned Knight family, have children who struggle with body dissatisfaction. Mothers can come to better alleviate their daughters' struggles by avoiding negative appearance-related interactions, by modeling body positivity, and by improving the emotional quality of the mother-daughter relationship. With an understanding that direct maternal influence, indirect maternal influence, and the emotional quality of the mother-daughter relationship contribute significantly to the development adolescent body image, mothers can strive to avoid appearance-related criticism, model a healthy sense of body satisfaction, and to grow emotionally

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closer to their daughters. These practices may act as preventative measures for the development of body dissatisfaction and eating disorders.

Research regarding direct maternal influence allows one to conclude daughters who are encouraged by their mothers to lose weight are more likely to engage in weight loss behaviors and exhibit higher levels of body dissatisfaction (Benedikt, Wertheim, & Love, 1997). It can also be concluded that maternal criticism can increase perfectionism behaviors and body dissatisfaction (Snizek, 2006; Taniguchi & Aune, 2013). Mothers can strive to help their daughters develop body satisfaction by refraining from giving criticism and encouragement to lose weight, and instead encourage lifestyles which promote physical, mental, and emotional healthiness.

Research on indirect maternal influence also suggests that daughters who see their mothers engaging in self-objectification and co-rumination are more likely to follow these patterns and experience body dissatisfaction (Arroyo & Andersen, 2016; Vincent & McCabe, 2000). This suggests that mothers who have a healthier body image are more likely to have daughters with body satisfaction. Mothers can model this behavior and attitude by speaking positively about their own bodies and

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refraining from engaging in verbal comparisons.

Based on existing research, one might infer that the emotional quality of the mother-daughter relationship is positively correlated with healthy levels of adolescent body satisfaction (Calam, Waller, Slade, Newton, 1990; Smith et al., 2016). Parents can help their daughters to develop healthy body image by being caring and loving to their daughters and accepting them regardless of their body type. Mothers can also allow their daughters to develop their own sense of autonomy by refraining from overprotection, which will in turn help daughters to develop a healthy sense of identity and body image. Although daughters' perceptions of the mother-daughter relationship predict body dissatisfaction more than the parents' perception of the relationship, mothers can demonstrate love and care to try to improve their daughters' perceptions of these relationships, and thus help them feel satisfied with themselves and their bodies.

A limitation of the research regarding mother-daughter relationships and body dissatisfaction is the subjective nature of these relationships. Much of the research focuses on the daughters' perceptions of mother-daughter interactions, as the reality of these relationships are difficult to measure. Future research

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might investigate the discrepancy between the relationship perceptions and the relationship reality and how those contribute to daughter body dissatisfaction. Future research should also take a more proactive approach and focus on ways that mothers can influence the development of positive body image. It is possible that verbal validation may have a positive influence on the development of body satisfaction. Research is also needed to explore the benefits of positive reinforcement based on accomplishments, such as education and work ethic, rather than physical appearance.

References

- Abraczinskas, M., Fisak, B., & Barnes, R. D. (2012). The relation between parental influence, body image, and eating behaviors in a nonclinical female sample. *Body Image*, 9(1), 93-100.
- Arroyo, A., & Andersen, K. K. (2016). The relationship between mother-daughter self-objectification: Identifying direct, indirect, and conditional direct effects. *Sex Roles*, 74(5-6), 231-241. doi:10.1007/s11199-015-0554-1
- Bandura, A. (1977). *Social learning theory*. Englewood Cliffs, NJ: Prentice Hall.
- Benedikt, R., Wertheim, E. H., & Love, A. (1998). Eating attitudes and weight-loss attempts in female adolescents and their mothers. *Journal of Youth and Adolescence*, 27(1), 43-57.
- Calam, R., Waller, G., Slade, P. D., & Newton, T. (1990). Eating disorders and perceived relationships with parents. *International Journal of Eating Disorders*, 9(5), 479-485. doi:AID-EAT2260090502>3.0.CO;2-I

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- Cheng, H., & Mallinckrodt, B. (2009). Parental bonds, anxious attachment, media internalization, and body image dissatisfaction: Exploring a mediation model. *Journal of Counseling Psychology*, 56(3), 365.
- Cooley, E., Toray, T., Wang, M. C., & Valdez, N. N. (2008). Maternal effects on daughters' eating pathology and body image. *Eating Behaviors*, 9(1), 52-61. doi:10.1016/j.eat-beh.2007.03.001
- Fredrickson, B. L., & Roberts, T. (1997). Objectification theory: Toward understanding women's lived experiences and mental health risks. *Psychology of Women Quarterly*, 21(2), 173-206. doi:10.1111/j.1471-6402.1997.tb00108.x
- Gustafson-Larson, A. M., & Terry, R. D. (1992). Weight-related behaviors and concerns of fourth-grade children. *Journal of the American Dietetic Association*, 92(7), 818-822.
- Hudson, J. I., Hiripi, E., Pope, H. G., & Kessler, R. C. (2007). The prevalence and correlates of eating disorders in the National Comorbidity Survey Replication. *Biological psychiatry*, 61(3), 348-358.
- Keery, H., Eisenberg, M. E., Boutelle, K., Neumark-Sztainer, D., & Story, M. (2006). Relationships between maternal and adolescent weight-related behaviors and concerns: The role of perception. *Journal of Psychosomatic Research*, 61(1), 105-111. doi:10.1016/j.jpsychores.2006.01.011
- Knobloch-Westerwick, S., & Crane, J. (2012). A losing battle effects of prolonged exposure to thin-ideal images on dieting and body satisfaction. *Communication Research*, 39(1), 79-102.
- Linville, D., Stice, E., Gau, J., & O'Neil, M. (2011). Predictive effects of mother and peer influences on increases in adolescent eating disorder risk factors and symptoms: A 3-year longitudinal study. *International Journal of Eating Disorders*, 44(8), 745-751. doi:10.1002/eat.20907
- Lowes, J., & Tiggemann, M. (2003). Body dissatisfaction, dieting awareness and the impact of parental influence in young children. *British Journal of Health Psychology*, 8(2), 135-147.

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- McGee, B. J., Hewitt, P. L., Sherry, S. B., Parkin, M., & Flett, G. L. (2005). Perfectionistic self-presentation, body image, and eating disorder symptoms. *Body Image, 2*(1), 29-40.
- Ogden, J., & Steward, J. (2000). The role of the mother-daughter relationship in explaining weight concern. *International Journal of Eating Disorders, 28*(1), 78-83. doi:AID-EAT9>3.0.CO;2-N
- Pike, K. M., & Rodin, J. (1991). Mothers, daughters, and disordered eating. *Journal of Abnormal Psychology, 100*(2), 198.
- Ricciardelli, L. A., & McCabe, M. P. (2001). Children's body image concerns and eating disturbance: A review of the literature. *Clinical Psychology Review, 21*(3), 325-344.
- Smith, J. E., Erickson, S. J., Austin, J. L., Winn, J. L., Lash, D. N., & Amrhein, P. C. (2016). Mother daughter relationship quality and body image in preadolescent girls. *Journal of Child and Family Studies, 25*(9), 2683-2694. doi:10.1007/s10826-016-0452-3
- Snizek, R. (2006). Parental criticism and eating disturbance in adolescent females: Implications for a multifaceted eating disorder prevention program. *Dissertation Abstracts International, 67*(06).
- Taniguchi, E., & Aune, R. K. (2013). Communication with parents and body satisfaction in college students. *Journal of American College Health, 61*(7), 387-396. doi:10.1080/07448481.2013.820189
- Thompson, J. K., Heinberg, L. J., Altabe, M., & Tantleff-Dunn, S. (1999). *Exacting beauty: Theory, assessment, and treatment of body image disturbance*. American Psychological Association.
- Vincent, M. A., & McCabe, M. P. (2000). Gender differences among adolescents in family, and peer influences on body dissatisfaction, weight loss, and binge eating behaviors. *Journal of Youth and Adolescence, 29*(2), 205-221. doi:1005156616173

When Two Roads Diverge: How Language Barriers Undermine Immigrant Parental Authority

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Abstract:

In the United States, immigrant families are one of the fastest growing and most diverse segments of the population (Zhou, 1997). Researchers have studied many facets of the immigration process that these families go through, such as acculturation gaps (Weiskirch & Alva, 2002), ethnic identity (Hurtado & Gurin, 1987), youth violence (Boutakidis, Guerra, & Soriano, 2006), and parenting styles (Nguyen, 2008). One construct that surfaces often in these studies is immigrant parental authority; some researchers hypothesize that the immigration experience could shift the authority structure in immigrant homes. The purpose of this literature review is to examine language barriers between immigrant parents and children as a possible cause of this authority shift and to synthesize how that shift is manifest in intellectual, social, and ethnic identity. The review focuses first on the perspective of immigrant parents, second on the perspective of their adolescent children, and concludes that language barriers have a powerful influence on parental authority from both perspectives.
Keywords: immigrant parents/adolescents, language barriers, parental authority, acculturation, intergenerational relations

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Introduction

Mario came to the United States when he was just 8 years old. Soft-spoken, shy, and very intelligent, he was just one of the hundreds of Cape Verdean adolescents in Boston's most immigrant-heavy neighborhoods. Mario's parents immigrated in search of a better life for their children, fleeing economic depression and lack of opportunity in the hope that the Cape Verdean community in Boston could provide a better home. By sixteen, Mario was completely fluent in English and caught between two cultures; he was winning awards at school and then returning home to a tiny, dilapidated apartment funded by his parents' work at the hospital laundromat. They spoke only Cape Verdean Creole at home. This young man lived in a world both culturally and linguistically divided along generational lines. Mario remembered little of Cape Verde and, while genuinely respectful of his parents' language and culture, faced a constant academic and social disconnect with them. These language and culture barriers are not unique to Mario or even the Cape Verdean community in Boston—in fact, they are faced by millions of immigrant families across the United States.

Significant psychological study has been devoted to immigrants' intergenerational conflicts here in the United

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States, with many researchers focusing specifically on language barriers within immigrant families. Although the diverse and mobile nature of this population makes it difficult to study linguistic situations like Mario's, enough significant research has been done to create an effective picture of their acculturation struggle. Quantitative studies often focus on measurable interactions like language brokering and how they affect factors like parent-adolescent closeness and cultural tradition (e.g. Roche, Lambert, Ghazarian, & Little, 2015; Weisskirch & Alva, 2002). Interestingly, qualitative studies often differ from quantitative studies in focus, typically observing how immigrants describe their experiences adjusting to American culture and the English language (e.g. Suarez-Orozco & Suarez-Orozco, 2002; Zhou & Bankston, 1998). While these studies produce mixed and sometimes contradictory results, almost all mention one significant aspect of the migration experience: the effect of language differences on immigrant parental authority.

In many cultures around the world, families are organized under the leadership of parents and grandparents who are experienced and knowledgeable members of their local dominant culture. These adults are typically responsible for educating and socializing their children. When a family stays

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within a particular culture and language for generations, this model is maintained fairly well. However, this pattern can be undermined or fundamentally shifted when a family uproots themselves to settle in a new country with a new language and culture (Suarez-Orozco & Suarez-Orozco, 2002). Migration usually results in a language divide between immigrant parents and their children, as children generally assimilate faster into both the new language and the new culture (Phinney, Romero, Nava, & Huang, 2001). The immigrant family structure may change as a result of that linguistic shift. This literature review focuses on understanding how those changes specifically affect the immigrant parents' authority over their adolescent children.

Although many gaps remain in the research on this subject, current literature suggests that language differences between immigrant parents and adolescent children negatively impact the perception of parental authority. The centrality of language itself in both social and cognitive processes provides a foundation for this argument. Further, these impacts can be seen through the eyes of both the parents and the children: first, when parents fail to master the new language, they may experience a degradation of social status, intellectual leadership, and social reliability, which lowers their self-perception of parental

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authority. Second, as adolescents master the new language, they may experience a shift in ethnic identity, familial responsibility, and social independence that lowers their perception of parental authority.

Language: The Shaper of Self and Society

In order to understand how language can affect the authority structure within the immigrant home, it is important to first establish how great an influence language has on the daily life of every human being. Language is key to social interaction, order, and solidarity (Giles, Bourhis, & Taylor, 1977). If people want to communicate complex needs and work together, coherent language is required. Language also helps determine ethnic identity, which is one's personal sense of belonging to an ethnic group and possession of feelings and attitudes associated with that membership (Hurtado & Gurin, 1987; Phinney et al., 2001). Within ethnic groups, distinct language is used as a symbol of identity and culture, as well as a mechanism for transmitting group feeling and differentiating between group members and outsiders (Giles et al., 1977).

While it is unlikely that language is the sole shaper of an individual's social ties or ethnic identity, it is clearly a significant

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factor in the development of those characteristics. This has serious ramifications for immigrant families, who often experience a notable shift in language and culture between generations (Roche et al., 2015). If language has such a significant influence on how people think, both about themselves and their community, what happens when an immigrant parent begins raising a child in a new country with a new language? Will the adolescent immigrant become fundamentally different and disconnected from his or her parents, simply by growing up thinking in a different language? Both quantitative research and case studies suggest that this is a possibility (Phinney et al., 2001; Suarez-Orozco & Suarez-Orozco, 2002), and that the immigrant parents' authority is at the heart of the process.

Immigrant Parents' Degradation of Authority

Upon arrival in the United States, immigrant parents and their children are placed into very different social environments that divide them linguistically and affect the speed of their acculturation. Typically, immigrant adolescents come in contact with the dominant culture and language much sooner through immediate enrollment in schools, while parents must adapt to the new economic system by quickly finding jobs,

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usually with other immigrants (Nguyen, 2008; Suarez-Orozco & Suarez-Orozco, 2002). Because of this dramatic difference in social environments, immigrant parents are typically much slower to learn the new dominant language than their children. This delay degrades parents' authority by lowering their social status, excluding them from their adolescent children's academic endeavors, and turning the shared hierarchy of social expertise upside-down.

Language's Effect on Parental Employment and Social Status

Language deficits primarily affect immigrant parents' social status through the jobs they are forced to take upon entering the country. Often they can only find work with other immigrants in factories or farms doing manual, unskilled labor; these jobs offer low wages in fields potentially unfamiliar to immigrants, who must accept the associated drop in status in order to help their families survive (Zhou & Bankston, 1998). In *Children of Immigration*, Suarez-Orozco & Suarez-Orozco (2002) describe the case study of a man who moved from a position in the upper levels of Mexican political power to scrounging for jobs in San Diego as a busboy, bakery truck driver, and eventually a bowling alley attendant, settling on the latter because he was

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“the most erudite man there” (p. 76). This story is typical of immigrants today, whose low-skilled factory or service sector jobs do not provide sufficient pay, insurance, or upward mobility for their families (Brubaker, 2001). While some immigrants arrive with little training or education, others have professional credentials and experience (Zhou, 1997). Lacking a functioning knowledge of English or acceptable American credentials makes it difficult for these immigrant parents to rise from menial labor to the professions they were trained for in their home country. Depending on their ages, these parents’ adolescent children may become cognizant of this social restructuring and begin to doubt the validity of their parents’ skills (Zhou & Bankston, 1998). Without gaining basic proficiency in English, the parents have few resources to change this situation. As a consequence, these immigrant parents may be left with a sense of disorientation in their role as financial providers, as well as sense of frustrated potential.

Parents’ Loss of Intellectual Leadership

In addition to social status, parental authority is tied closely to the “intellectual leadership” that a typical parent wields over his or her children. By previously passing through the schools and

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curriculum their children will face, parents and grandparents acquire a “map of experience,” which they can use to guide their children through school (Suarez-Orozco & Suarez-Orozco, 2002). For immigrant parents, however, this model of intellectual leadership can be difficult to achieve in a new country, mostly because the language gap keeps them from understanding their children’s academic world.

Researchers often operationally define a parent’s intellectual leadership simply as being able to help his/her child with homework, which studies show to be very important. Rumbaut (1994) studied a sample of over 5,000 immigrant children in San Diego and Miami, discovering that parent-child conflicts were significantly less likely to occur in homes where the parents or siblings were available to help with homework. Other studies of distressed urban school districts agree, asserting that immigrant parents’ inability to involve themselves in their children’s schoolwork may compound all the acculturation difficulties the adolescents already face (Boutakidis, Guerra, & Soriano, 2006). Whereas in the home country parents would be up-to-date on the progress of their children in school, immigrant parents are sometimes deceived when their English-fluent children mistranslate or mislead them while discussing

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grades and assignments (Boutakidis et al., 2006; Suarez-Orozco & Suarez-Orozco, 2002). If the immigrant parents are able to communicate somewhat effectively in a parent-teacher conference, they receive first-hand information they can use to praise or punish their child. However, this is often not the case. Suarez-Orozco & Suarez-Orozco (2002) describe an incident, among others, in which an adolescent used his parents' ignorance of American grading policy to pass off an "F" (failing grade) as "Fabulous." Though extreme, this example demonstrates how immigrant parents can lose their intellectual authority because of a language barrier with their children.

Immigrant Parents' Social Reliance on their Children

Outside of the academic world of their children, immigrant parents may experience degraded authority as they rely on their children to broker in social situations. Social expertise is another element of the "map of experience" that helps parents establish authority. While in many subsets of American culture the stereotype of teenagers is an ambivalence towards family and rejection of authority, immigrant families may come from cultures where this is not the norm (Zhou, 1997). Thus, as immigrant parents watch their children learn English and

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become Americanized faster than they can keep up, they enter unknown social territory. They may fear that their children will leave them, assimilating to American culture and abandoning their roots (Zhou, 1997). However, the immigrant parents must still rely on their children for social brokering. As Lan Cao, a Vietnamese refugee who immigrated as a child with his mother, wrote, "I was the one who told my mother what was acceptable and unacceptable behavior" (Suarez-Orozco & Suarez-Orozco, 2002, p. 75). A parent in this situation is experiencing a combination of apprehension for the future and dependence in the present that, while difficult to quantify, is probably opposed to their self-perception of authority.

One well-documented and controversial example of the immigrant parent's social dependence is found in the practice of language brokering, in which the adolescent translates a document or social situation for his or her parents. Language brokering is useful for researchers because it permits immigrant parents' reliance on their children to be quantifiably assessed. However, psychologists debate whether this unique interaction helps or harms the adolescents' perception of parental authority, and studies have found evidence for both sides (Chao, 2006; cf. Weisskirch & Alva, 2002). In their introduction on language

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brokering and parent-child relationships, Roche et al. (2015) cite examples of research which assert that language brokering 1) promotes positive parent-child closeness, 2) has no influence on the parent-child relationship, and 3) decreases parental authority by “adultifying” youth (p. 78). These assertions contradict each other, but analysis of the literature shows that studies with quantitative measurement of variables favor the first two conclusions, while qualitative research and case studies support the third (Cervantes & Cordova, 2011; Weisskirch & Alva, 2002). Results from both approaches may be valid, and the effects of language brokering may be too culture- and context-specific to warrant generalizations to immigrants as a whole. While additional research is needed to substantiate this claim, logic and case studies suggest that language brokering reverses the typical authority structure in the immigrant family, conferring dependency on the parent and authority on the child.

Immigrant Adolescents’ Shift in Perception of Parental Authority

It is important to consider the perspective of adolescents, in addition to parents, when discussing the effects of linguistic shifts

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on immigrant families and their authority structures. Just as not being able to speak the dominant language may cause changes in immigrant parents' self-perception of authority, status, and leadership, adolescents who observe these shifts in their parents may have altered perceptions of parental authority, familial responsibility, and social independence.

The Influence of Ethnic Identity in Adolescent Perception of Authority

As highlighted earlier, ethnic identity is a crucial cultural element for many people, and language is a strong determining factor for that identity (Phinney et al., 2001). Many studies highlight the strong correlation between the ability to read and write in a language and ethnic identity as a member of the group that espouses that language (Bankston & Zhou, 1995; Mann, 2004; Phinney et al., 2001). This correlation appears to exist across different cultures and languages, suggesting that the languages which an immigrant retains or learns will largely determine which ethnic communities the individual will have access to (Phinney et al., 2001). This has several implications for how adolescents perceive their parents' authority.

There are social advantages to maintaining ethnic

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identity through language which may stabilize parental authority. The degree to which immigrant adolescents retain or lose their mother tongue determines how much “social capital” they have with their native culture (Zhou, 1997). For example, if a Mexican adolescent immigrant maintains her Spanish, along with a sense of the social rules of the older Mexican generation, she will also keep her access to support and control from her non-English speaking parents and membership in their ethnic communities. Bankston and Zhou (1995) posit that advanced ethnic language abilities bind immigrant children more closely to their traditions, their families, and communities that instill the values of academic achievement. If these adolescents maintain the same ethnic identity and language as their parents, they may be more likely to respect parental authority within that identity as it takes new forms in a new country.

However, the opposite of this positive trend often occurs, as immigrant adolescents migrate to the United States, learn English quickly, and shift to an Americanized ethnic identity. Suarez-Orozco and Suarez-Orozco (2002) explain this shift through the experience of Esmeralda, who immigrated from a Spanish-speaking country to the U.S. as an adolescent. She describes that as her and her siblings English vocabularies grew,

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they began to form a bond between them which excluded their mother and grandmother. The older women could only watch with worry as the children adopted an ethnic identity which was unavailable to them. This ethnic separation is especially evident in cases of “relayed” or “serial” migration, in which members of an immigrant family arrive in a new country at different times. The children that arrive first have more time to develop an American ethnic authenticity, which distinguishes them from the family members that arrive later. This disparity strains perceptions of parental authority and relationships between serially migrating siblings (Zhou, 1997). There are numerous contextual factors that influence whether an adolescent will take the former approach and retain a stake in the native ethnic identity, or the latter and separate themselves along generation lines (Portes & Rumbaut, 1996). However, in preserving parental authority, the key seems to be simply a consonant approach to acculturation between immigrant parents and their children—both acculturate at the same time, both remain unacculturated, or both agree on selective acculturation. When generations disagree on this approach, parental authority suffers.

Increased Familial Responsibility Creates Unstable Authority Structures

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As adolescent immigrants push far ahead of their parents in mastery of the new language, they inherit a gradually increasing responsibility for the success and acculturation of the family. This is evident in the aforementioned process of language brokering, in which children are given a role filled with unsolicited power that they may not be cognitively or linguistically prepared for (Weisskirch & Alva, 2002). It must be noted that an adolescent with English ability may be seen as a great asset by his or her parents, which could be a beneficial interchange. Some studies demonstrate an increase in parent-child closeness associated with frequent language brokering for certain immigrant populations (Roche et al., 2015; Dorner, Orellana, & Jimenez, 2008). However, qualitative studies show that an adolescent can be very close to a parent and simultaneously feel that that parent has lost their decision-making authority, which means that parental authority structures may suffer even when parent-child closeness does not. As Lan Cao described this phenomenon in his own life, “I would have to forgo the luxury of adolescent experiments and temper tantrums, so that I could scoop my mother out of harm’s way and give her sanctuary” (Suarez-Orozco & Suarez-Orozco, 2002, p. 75). Interestingly, this situation seems to illustrate that Cao’s increased authority

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led to greater closeness, but it also led to lower perception of parental authority. As adolescents like Cao begin to take over decisions regarding what is culturally “safe” or appropriate for the family to do, they perceive that their parents no longer hold the same degree of authority that was instinctive in the home country.

When adolescents take on this new level of familial responsibility, they may experience a variety of negative effects. Immigrant parents must struggle with acculturation stress alongside their children, which means that they are unavailable to help their adolescents cope with cultural conflicts (Ainslie, Tummala-Narra, Harlem, Barbanel, & Ruth, 2013). This could confer a sense of independence on adolescents, but also may force them to follow their own best cultural judgment at an impressionable age. Additionally, adolescents may be exposed to family secrets while translating in medical or legal situations, creating disillusionment or anxiety (Suarez-Orozco & Suarez-Orozco, 2002). Finally, acculturation “stressor events” often precede mental health problems, but adolescent immigrants may have to face these experiences without much parental guidance (Cervantes, Fisher, Córdova, & Napper, 2012). These risks may undermine the adolescents’ perception of parental

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authority.

Increased Adolescent Independence and Social Equality with Parents

Upon entering the United States, immigrants often find an adolescent culture which focuses on peer relationships rather than family ties and independence rather than familial roles. This culture of independence encourages adolescent immigrants to separate themselves from their families, but as just described, immigration also bestows a great weight of family responsibility upon them; this dichotomy can be a large source of stress (Weisskirch & Alva, 2002). Interestingly, Roche et al. (2015) found that immigrant parents reported no higher level of disagreements with their children when the children brokered for them more frequently. However, their children did report more disagreements. This highlights how adolescent acculturation could cause differences in perceived intergenerational conflict. As immigrant adolescents encounter the American youth culture, they may have to choose between adopting a stronger peer orientation and lower respect for authority or staying family-oriented and respectful of authority (Zhou, 1997). This decision is hard make for many non-immigrant American

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youth, whose parents already have command of the language and understanding of the culture; for adolescent immigrants, language barriers and cultural dissonance with parents only compound the difficulty. If an immigrant family comes from a culture that values deep-seated family ties, the younger family members may experience anxiety that those ties will keep them from becoming “American,” and therefore may seek independence from them. However, with research asserting the importance of ethnic identity within the home (Bankston & Zhou, 1995; Phinney et al., 2001), there is an implication that these adolescents would benefit more by avoiding total assimilation to the American youth culture.

Conclusion

The results of decreased parental authority in immigrant families may be more damaging in some contexts than in others. Specifically, research demonstrates that parental authority and knowledge safeguards adolescents most when it is applied to their choices of safety and well-being, rather than the choices that fall within the adolescents’ “personal jurisdiction” like clothing and grooming (Roche et al., 2015; Smetana, 1995). While this assertion may seem obvious, it has serious rami-

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fications. It means that parents are most effective when they have authority over behaviors like whom their children hang out with, what they do with unsupervised time, and how they do their schoolwork. For immigrant parents with language barriers, these important areas of authority are often the ones that suffer most. Lack of English ability means that immigrant parents take lower paying jobs, often multiple ones which take them away from home when their kids are out of school. Consequently, they have much less influence over the adolescents' unsupervised time, and less awareness of whom they spend that time with. Language barriers make immigrant parents unequipped to help with schoolwork or communicate with teachers, two practices that have numerous protective benefits for adolescents. When these difficulties are joined with decreased social status, acculturation stress, and turbulent ethnic identities, the immigrant parent's authority over their adolescent children must logically suffer.

However, the solution to these problems is not so simple as to instruct parents to learn English. In fact, studies that point out the problems associated with parental language barriers also provide exciting possibilities to help these immigrant families. This review demonstrated how ethnic identities and bilingual-

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ism can provide a support system and establish high expectations for adolescent success, especially in academics (Rumbaut, 1994). If youth can maintain positive connections in the native and the new culture, their high expectations may enable them to outstrip the students of even the dominant culture in academic achievement (Bankston & Zhou, 1995). Further, it has been demonstrated that a key to cohesion for immigrant families is open communication about how they will acculturate, whether that means remaining unacculturated or acculturating at the same rate (Zhou, 1997). If parents and children set expectations for how they will adapt together to their new country, they may be able to create a climate where each is useful to the other. Society at large can assist by helping immigrant families understand these potential difficulties when they arrive and by providing adequate multilingual services in school and work.

In summary, the reviewed literature on immigrant families supports the assertion that language barriers undermine immigrant parental authority. From the perspective of parents, lowered social status and employment level, as well as inability to assist with homework and social reliance on children, combine to decrease self-perception of authority. For adolescent immigrants, faster linguistic acculturation may affect

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their perception of parental authority by altering their ethnic identity, increasing their familial responsibility, and changing their attitudes toward intergenerational relationships. However, there are gaps in the literature that offer directions for future research. It is unclear whether practices like language brokering undermine or bolster immigrant parental authority because the current literature does not separate authority from closeness with parents, which are likely two distinct constructs. Also, while this literature review suggests some results of decreased immigrant parental authority, more research is needed into its potential long-term consequences on family structure and the mental health of parents and children. Finally, the development of educational strategies and interventions could benefit many immigrant families, especially if implemented early in the acculturation process.

References

- Ainslie, R. C., Tummala-Narra, P., Harlem, A., Barbanel, L., & Ruth, R. (2013). Contemporary psychoanalytic views on the experience of immigration. *Psychoanalytic Psychology*, 30(4), 663-679. doi:10.1037/a0034588
- Bankston, C. L., & Zhou, M. (1995). Effects of minority-language literacy on the academic achievement of Vietnamese youths in New Orleans. *Sociology of Education*, 68(1), 1-17. doi:10.2307/2112760
- Boutakidis, I., Guerra, N. G., & Soriano, F. (2006). Youth vio-

LANGUAGE AND IMMIGRANT PARENTAL AUTHORITY

- lence, immigration, and acculturation. In N. G. Guerra, E. P. Smith (Eds.), *Preventing youth violence in a multicultural society* (pp. 75-99). Washington, DC, US: American Psychological Association. doi:10.1037/11380-003
- Brubaker, R. (2001) The return of assimilation? Changing perspectives on immigration and its sequels in France, Germany, and the United States. *Ethnic and Racial Studies*, 24(4), 531-548. doi:10.1080/01419870120049770
- Cervantes, R. C., & Cordova, D. (2011). Life experiences of Hispanic adolescents: Developmental and language considerations in acculturation stress. *Journal of Community Psychology*, 39(3), 336-352. doi:10.1002/jcop.20436
- Cervantes, R. C., Fisher, D. G., Córdova, D., & Napper, L. (2012). The Hispanic Stress Inventory-Adolescent Version: A culturally informed psychosocial assessment. *Psychological Assessment*, 24(1), 187-196. doi:10.1037/a0025280
- Chao, R. K. (2006). The prevalence and consequences of adolescents' language brokering for their immigrant parents. In M. H. Bornstein, L. R. Cote, M. H. Bornstein, L. R. Cote (Eds.), *Acculturation and parent-child relationships: Measurement and development* (pp. 271-296). Mahwah, NJ, US: Lawrence Erlbaum Associates Publishers.
- Dorner, L. M., Orellana, M. F., & Jimenez, R. (2008). "It's one of those things that you do to help the family": Language brokering and the development of immigrant adolescents. *Journal of Adolescent Research*, 23, 515-543.
- Giles, H., Bourhis, R.Y., & Taylor, D.M. (1977). Towards a theory of language in ethnic group relations. In H. Giles (Ed.), *Language, ethnicity and intergroup relations* (pp. 307-348). London, UK: Academic Press.
- Hurtado, A., & Gurin, P. (1987). Ethnic identity and bilingualism attitudes. *Hispanic Journal of Behavioral Sciences*, 9(1), 1-18.
- Mann, M. A. (2004). Immigrant parents and their emigrant adolescents: The tension of inner and outer worlds. *The American Journal of Psychoanalysis*, 64(2), 143-153. doi:TA-

LANGUAGE AND IMMIGRANT PARENTAL AUTHORITY

JP.0000027269.37516.16

- Nguyen, P. V. (2008). Perceptions of Vietnamese fathers' acculturation levels, parenting styles, and mental health outcomes in Vietnamese American adolescent immigrants. *Social Work, 53*(4), 337-346.
- Phinney, J. S., Romero, I., Nava, M., & Huang, D. (2001). The role of language, parents, and peers in ethnic identity among adolescents in immigrant families. *Journal of Youth & Adolescence, 30*(2), 135.
- Portes A., & Rumbaut R. G. (1996). *Immigrant America: A portrait* (2nd ed.). Berkeley: Univ. Calif. Press.
- Roche, K. M., Lambert, S. F., Ghazarian, S. R., & Little, T. D. (2015). Adolescent language brokering in diverse contexts: Associations with parenting and parent-youth relationships in a new immigrant destination area. *Journal of Youth and Adolescence, 44*(1), 77-89. doi:10.1007/s10964-014-0154-3
- Rumbaut, R.G. (1994). The crucible within: Ethnic identity, self-esteem, and segmented assimilation among children of immigrants. *International Migration Review, 28*(4), 748-94.
- Smetana, J. G. (1995). Parenting styles and conceptions of parental authority during adolescence. *Child Development, 66*, 299-316.
- Suarez-Orozco, C., & Suarez-Orozco, M. M. (2002). Children of immigration. doi:10.1177/0272431614566944
- Weisskirch, R. S., & Alva, S. A. (2002). Language brokering and the acculturation of Latino children. *Hispanic Journal of Behavioral Sciences, 24*(3), 369-378. doi:10.1177/0739986302024003007
- Zhou, M. (1997). Growing up American: The challenge confronting immigrant children and children of immigrants. *Annual Review of Sociology, 23*, 63-95. doi:10.1146/annurev.soc.
- Zhou, M., & Bankston, C. L. (1998). *Growing up American: How Vietnamese children adapt to life in the United States*. New York: Russell Sage Foundation.

Confused Existentialism as a Factor in College Students' Depression

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Abstract:

Although “meaning in life” and “existentialism” may be considered ambiguous in psychology, the former term became a psychological construct with implications for psychological well-being. In young adulthood, the transition to college can be a difficult process because of social pressures incident to the adjustment to adulthood, including the need to establish an adult identity. Consequently, meaning in life may be overlooked in the confusion. I argue that a focus on meaning in life can be beneficial for college students in moderating their short- and long-term perspectives, physical health, and emotional health.

*Intuition: The BYU Undergraduate
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Until the 1950s, “meaning in life” was an ambiguous concept that had rarely appeared in the psychological literature (Feldman & Snyder, 2005). However, the concept gained wide notice with the publication of Viktor Frankl’s *Man’s Search for Meaning* in 1946 (Frankl, 1946/2006). As a prison-camp survivor in the Jewish Holocaust of World War II, Frankl had observed men and women pushed to their emotional and physical breaking points by cruel disconnection from the lives they had known earlier. Later, as a practicing psychiatrist, Frankl concluded that prisoners who recognized a purpose for their suffering had not succumbed to chronic depression and suicide. Although a person might suffer severe and sustained loss, there were those who had maintained feeling and who acted in ways that brought them meaning in life.

Frankl’s book and his accompanying logotherapy focused on meaning in life and its relation to psychological well-being. Logotherapy was founded on the claim that mental illness stems from an “existential vacuum” (p. 106), that is, from a lack of meaning. The therapy was designed to help the existentially confused individual discover personal meaning in her or his life and return to a state of mental equilibrium (Feldman & Snyder, 2005; Robotmili et al., 2015).

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Despite initial interest in logotherapy, critics found it authoritarian in its conclusions and unduly biased by Frankl's traumatic experience in the concentration camps (Lancaster & Carlson, 2015,). Nonetheless, it has remained a major influence in existential psychology (Steger, Frazier, Oishi, & Kaler, 2006) and more recently has reemerged in research on the psychological benefits of establishing a purpose in life (Steger et al., 2015; Zhang, Shi, Liu, & Miao, 2014).

Adjusting to College Life

Leaving the comforts of home to enroll in a college or university is a common practice in much of the world. In addition to further one's formal education, college has become a crucial period during which young adults further develop a sense of self and a meaning in life, (Mohanty, Pradhan, & Jena, 2015; Steger, Fitch-Martin, Donnelly, & Rickard, 2015; Zhang et al., 2013). Although the transition is relatively easy for some students, it is daunting others, especially for those unfamiliar with living independently. Feeling overwhelmed and beleaguered is a common experience.

Rates of depressive symptoms have increased in US college students. Schnetzer, Schulenberg, and Buchanan (2013)

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reported that 30% of students indicated having serious depressive symptoms. Students have cited stress caused by their studies, their employment, and peer pressure as a major factor in depression. Many have acknowledged using self-medication for stress, including alcohol and other substances (Meisel & Palfai, 2015; Schnetzler, 2013). Excessive drinking has even been associated with diminished academic performance and increased promiscuous behavior and physical injury (Maddi, Harvey, Khoshaba, Fazel, & Resurreccion, 2012; Meisel & Palfai, 2015).

The Influence of Meaning in Life in College Students' Short- and Long-term Outlooks

Meaning in life can affect individuals' views of life on a daily basis as well as in the long term. According to Machell, Kashdan, Short, and Nezlek (2015), they found that meaning in life is influenced by personal identity, goals, and felt responsibility. Developing a sense of one's identity continues during the college years. and gives direction to one's college life and to life beyond college (Feldman & Snyder, 2005). To the extent that new students are surrounded by peers from other states and countries, majors, and cultural backgrounds, they may feel

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pressures to alter the personal values they arrived with identity in order to better fit in with others (Abeyta, Routledge, Juhl, & Robinson, 2015; Robotmili et al., 2015; Zhang et al., 2014). Consequently, the personal identity they entered college with may consolidate with others' identities, thus altering the meaning in life they entered with. In the extreme, they may lose such meaning (Machell et al., 2015) and embrace a form of nihilism. Formulating and maintaining goals are also part of college life, given the deadlines and responsibilities it brings (Mohanty et al., 2015). Feldman and Snyder (2005) observed that meaning in life can be associated with a person's perception of his or her own goal-oriented achievement. Making and following personal goals may also enhance one's understanding of and coping with the evolving environments and expectations that college students confront (Mohanty et al., 2015; Yalcin & Malkoc, 2015). For example, a student focused on getting into medical school and becoming a doctor may cope more effectively with a failed test or a breakup knowing that is working toward something larger. Students may also be more likely to avoid actions that would jeopardize their meaning in life, especially when that meaning is largely defined by their goals (Meisel & Palfai, 2015).

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Responsibility for one's meaning in life may also influence short- and long-term outlooks. For Frankl, "creative, experiential, and attitudinal" values contribute to meaning in life (as cited by Robatmili et al., 2015, p. 5). Having a sense of who one is as a student is and what one wants to do with one's life may enhance one's felt responsibility to pursue one's goals and thereby sustain one's meaning in life (Mohanty et al., 2015).

Although meaning in life was initially applied to a long-term focus, it may exist and be changed in the short term as well (Machell et al., 2015). To the extent that personal identity, goals, and responsibility are fluid, the extracurricular experiences of college students incident to social gatherings, sororities and fraternities, and clubs may factor into students' daily and future outlooks as much or more than curricular experiences do. They may also contribute to students' depression, including feelings of uncertainty and hopelessness, to a greater extent as well (Feldman & Snyder, 2005)

Meaning in Life in Relation to Health

Meaning in life may also influence the health of college students through the use of leisure time such as recreational sports, watching movies, and otherwise hanging out. Zhang et al.

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(2014) reported that 96% of students spent time in relaxing or recreational activities. The authors dichotomized these activities as either beneficial or harmful. Beneficial activities, like sports, recreational games, and other social interactions were positive. By contrast, playing video games or watching Netflix were potentially negative in terms of wasted time, social isolation, and poorer health.

Schnetzer et al. (2013) studied levels of alcohol consumption and found that they were much lower in the same age cohort among those not enrolled in college than among those who were. The authors speculated that the stress of rigorous courses, the need for social acceptance, or money worries may induce students to turn to alcohol or other substances in order to cope (see also Zhang et al., 2014). In turn, this reliance may lead to increased violence and unprotected sex as well as to decreased academic performance (Meisel & Palfai, 2015; Steger et al., 2015).

Because meaning in life may lead to a perception that one's life is satisfactory and worth living (Yalcin & Malkoc, 2015), the individual may feel more inclined to adopt healthful practices. Students who decline to use harmful drugs or to binge drink at a party because they do not want to damage their

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brain or injure their body otherwise may perceive a different meaning in life because they recognize that drug-induced pleasure can have a lasting impact that is not worth the risk, despite seeing their peers drinking for pleasure (Grossbard et al., 2016; Meisel & Palfai, 2015).

Meaning in life may go beyond intangible influences. As a student can recognize that there is more to his or her life than just living for the moment because of meaning, that student may be more likely to care for his or her body by apportioning proper leisure time, moderating drinking levels, and actively taking part in maintaining physical health. If the student does not have a sense of meaning, he or she may be more prone to feel depressed by engaging in activities that seclude themselves from others, use substances that distort their psychological functioning, or not feel motivation or reason in attending to their health.

Meaning in Life in Relation to Emotional Health

Just as meaning in life may influence short- and long-term physical health, it may also be a factor in emotional health. Frankl observed that hope is a primary component of meaning in life (see Feldman & Snyder, 2005; Yalçın & Malkoç, 2015).

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For college students, hope may signal the possibility that good will prevail despite stressful and difficult challenges (Lancaster & Carlson, 2015). Having hope contextualizes problems as transient and surmountable. Moreover, students who report being hopeful also often report that they feel happy (Steger et al., 2006; Yalçın & Malkoç, 2015). This conjunction may result from the individual's use of goals to sustain focus and orientation (Mohanty et al., 2015).

Conclusion

As proposed by Frankl and supported by others, the meaning in life plays a role in daily life, including health, and emotional well-being. Because college is a unique experience in which young adults leave the comforts of home, it has the potential for a negative psychological impact on those students who are unprepared for such a dramatic change (Lancaster & Carlson, 2015). The demands of professors, future careers, unfamiliar environments, and personal maintenance mean that students' values, beliefs, choices, and personality may change during the college years and alter their long-term outlook (Mohanty et al., 2015). In particular, the college experience may alter their perception of meaning of life as an adult (Nelson, Willoughby,

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Rogers, & Padilla-Walker, 2015). Researchers have shown that, for college students, meaning in life may conduce to emotional health by promoting coping with the stress, to new allegiance to personal values, to establishing and maintaining goals, and to hope (Abeyta et al., 2015; Mohanty et al., 2015; Yalçın, & Malkoç, 2015). By contrast, meaning in life may contribute to depression, runaway leisure time, the excessive consumption of alcohol, and other substances, and the forfeiture of values to fit in (Meisel et al., 2015, Robotmili et al., 2015; Zhang et al., 2014).

It is important for college and university administrators to consider the availability of therapies based on meaning in life (e.g., logotherapy or cognitive behavioral therapy) as well as workshops and extracurricular opportunities designed to enhance hope, goal-setting and goal-achievement, coping with stress, and healthful living (Feldman & Snyder, 2005; Yalçın & Malkoç, 2015).

References

- Abeyta, A. A., Routledge, C., Juhl, J., & Robinson, M. D. (2015). Finding meaning through emotional understanding: Emotional clarity predicts meaning in life and adjustment to existential threat. *Motivation and Emotion*, 39(6), 973-983. doi:10.1007/s11031-015-9500-3
- Feldman, D. B., & Snyder, C. R. (2005). Hope and the meaningful life: Theoretical and empirical associations between

EXISTENTIALISM AND DEPRESSION

- goal-directed thinking and life meaning. *Journal of Social and Clinical Psychology*, 24(3), 401-421. doi:10.1521/jscp.24.3.401.65616
- Frankl, V. E. (2006). *Man's search for meaning* (original edition published in 1949). MA: Beacon Press.
- Grossbard, J. R., Mastroleo, N. R., Geisner, I. M., Atkins, D., Ray, A. E., Kilmer, J. R., & ...
- Turrisi, R. (2016). Drinking norms, readiness to change, and gender as moderators of a combined alcohol intervention for first-year college students. *Addictive Behaviors*, 5275-82. doi:10.1016/j.add-beh.2015.07.028
- Lancaster, S. L., & Carlson, G. C. (2015). Meaning made, distress, and growth: An examination of the integration of stressful life experiences scale. *International Journal of Stress Management*, 22(1), 92-110. doi:10.1037/a0038296
- Nelson, L. J., Willoughby, B. J., Rogers, A. A., & Padilla-Walker, L. M. (2015). "What a view!": Associations between young people's views of the late teens and twenties and indices of adjustment and maladjustment. *Journal of Adult Development*, 22(3), 125-137. doi:10.1007/s10804-015-9206-5
- Machell, K., A., Kashdan, T., B., Short, J., L., & Nezlek, J., B. (2015). Relationships between meaning in life, social and achievement events, and positive and negative affect in daily life. *Journal of Personality*, 83(3), 287-298. doi: 10.1111/jopy.12103
- Maddi, S. R., Harvey, R. H., Khoshaba, D. M., Fazel, M., & Resurreccion, N. (2012). The relationship of hardiness and some other relevant variables to college performance. *Journal of Humanistic Psychology*, 52(2), 190-205. doi:10.1177/0022167811422497
- Meisel, S. N., & Palfai, T. P. (2015). Meaning in life goal pursuit moderates the effects of social influences on college student drinking. *Journal of Applied*

EXESTENTIALISM AND DEPRESSION

Social Psychology. 45(10),

561-567. doi:10.1111/jasp.12319

Mohanty, A., Pradhan, R. K., & Jena, L. K. (2015). Curiosity and meaning of life leading

towards personal growth: The role of emotional intelligence.

Journal of the Indian

Academy of Applied Psychology, 41(2), 226-235.

Robotmili, S., Sohrabi, F., Shahrak, M. A., Talepasand, S.,

Nokani, M., & Hasani, M. (2015).

The effect of group logotherapy on meaning in life and depression levels of Iranian

students. International Journal for the Advancement of Counselling, 37(1), 54-62.

doi:10.1007/s10447-014-9225-0

Schnitzer, L. W., Schulenberg, S. E., & Buchanan, E. M. (2013).

Differential associations

among alcohol use, depression and perceived meaning in male and female college

students. Journal of Substance Use, 18(4), 311-319. doi:10.3109/14659891.2012.661026

Steger, M. F., Fitch-Martin, A. R., Donnelly, J., & Rickard, K. M.

(2015). Meaning in life and

health: Proactive health orientation links meaning in life to health variables among

American undergraduates. Journal of Happiness Studies, 16(3), 583-597,

doi:10.1007/s10902-014-9523-6

Steger, M. F., Frazier, P., Oishi, S., & Kaler, M. (2006). The meaning in life questionnaire:

Assessing the presence of and search for meaning in life. Journal of Counseling

Psychology, 53(1), 80-93. doi:10.1037/0022-0167.53.1.80

Yalçın, İ., & Malkoç, A. (2015). The relationship between meaning in life and subjective well-

being: Forgiveness and hope as mediators. Journal of Happiness Studies, 16(4), 915-929,

EXESTENTIALISM AND DEPRESSION

doi:10.1007/s10902-014-9540-5

Zhang, S., Shi, R., Liu, X., & Miao, D. (2014). Passion for leisure activity, presence of meaning, and search for meaning: The mediating role of emotion. *Social Indicators Research*, 115(3), 1123-1135. doi:10.1007/s11205-013-0260-8

