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Continuing the Vision of the GJCP
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I am excited and pleased to present the second issue of the Graduate Journal of Counseling Psychology (GJCP), an academic psychology journal created by and for graduate students within the Department of Counseling and Educational Psychology (COEP) at Marquette University. In keeping with the mission set forth by the founders of GJCP, for the second issue the editors focused on how the journal may be best utilized to benefit counseling students at Marquette. After speaking with many students and faculty about how to maximize the benefit of having an in-house journal, an underlying theme emerged. In many of our conversations the value of the journal as an educational tool for graduate students was not overlooked.

The GJCP was founded with two goals in mind: (1) to encourage junior level counseling psychology graduate students to conduct research and present their findings in a peer-refereed journal; and (2) to disseminate conceptually- and empirically-based research on topics relevant to the field of counseling psychology. Building on the ideas of the founding editors, this year’s editors tried to accommodate the hopes of students and faculty that the journal be used as an interactive educational tool.

One way that we tried to enhance the educational value of the journal was the establishment of a rubric system for rating the quality of manuscripts. Not only did we want to give the authors of the papers constructive narrative feedback, but we also wanted to be accountable for the criteria we were using to determine the quality of the manuscripts. Our editors were able to establish a rubric system for which the reviewers could rate papers on various criteria. The establishment of a rubric was truly an educational process as we searched for existing manuscript rubrics and discussed what the criteria of our journal should look like. We established six criteria through which the reviewers would evaluate articles submitted to GJCP (relevance of topic to GJCP, contribution to the field, organization and clarity, quality of writing, adherence to APA style, and overall evaluation). These criteria established a framework through which we would evaluate the articles submitted to the journal in 2009.

Another way the editors tried to enhance the educational value of the journal was through the examination and discussion of the components of a quality paper. We then extended this conversation to talk about the qualities which make a review helpful and constructive. Next, we discussed the literature about the process of reviewing and how to write a constructive, balanced, and successful review. Looking back on the past
year, one can see not only has the journal provided a vehicle through which authors can present findings and improve their writing but also the journal has provided a place where those involved in the editing process can practice editing and review skills that are valuable to the field.

There is still much room for the journal to evolve and grow. Future editors may want to expand the journal to include submissions from other counseling psychology graduate students or arrange to have visiting editors from other schools. There are many possibilities for future editors to shape.

I would encourage those in the COEP department who have not yet gotten involved in the journal to do so. It is a very unique and exciting opportunity we have at our disposal! Many thanks to all of the people who made the second edition of GfCP possible: journal founders Marc Silva and Marisa Green, our faculty advisor Dr. Lisa Edwards, our journal contributors, and all of the editors (Robert Bouley, Rebekah Chee, Alison Lafollette, Ryan Mattek, Jeff Poterucha, Jayson Rodriguez and Linn Visscher). Thank you!

ORGANIZATION AND CONTENT OF ISSUE

This issue includes 12 articles organized within four sections. Section A represents the Focus on Gender section. These review articles focused on gender identity and gender role strain, respectively. Jones reviews the literature on the gender identity development of intersex individuals and proposes future research in areas that are lacking clarity. Next, Gutzwiller explores male gender role strain and proposes that group counseling addressing male gender role strain may be an effective intervention for the psychological conflict surrounding gender role strain.

Section B of this issue contains three review articles focusing on assessment and intervention. Silva begins with a review of the diagnosis and treatment of pediatric epilepsy. Next, Haase discusses treatment interventions for co-occurring personality disorder and substance use disorder. Faith wraps up the section with a discussion of the etiology and treatment of dependant personality disorder.

Section C contains the group counseling and group education articles. First, Faith discusses designing a stress management group for homeless women. Next, Orecchia reviews the current practice and research on sex education groups for adolescent girls. Para concludes this section with a review and discussion of group counseling interventions for complicated grief.

Section D includes two articles focusing on university counseling. Lafollette examines the development and evolution of university
counseling. Sokol reviews the history of counseling within the university and reviews the roles and functions of those who provide counseling services in the university.

Section E showcases the theoretical and conceptual contributions to this issue. Kubokawa and Ottaway address cultural sensitivity in the positive psychology movement. Next, Sokol reviews the literature concerning Erikson's theory of identity development throughout the lifetime.

Each article selected for publication meets the following criteria (a) the topic is relevant to the field of counseling psychology; (b) the writing is concise and accessible to graduate students; and (c) the article contains an adequate review of the conceptual and empirical literature.

I am delighted to present the second issue of GJCP. I hope you find the series of articles in this issue interesting and thought provoking.
Amy E. Kowalski

Amy Kowalski obtained a Bachelor of Arts degree in psychology from Illinois Wesleyan University and recently graduated with a masters in counseling from Marquette University. Her clinical and research interests include (1) multicultural counseling (2) racial and ethnic identity (3) culturally specific wellness/health interventions (4) positive psychology. Her career goals include obtaining a PhD in Counseling and teaching/researching in a university setting.
The Third Sex: Gender Identity Development of Intersex Persons
Laci Jones

Abstract: Gender identity is influenced by the biological make-up of the individual and society’s expectations for that particular sex. For individuals born with ambiguous genitalia, gender identity development is altered beginning at birth when the biological sex is undetermined. The following literature review examines how individuals born with ambiguous genitalia and assigned a biological sex at birth develop a gender identity. The review discusses cross-cultural sex assignment of intersex infants, the maintenance of the sex label throughout the individual’s lifespan, and the influence the label may have on the person’s gender identity development. Due to minimal research on the topic no direct conclusions are made, and suggestions for future research are discussed.

Contemporary Western societies often use the terms sex and gender interchangeably (Diamond, 1995). Yet this synonymous use is misleading. Sex is defined as the biological basis of being male or female while gender is socially taught, imposed or chosen based on cultural expectations (Newman, 2002). Gender role is the socially assigned behaviors, expectations and attitudes of being male or female in a culture. One’s gender identity, in turn, is a person’s persistent image of oneself as either predominately masculine, feminine, or androgynous based on the gender roles ascribed to his or her culture (Berk, 2007; Money, 1994). Although one’s sex, gender and gender identity are usually in congruence, it is not necessarily so (Diamond, 1995).

Based on these definitions, the development of one’s gender identity is influenced by the biological make-up of the individual and society’s expectations for that particular sex. How do those individuals born with ambiguous genitalia develop a gender identity? In Western two-sex societies, a person’s sex is usually determined by the presence or absence of external genitalia (Money, 1994). More specifically, the presence of a penis signifies that a person is male. This sex determination is almost always made at birth (Bostwick & Martin, 2007). When infants are born with physical features of both sexes and are “assigned” a gender based endocrine, karyotype, fertility potential and external appearance, this “first step” of gender identity development is compromised.

Although research comparing gender identity development of intersex individuals to non-intersex people is minimal, current findings show that intersex people assigned a sex at birth have problems developing a strong gender identity in both childhood and adulthood (Bostwick & Martin, 2007; Dittman, 1998; Sobel & Imperato-McGinley, 2004) and the rate of gender change of intersex individuals is higher than in the general
population (Meyer-Bahlburg, 1994). Furthermore, many intersex individuals are never told of the circumstances surrounding their birth, leading to potential psychological issues and familial strife once the truth is revealed or uncovered. The following paper addresses the standard medical and cultural practice of assigning intersex infants as either male or female at birth, the medical and social interventions needed to maintain that label throughout the person’s lifespan, and the practice’s subsequent influence on the gender identity development of the individual. Does assigning a sex at birth help or hinder the gender identity development of intersex individuals?

**THEORIES OF GENDER IDENTITY DEVELOPMENT**

Even with today’s technological and medical advancements, the exact determinates of gender identity still remains relatively unknown (Bostwick & Martin, 2007). No matter the underlying cause, children identify themselves as either male or female at a very early age and this identification continues throughout adolescence (Berk, 2007). Research shows most toddlers behave in ways that can be defined as generally masculine or feminine, and by age two most children can clearly state their core gender affiliation (Bostwick & Martin, 2007). Throughout early and middle childhood, children begin to understand that boys and girls can behave in ways and perform activities that are gender atypical, and girls’ identification with feminine traits declines between third to sixth grade (Berk, 2007). Boys at this age identify more strongly with masculine traits. During adolescence, gender intensification occurs and both sexes begin to take on more traditional gender identities. Biology, cognition and societal norms all influence a teenager’s desire to present him or herself in more gender stereotypical ways. Gender intensification declines by late adolescence and most individuals leave their teenage years with a clear gender identity, but not all teens progress at the same rate (Bostwick & Martin, 2007).

The research discussed above shows that gender identity development begins even before toddlers have the vocabulary to accompany their newfound sense of self. What influences this seemingly innate form of development? Some researchers state that the main influence is environmental factors including rearing conditions, societal expectations, cultural norms, and the child’s corresponding external genitalia rather than on the presence of chromosomes, gonads or hormones (Dittmann, 1998; Money, 1994; Newman, 2002). The view that there is a critical period for sex and gender identification dominated the medical and psychological fields well into the 1980s (Bostwick and Martin, 2007). Edward Money
believed that children develop a gender identity by comparing their body to others, and that gender identity became fixed between the age of 18 months and five years. Prior to the 1980s, researchers believed that children were a blank slate and developed a gender identity based on how they were raised.

There are several other theories in addition to Money’s that emphasize nurture in the development of gender identity. The social learning theory states that children begin to act in gender specific ways before they identify themselves as male or female (Berk, 2007). Children pick up gender-typical behavior through modeling and reinforcement and only after they develop higher level thinking skills will they then attribute such behaviors to their own identities. The cognitive-development theory explains that once children learn that their sex is permanent and biologically based, they use this information to guide their behavior in sex-appropriate ways (Newman, 2002). Gender schema theory states that very young children learn gender typical behaviors and expectations from others and slowly begin to develop gender schemas, a way to interpret their experiences as masculine or feminine. Once they can identify their own sex, they select gender schemas that are most in line with being male or female. Finally, constructionist theorists believe that one’s biological sex is individually interpreted based on a particular culture’s social practices and gender norms (Newman, 2002).

While many theories point to nature’s dominate influence on gender identity development, there are numerous researchers that believe prenatal hormones, specifically androgens, are the primary determinant of future gender identification (Diamond & Watson, 2004; Dittman, 1998; Reiner & Gearhart, 2004; Sobel & Imperato-McGinley, 2004). In their reviews of early animal research, Dittman (1998) and Money (1994) state that manipulating the hormone levels of developing mammal fetuses can both masculinize and demasculinize the animal’s brain development. More recent human subject research has shown that genetic males who cannot respond to androgens due to a genetic defect often identify themselves as female after puberty, regardless of the sex they were raised (Wilson, 1999). Sobel and Imperato-McGinley (2004) show that individuals with Complete Androgen Insensitivity (CAI), a genetic condition where XY fetuses are unable to respond normally to testosterone, identify themselves as female. Diamond (1995) goes as far to proclaim there are no documented cases where a “normal individual, even without suitable genitalia, has accepted rearing or life status...of the sex opposite to that of his or her natural genetic and endocrine history” (p. 66).
The debate on the influence of nature versus nurture in gender identity development is not one to abate anytime soon. Although the discussion continues, most current researchers believe that biological sex, androgen influence, physical characteristics, parental rearing and cultural norms all interact to influence an individual’s identification as either masculine or feminine, male or female (Bostwick & Martin, 2007; Reiner & Gearhart, 2004; Sobel & Imperato-McGinley, 2004).

**INTERSEX CONDITIONS AND GENDER ASSIGNMENT**

As stated above, gender identity development begins the moment a baby is born and the doctor exclaims “It’s a boy!” or “It’s a girl!” But what about infants who’s biological sex is not so clearly defined? Current estimates state that approximately 1/4,500 births have no clear consensus of the biological sex of the child (Vilain, 2006). During fetal development, all embryos contain tissue that has the potential to develop as either male or female. In most cases, the fetus develops in accordance with its chromosomal sex and the child is born with “normal” genitalia. But in a small percentage of cases, the hormonal sequence is skewed and babies with ambiguous brains or bodies result (Bostwick & Martin, 2007). The exact sequence of fetal sex development and the cause and outcome of all intersex conditions are beyond the scope of this article, but more information can be found in Bostwick and Martin (2007) and Sobel and Imperato-McGinley (2004).

Although not all babies born with ambiguous genitalia are diagnosed as having an intersex condition, societal expectations have historically forced such babies to be “assigned” a gender at birth (Bostwick & Martin, 2007). During the mid to late twentieth century, John Money and his research team at Johns Hopkins University lead the predominate practice of using an *optimal gender* paradigm to determine whether to assign an infant male or female. Prior of the advancement of chromosomal and endocrinological testing, most intersex babies were “made” into girls due to difficulties in constructing a working penis, which was often defined as being large enough for vaginal intercourse. Because Money believed that nurture was solely responsible for a child’s gender identity and that the critical period for gender identity development didn’t being until the middle of the second year of life, gender identity was theorized to develop “normally” as long as any surgical reconstruction was completed prior to the 18th month and that parental rearing corresponded to the assigned sex.

Current medical protocol for intersex infants is not as extreme as Money’s original recommendations. Newborns with ambiguous genitals are generally still assigned a sex, but only after endocrine and karyotype
testing has been preformed (Bostwick & Martin, 2007). Input from pediatricians, geneticists, pediatric endocrinologists, urologists, gynecologists and parents are sought prior to making the sex determination (Meyer-Bahlburg, 1994). Surprisingly, mental health professionals are rarely consulted in this decision making process. The current trend is moving away from infant genital surgery, and the Intersex Society of North America recommends surgery only when it is absolutely necessary for the health of the infant (Sobel & Imperato-McGinley, 2004). Instead, the society recommends waiting until the child or adult is old enough to request surgery with his or her full informed consent. Yet not all cultures recommend sex assignment immediately at birth, nor advocate the use of genital surgery to align physical features with social sex. The following section discusses the cultural variance in gender and sex practices.

**GENDER IDENTITY AND CULTURE**

Up to this point the discussion has focused on the binary sex model of Western societies and the male/female gender roles and identities of such cultures. Although gender identity development patterns of intersex individuals can be somewhat generalizable due to the unique nature of the condition, the cultural context of the individual must be taken into account when discussing the topic. In her review on gender and culture, Newmann (2002) states that worldwide there is wide variation on what constitutes sex and gender and what is considered gender-variant. In certain cultures, physical characteristics are not enough to identify biological sex and elaborate rituals take place to determine the sex of a newborn baby. Some cultures, including several American Indian tribes, have a third sex assigned to individuals who transcend purely male and female gender lines. Certain religions present deities as having both male and female physical features or the ability to change gender, and such characteristics increase spiritual power.

The most studied example of culturally specific gender change is a form of XY intersexuality titled 5-alpha reductase deficiency, a condition where because of an enzyme deficiency, babies are born with ambiguous genitalia and raised as girls but experience a “male puberty” at adolescence where their voices drop, genitals grow, and they develop male physical characteristics (Sobel & Imperato-McGinley, 2004). This condition has been found in isolated communities in the Dominican Republic, New Guinea and Turkey, and sporadically in the descendents of original inhabitants of these areas. The main character of the popular book Middlesex by Jeffrey Eugenides likely had this diagnosis (Bostwick &
Martin, 2007). In her review of literature on the disorder, Newman (2002) states that the phenomenon is socially accepted in these communities and most children successfully change to a male gender identity during puberty. She concludes that planning the appropriate interventions for an intersex or gender variant child must be managed in the context of the individual’s culture, while at the same time considering the dominate gender system if different from the immediate familial culture.

WESTERN CULTURE INTERSEX GENDER IDENTITY DEVELOPMENT

Even though today’s doctors are more likely to hold off on performing genital surgery and take more information into account than just physical appearance when assigning gender, there is no research on the long-term psychological consequences of growing up with genital ambiguity. Also, the minimal research on gender and sexual identity of intersex individuals is mostly limited to case studies and is difficult to generalize to the over 15 different types of intersexuality (Vilain, 2006). The following section discusses the gender identity development of intersex individual with this limitation in mind.

Children in Western societies born with ambiguous genitals begin their life amongst a flurry of doctors, tests, pokes and prods. This in and of itself makes the early psychosocial development of intersex children very different from those with clearly defined male or female genitals, and this context may influence the gender role behaviors and subsequent gender identity of intersex children (Meyer-Bahlburg, 1994). This context also influences the familial relationships of intersex families. Sex ambiguity often leads to family confusion surrounding the “true” sex of the child. This could lead to conflict both within the family and between the family and the physicians who made the sex recommendation, resulting in an ambiguity of rearing not commonly found in non-intersex children. Due to this ambiguity or possibly from fear of that their child will not conform to his or her sex assignment, caregivers may promote or discourage certain types of behaviors and interests when children show sex-atypical preferences. Although influential, early caregiver decisions does not guarantee acceptance of sex in later childhood, adolescence or adulthood, possibly due to the factors listed above (Bostwick & Martin, 2007).

Family conflict and ambiguity of rearing are not the only roadblocks in the gender identity development of intersex people (Meyer-Bahlburg, 2007). Children and adolescents may have body image issues due to the physical appearance of their genitals or with the development of sex-opposite secondary sex characteristics during puberty. Their peers may ostracize them due to their physical appearance or gender-atypical
behavior. Some intersex adolescents may find themselves attracted to same-sex partners and begin to question their sexual orientation or sex assignment. In some cases, children and adolescents may wholly reject their sex assignment and begin to overtly request a sex reassignment (Reiner & Gearhart, 2004).

Not all intersex children vocally request a desire to switch to the other sex, but many do report a feeling of being different from their assigned sex and identifying more with the opposite gender. In Bostwick and Martin’s (2007) case study a woman did not know she was born with an intersex condition until she was 48 years old. The investigators show that the client identified herself as a tomboy as a child and preferred male playmates. Although she never identified herself as being physically male, she grew up feeling like she had “the brain of a man” (p. 1499). She continues to live as a woman but is relieved to know that her gender identity confusion stems from a biological condition. Dittman’s (1998) case study of an intersexual German man who began life labeled a male, then was raised as a female after the age of four years old, shows that the patient began to seriously doubt her female sex around eight years old and “never felt as a girl or woman” (p. 261), but did not choose to live life as a male until he was 18 years old. The preceding paragraphs show that the gender identity of intersex individuals is not static and can change throughout the lifespan due to biological, psychological, societal and cultural influences.

**CONCLUSION**

Vilain (2006) argues that future gender identity should be the primary influence when assigning sex to an intersex infant, regardless of physical genitalia, karyotype or endocrinological data. Yet informed, research based conclusions about gender identity development of intersex infants is extremely difficult due to the limited and inconsistent data on such rare diagnoses (Reiner & Gearhart, 2004). Questions of gender identity may dominate the life of an intersex individual or be of no consequence at all (Bostwick & Martin, 2007). And for individuals who do struggle with gender identity and change their social sex, there is the possibility that they are not changing their gender identity at all but instead changing their gender role and they way they present themselves to society (Sobel & Imperato-McGinley, 2004). Some argue that sex assignment should be postponed until parents and doctors can observe the child’s normal development, but in a binary sex society, how can a child ever be raised gender neutral? Not until more comprehensive, cross-cultural and longitudinal research on both sex-assigned and gender-neutral individuals
is conducted can the influence of sex assignment of intersex individuals be fully understood.

REFERENCES


Laci Jones
Laci Jones received her BA in psychology and JBA in journalism at the University of Wisconsin-Madison. She is currently working toward her MA degree in Counseling, Adult Community Counseling specialization at Marquette University. Her clinical interests include women’s mental health and abuse issue as well as couple’s counseling. Her career goals include providing counseling services in a nonprofit setting, specifically working with individuals who are low income.
The Need for Research on Child and Adolescent Group Practices for Male Gender Role Strain

Michael Gutzwiller

Abstract: Male adolescents and children experience psychological conflict surrounding the understanding and integration of male gender norms into their self-identities as men and boys. This trouble may lead to an interruption of maturation and an indefinite prolonging of adolescence resulting in a gender identity deficit or sense of incompleteness and inadequacy as a male. Though there is little research in this area, group counseling can be an efficient and cost effective means of addressing the issue, increasing male self-esteem, and decreasing incidents of aggressive behavior. Ultimately, more research is needed to support the continued work in and exploration of group work pertaining to male youth gender role strain.

Research suggests that men and boys are suffering from unrecognized and unattended psychological and emotional distress (Chu, Porche, & Tolman, 2005). One area this can be especially seen is in the psychological conflict surrounding the understanding and integration of male gender norms into the self-identities of men and boys. Chu, Porche, and Tolman (2005) suggest that this integration is rarely successful and the masculine ideals that extend from the cultural gender norms are nearly impossible to achieve, resulting in a gender norm discrepancy. Nowhere is this process of assimilation and letdown more prominently felt than in childhood and adolescence (Richmond & Levant, 2003).

For many counseling professionals who deal with issues pertaining to the child and adolescent male gender norm paradigm and self-esteem, group counseling may be the most viable, cost effective, and preferred method of treatment. Research shows group therapy in general to be more effective than no treatment or placebo and as effective as individual or other counseling methods (Hoag & Burlingame, 1997; Kivlighan, Coleman, & Anderson, 2000). In terms of child and adolescent groups, research is slim. Hoag and Burlingame (1997) found the existing literature lacking in sophisticated methodology and specific variables, though it suggests that group treatment for children and adolescents is popular and seemingly effective despite the lack of empirical support. Further, Hoag and Burlingame (1997) note that compared to efficacy research for adult group therapy, efficacy research for child and adolescent group therapy is lagging far behind.

Based on the psychological and emotional needs of boys and the body of literature, or lack thereof, addressing the male gender norm paradigm and its treatment in group work, more research is needed both on group techniques aimed at the young male population and the efficacy of such treatment. In order to support this claim, this review will first examine the
current literature pertaining to the male gender norm paradigm and why it is important. Second, this review will explore the literature about group practices in this area including multicultural issues. Last, this review will offer an analysis of the current literature and offer suggestions for continued research and application of findings. As a note, this review will focus on the male gender norm paradigm for heterosexual males.

THE GENDER NORM PARADIGM

A broad stereotype exists in our current culture that suggests male emotional deficiencies are merely a quality of being a man. In this view men and boys simply do not have the capabilities to express difficult emotions nor do they have the ability to establish close meaningful relationships on the same level as girls and women (Chu et al., 2005). Emotional distress is not something that is acceptable for men and boys to struggle with and any external displays of internal emotional struggles are simply chalked up to 'boys being boys.' This perspective has become entrenched in our current societal view of masculinity and has become a part of the male gender norm (Chu, et al., 2005). The male gender norm, or hegemonic masculinity as institutionalized in the European American, middle class culture in the United States, places the greatest importance on stereotypical masculine qualities such as physical and athletic prowess, aggression, emotional isolation and interpersonal distance, self-sufficiency, and heterosexual dominance over women (Chu et al., 2005; Enns, 1992; Phillips, 2005; Weber, 2006).

A survey of the counseling literature seems to support this view. A search using the PsychInfo search engine turned up 8,581 listings under the term 'human males' and 25,213 listings under the term 'human females' and a search using the ERIC search engine turned up 13,738 listings under the search term 'males' and 30,327 listings under the search term 'females'. Further refinements of search terms to include 'self-esteem', 'group counseling', and 'group therapy' continue the more than 2:1 ratio of articles pertaining to women and girls compared to men and boys. One implication is that more attention is paid to the psychological and emotional issues of women than men.

The research conducted by Thompson and Pleck suggests two models of masculinity (Chu et al., 2005). The first takes a trait perspective whereby individuals inherently possess psychological traits of masculinity to varying degrees. Male identity is thus evident through the display of masculine qualities or social behaviors. The second model of masculinity is a normative approach that focuses on a social-cultural construction of gender roles (Chu et al., 2005; Richmond & Levant, 2003). Male identity is
constructed through a person’s attitudes toward and assimilation of culturally defined gender roles that are often changing and contradictory (Chu et al., 2005; Richmond & Levant, 2003). The gender role strain paradigm rests heavily on the second model. The conflict lies in the fact that while the male gender norm is widely recognized by boys few, if any, ever fully attain it (Chu et al., 2005; Johnson & Hayes, 1997; Richmond & Levant, 2003).

There are three forms of gender role strain in males as described by Pleck: discrepancy strain, dysfunctional strain, and trauma strain (Chu et al., 2005). Discrepancy strain is when an individual does not meet a specific internalized quality of masculinity. An example of discrepancy strain would be when a boy is poor at athletics, especially compared to his peers. Dysfunctional strain is when a male individual succeeds in conforming to the masculine gender norm role. This can be problematic and psychologically distressing for boys due to the fact that many of the behaviors considered typically masculine, such as aggression or physical dominance, when embodied completely, are potentially harmful and unhealthy behaviors. Further, these behaviors often cause conflict with others and alienate an individual causing confusion as to why the masculine ideology is so desired and at the same time shunned. Trauma strain pertains to specific groups of males who have experienced critical and intense gender role strain in which sex differences are heightened and pressure to conform to gender norms are acute (Chu et al., 2005). Examples of these groups would be soldiers and veterans, professional athletes, gay and bisexual men, men of color, and survivors of abuse (Chu et al., 2005). Richmond and Levant place adolescent boys in the trauma strain group.

GENDER NORMS

Richmond and Levant suggest (2003) boys face greater pressure than girls to adhere to rigid gender norms. The manner in which boys confront this issue and reconcile the inherent discrepancies within it is one of the greatest developmental hurdles for boys (Richmond & Levant, 2003). Boys who display more hegemonic masculine traits are more likely to present problematic externalizing behaviors such as school suspension, substance abuse, trouble with the police, and sexual activity (Richmond & Levant, 2003). These troubles may lead to an interruption of maturation and an indefinite prolonging of adolescence resulting in a gender identity deficit or sense of incompleteness and inadequacy as a male (Johnson & Hayes, 1997). Boys who fail to live up to the masculine gender norms often experience psychologically traumatic exclusion from parents, peers, and
teachers, as well as members of the opposite sex (Richmond & Levant, 2003). This rejection often results in a cyclic, redoubled effort to conform, which inevitably leads again to failure.

These descriptions of successful assimilation of and failure to achieve masculine gender norms correlate with the normalized concept of the popular individual and the outcast. In a study conducted with adolescents from a large city public school, Phillips (2005) found that adolescent boys from both groups could easily recognize and articulate what qualities were popular and cool and what qualities were not and further, identify their own status along the continuum. In nearly every instance, the qualities the boys identified as popular and cool were qualities of the masculine gender norm, while the qualities that were not considered popular and cool were not qualities of the masculine gender norm (Phillips, 2005).

In a school setting where much of this process is played out, experiences enforcing and reinforcing gender norms can have a profound effect on self-esteem. Boys may experience “negative social feedback, and/or internalized negative self judgments that can result, for example, in low self-esteem” (Chu et al., 2005, p. 96). While little to no research has been conducted on the connection between male gender role attitudes and masculine ideology and self-esteem, research with women has indicated a strong relationship between female gender role attitudes and self-esteem (Chu et al., 2005). Hendel (2006) lists a number of common signs of low self-esteem in males, including “exaggerated bragging, engaging in attention-seeking behaviors, verbal and physical aggression, displays of arrogance, conceit, narcissism and egotism, and displaying a sense of superiority over others” (p. 175). These signs of low self-esteem could easily be confused with qualities of hegemonic masculinity and, in that context, instead be mistaken as signs of high self-esteem. It would be fair to predict that a correlation exists between masculine gender norms and self-esteem.

GROUP PRACTICES

There is little research pertaining specifically to this topic or even group work with men apart from groups for men who physically or sexually abuse their partners and groups for male survivors of sexual abuse. While an argument could be made that these populations could be considered part of the gender role strain issue, specifically trauma strain, these articles do not address the issue in this way nor is the group work discussed therein necessarily applicable. Further, the vast majority of these articles do not focus on child and adolescent males. A search of the recent literature only revealed a small number of articles that could be
considered applicable to the discussion of group work pertaining to male gender role strain and issues of male self-esteem. The articles that could be located consist of one article discussing the clinical application of the gender role strain paradigm in group treatment for adolescent boys and one article describing a masculine identity focused group for men that could potentially have application to work with children and adolescents. Somewhat off topic but still relatively applicable to this discussion are one article addressing the relationship of client behavior and therapist helping skills in group work with aggressive adolescent boys, and two articles addressing group counseling for African-American adolescent males.

Adolescent Groups

Richmond and Levant (2003) offer an example of group treatment for adolescent boys focusing on the gender role strain paradigm. They believe that group treatment presents an effective means of addressing the issue and facilitating new ways of thinking apart from stereotypical social norms of masculinity. Their group consisted of seven white, middle class, heterosexual boys between the ages of 15 and 17, six of whom were court mandated to group counseling due to aggressive behavior and one who was referred by his mother due to recent depressive behaviors connected to the recent death of his father. The group leaders were a white, Catholic, heterosexual, female graduate student in her mid-twenties and her supervisor, a white, Jewish, heterosexual, middle-aged male. Within the context of the gender role strain paradigm, their goal was to create cohesiveness among the group members and increase the development of interpersonal relationships. The group met for a predetermined 16 sessions.

In order to lend structure to the meetings, the group was built around a “game” consisting of discussion topic cards (Richmond & Levant, 2003). Each group member turned over a card, read the topic word, and the entire group was encouraged to discuss the topic revealed. Topics ranged from non-threatening topics such as “video games” and “movies” to more controversial topics such as “sex” and “fear”. By the end of the third session fewer cards were needed to engage conversation and form cohesion. The researchers noted that initially the boys were reluctant to discuss topics that involved more emotionality, choosing instead to adhere to gender norms. Most of the boys, however, expressed a desire to alleviate the emotional difficulties they were attempting to cope with, specifically anger, substance abuse, and school and gang violence. During these discussions, the leaders implicitly focused on the dimensions of traditional masculinity described in the Male Role Norms Inventory (Fear and Hatred
of Homosexuals, Restrictive Emotionality, Nonrelational Attitudes Toward Sex, Achievement/Status, Avoidance of Femininity, Aggression, and Extreme Self-Reliance), calling attention to specific instances when the boys expressed adherence to traditional norms of masculinity and questioning their utility (Richmond & Levant, 2003).

The effectiveness of the group was questionable at best. At the end of the 16 weeks, the boys had reflected on these difficult topics and how they manifest in their own beliefs about masculinity but as the authors note, were unable or unwilling to effectively change their behaviors outside of the safety of the group (Richmond & Levant, 2003). The authors suggest this was due to limited social support. Despite this fact, the authors offer as evidence of the success of the treatment that, despite being mandated to participate in only 12 sessions, several of the boys continued to attend group for the entire duration. They also suggest that the boys’ willingness to discuss the topics openly demonstrated that group cohesiveness was effectively built and the boys in the very least began to challenge their internalized concepts of traditional masculinity. As further evidence of success, three of the boys were excused from the parole system and no longer had to meet with a social worker at the conclusion of group. No formal pre- or posttests were administered and there was no mention of multicultural considerations apart from identifying the composition of the group.

**Adult Groups**

Johnson and Hayes (1997) presented an identity-focused group for adult males that addressed many of the same issues in a shorter, more structured manner. This group model could potentially have applications with child and adolescent males. Their group model differentiates between male gender role and male gender identity whereby gender role is comprised of the hegemonic masculinity prevalent in a culture and gender identity is comprised of an individual’s internal perception of maleness or male self-image (Johnson & Hayes, 1997). They cite studies that show anecdotal evidence that masculine gender identity is correlated positively with self-efficacy and assertiveness and correlated negatively with maladjustment. Thus, in their group work the researchers focus on the consolidation of male gender identity as a means of reducing internalized self-shame due to a sense of incompleteness and inadequacy and as a means of restructuring maladaptive self-perceptions and schemas (Johnson & Hayes, 1997).

Johnson and Hayes (1997) developed an 8-session group that included 8 men between the ages of 24 and 45 selected from the researchers’
individual casework. The participants sought out individual counseling for a variety of issues ranging from anxiety to relationship problems and each had previously expressed interest in exploring further issues of male identity. All of the men were active duty soldiers; 6 were Caucasian and 2 were African-American. The two male leaders hoped to be able to model attitudes and behaviors for the men as well as offer permission for change. Highly structured, each session began with the participants pairing up and leaving the room to discuss the topic of the day for 20 minutes in order to build a rapport with another member as well as provide an inroad into larger group cohesion (Johnson & Hayes, 1997).

The first session focused on explaining the group rules and expectations and developing trust and group cohesion (Johnson & Hayes, 1997). The leaders then led the group members in a discussion about the various identities the members experienced as men (American men, husbands, fathers, military men, etc.) and the relationships and difficulties that extended from them. The culmination of the first session involved the members introducing themselves as men to the rest of the group as a sort of initiation ritual. The second and third sessions focused on the members’ relationships with other men, specifically their fathers, and other significant men or mentors in their lives. The discussion that followed, both in dyads and large group, were emotionally laden and led to a shared experience of grieving, acceptance, and value as the members recognized pieces of their own experiences in the others’ stories. The third and fourth sessions focused on the members’ relationships with women and children in regards to how these relationships impacted their identities as men. Activities included finger painting emotions about an important woman in their lives and bringing in pictures or symbols of children who were particularly meaningful to the men. The fifth through seventh sessions were built around the concept of each member’s personal myth. Members were asked to draw their life maps that plotted in time-line manner the important people, experiences, and events in their past and present as well as potential future development that shaped each man’s identity. Each member was given ample time to share his story with the group as a narrative or a personal myth and led to experiences of strong emotions, feedback, and often confrontation. The final session was devoted to ending the group, summarizing the progress each member had made in the short time of group. The session ended with each member saying good-bye to the others in a meaningful way that encompassed their masculine identities. The researchers mention no use of a pre- or posttest and no multicultural considerations were mentioned apart from the composition of the group. While this group was not designed for male youth, adaptations could be easily made. The discussions of the members’
relationships with their fathers and other mentors, important women in their lives, and peers are especially adaptable as well as the personal myth sessions.

Other Group Research

No other articles could be located which pertained directly to group work focused on child and adolescent male gender role strain. There is a small collection of literature that addresses other issues that may impact this discussion. Shechtman (2004) examines the relationship of client behaviors and therapist helping skills in individual and group treatment of aggressive boys. Shechtman (2004) investigated 25 group treatments and 26 individual treatments of boys from 32 Israeli elementary schools selected for their aggressive behavior based on teacher rankings. The Child Behavior Checklist and the Teacher Report Form were used to measure levels of aggression and were administered pre and post group and Hill's Helping Skills System was used as a measure of therapist helping skills (Schechtman, 2004). Group work focused mainly on bibliotherapy techniques designed to reduce aggression, manage anger, and increase impulse control. Despite the fact that no discussion of male gender role or gender identity was conducted during group, the results of this study show that group treatment resulted in a larger decrease in aggression than in individual treatment, as well as a larger decrease in aggression by way of teacher reports than student self-reports. The larger decrease in teacher reports lends strength to the efficacy of this group work as teacher reports are more objective than student self-reports. Therapist helping skills were found in this study to have no specific effect on the outcome of the groups (Schechtman, 2004). As to group work in general with boys, the findings of this study agree with the research of Hoag and Burlingame (1997) in that group treatment can be used effectively and is superior to individual therapy regarding cost-effectiveness (Schechtman, 2004).

Enns (1992) briefly notes in a study of consciousness-raising and assertiveness training groups for women that men would benefit from an increase in self-esteem stemming from the exploration of forces that shape self-definition. Men’s groups focused on exploring the connection between gender roles and self-esteem may provide a means for men to learn to relate to each other differently, share common experiences, and build support for change not supported elsewhere in the culture (Enns, 1992). Enns (1992) notes, however, that at the time of her writing research in this area did not exist and that adaptations of women’s groups could be made to accommodate men. No follow-up articles or data could be located.
MULITCULTURAL CONSIDERATIONS

None of the articles available for this review contained specific considerations for racial/ethnic populations. Two studies were located addressing group counseling for African-American males that, while not directly connected to the subject of this review, report findings that could be integrated into male gender role strain work with multicultural youth. Utsey, Howard, and Williams (2003) posit that an African worldview must be incorporated into counseling groups of African-American youth. This view holds that the individual must identify with the community in order to find meaning in life, uphold obligations to other members of the community, and to think and act in a manner that promotes the survival of the community as a whole (Constantine, Alleyne, Wallace, and Franklin-Jackson, 2006; Utsey et al., 2003). One’s individual value is intrinsically connected to his or her contribution to the community, family, or nation (Constantine et al., 2006; Utsey et al., 2003). The researchers developed a model for a mentoring group with African-American adolescent males based on five principles: group above self, respect for self and others, responsibility for self and community, reciprocity, and authenticity (Utsey et al., 2003). Anecdotal evidence from a case study of one individual involved in a group using this model suggests effective change in attitudes and behaviors in participants and the development of healthy relationships with African-American role models (Utsey et al., 2003). Even though this model was not focused on gender role strain, the principles it sets forth offer certain considerations when dealing with issues of gender role strain.

Bradley (2001) focused on the disparity of images the current culture cultivates of European-American adolescent males and African-American adolescent males. The stereotype is that behaviors of African-American adolescent males who display maladaptive behaviors are perceived as dangerous, or a menace or threat to society while the same behavior of European-American adolescent males is virtually excused (Bradley, 2001). The internalization of this negative stereotype by African-American boys leads to higher levels of anxiety, lower academic performance, and lower levels of self-esteem. Bradley (2001) found through a case study of one boy from a group focused on the needs of African-American males that group work of this nature could markedly increase the academic success of African-American male students. Further, Bradley (2001) suggests that counselors must be more proactive in delivering interventions to diverse populations in order to meet their unique needs.
ANALYSIS AND FURTHER RESEARCH

The gender role strain experienced by males across cultures is evident. Research suggests that child and adolescent males are particularly at risk for negative consequences related to the struggle to internalize self-concepts of masculinity. Forbes (2003) notes the difficulty male youths experience can be seen in high incidents of depression, violence, substance abuse, and feelings of alienation. Further, male youths often are not equipped with the emotional and conceptual means to effectively change (Forbes, 2003).

Group work literature on this subject is slim to none. The articles located for this review summarize the role strain issue and present potential group work models for male youth or models that could be adapted to male youth, but offer no evidence of effectiveness other than anecdotal observations. Variables were not operationalized, outcomes were not scientifically measured, and results were not clinically generalizable. In short, there is no clinical research supporting the efficacy of group work with male youth addressing the gender role strain paradigm. Further research is needed on the efficacy of group work, specifically on process and outcome variables related to male gender role strain such as the etiology and prevalence of the issue among different populations, and the effects of gender role strain on both short term and long term masculine identity development. Clinical studies are also needed to assess the generalizability of results.

Multicultural issues fare no better with regards to the gender role strain. The emphasis on developing a multicultural approach to counseling is so prevalent in the counseling profession today but is almost completely non-existent in literature on male gender role strain and related issues. Enns (1992) notes that issues related to gender roles vary greatly across cultures and ethnicities. Latinos, for example, have conceptualizations of gender (marianismo, machismo, and hembrismo) that do not have equivalents in the dominant European-American culture (Enns, 1992). African-American males experience acute racism that can contribute to issues of psychological distress, such as rage, anger, resentment, grief, and despair (Mahalik, Pierre, and Wan, 2006). Research suggests that African-Americans who identify strongly with a positive Black identity have better mental health than those who identify with White culture in the US (Mahalik et al., 2006). These factors, among many others greatly complicate the gender role strain for racial/ethnic populations. In this context, factors such as aggression and substance abuse become double-edged swords, laden with emotional impact and difficulty on two fronts: masculine ideology as well as racial identity. It is
clear that further research is needed to develop a deeper understanding of the impact of racial and ethnic identity on the gender role strain paradigm in ethnically and racially diverse male populations.

The gender role strain paradigm stands as an intriguing piece of the emotional life of boys. Group work addressing gender role strain could provide a viable, cost-effective means to reduce incidents of aggression among male youth, increase academic performance, and increase levels of positive self-concept and self-esteem. Schools and community clinics could incorporate into group work issues pertaining to masculine identity development, specifically reinforcing thoughts and behaviors that positively challenge social norms, and teaching life skills to better cope with gender role strain. Ultimately, more research is needed to support the continued work in and exploration of group work pertaining to male youth gender role strain.

REFERENCES


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Introduction to Pediatric Epilepsy for Neuroscientists: A Literature Review

Marc A. Silva

Abstract: A review of pediatric epilepsy is presented, with emphasis on diagnosis, taxonomy, associated psychological problems, and treatment. Epilepsy refers to a family of disorders, characterized by two or more unprovoked seizures more than 24 hours apart in a child over one month of age post birth. Epilepsy is the most common pediatric neurological disorder, effecting approximately 0.3% to 1% of patients under that age of 18. Seizures are typically classified according to (1) location of seizure onset in the brain (i.e., focal versus bilateral); (2) semiology (i.e., clinical symptoms); (3) etiology (symptomatic, idiopathic, and cryptogenic); and (4) syndrome (are epileptic disorders with specific clusters of signs and symptoms that occur together and have several typical features). Childhood epilepsy is associated with many types of cognitive and psychosocial dysfunction. Treatments aimed at reducing or eliminating epileptic seizures include pharmacotherapy, surgery, and the ketogenic diet. Psychological treatments help address the psychosocial problems associated with childhood epilepsy.

Approximately 150,000 people develop epilepsy each year in the U.S. (National Institutes of Health [NIH], 1990). Prevalence in the U.S. population is typically estimated between 0.5% and 1% (Solomon & Pfeffer, 1996) but could be as high as 5% (Novick & Arnold, 1988). Epilepsy is the most common pediatric neurological disorder (Bennett & Ho, 1997; Hagar, 2008), effecting approximately 0.3% to 1% of patients under that age of 18 (Cowan, Bodensteiner, Leviton, & Doherty, 1989; Pellock, 2004; Rutter, Graham, & Yule, 1970; Solomon & Pfeffer, 1996). Most individuals diagnosed with epilepsy experienced initial symptoms of the disorder prior to age 20 (Novick & Arnold, 1988; Solomon & Pfeffer, 1996), with median age of onset between 5 and 6 years old (Shinnar & Pellock, 2002). Each year, 20,000 to 45,000 new cases of epilepsy are diagnosed in U.S. children and adolescents (Hauser, 1994; Shinnar & Pellock, 2002). There are approximately 300,000 children in the U.S. living with epilepsy (Solomon & Pfeffer, 1996), although others indicate this number could be as high as one million (Hartlage & Telzrow, 1984). Children 1 to 12 months of age post-birth are at the highest risk for developing epilepsy (Hauser, 1994; Shinnar & Pellock, 2002). Findings about gender-related risk factors have been inconsistent (Anderson, Northam, Hendy, & Wrennall, 2001).

Definitions and explanations of terminology common in the epilepsy literature are provided in the next section (see also the glossary, Appendix A).
TERMINOLOGY

Epilepsy is a family of disorders characterized by recurrent seizures. Specifically, epilepsy (also referred to as seizure disorder) is defined as two or more unprovoked seizures more than 24 hours apart in a child over one month of age post birth (Commission of Epidemiology and Prognosis, International League Against Epilepsy [CEP/ILAE], 1993). Experiencing a single seizure, which is not entirely uncommon among children, is insufficient. Seizures must be recurrent to obtain a diagnosis of epilepsy (Bennett & Ho, 1997; Novick & Arnold, 1988; Solomon & Pfeffer, 1996).

Seizures occur when there is atypical electric activity in the brain (Hagar, 2008). In normal brain functioning, the firing of excitatory and inhibitory neurons is cooperative and balanced, which allows normal voluntary and involuntary sensory and motor movements to take place (e.g., controlled eye and limb movements). Seizures are the result of abnormal, excessive, paroxysmal, and uncontrolled discharge of neurons (CEP/ILAE, 1993; Novick & Arnold, 1988; Solomon & Pfeffer, 1996). Seizures interfere with normal functioning, with clinical manifestations that include abrupt disturbances of consciousness, speech, language, cognition, affect, sensory experiences (e.g., tingling, misperceptions), motor movement (e.g., muscle stiffening and jerking), and behavior (Bennett & Ho, 1997; Hagar, 2008; Novick & Arnold, 1988; Solomon & Pfeffer, 1996). Other epilepsy-related terminology readers should be familiar with include the following: ictal or intraictal, which refers to the period of time the epileptic seizure is experienced; postictal, which refers to the period of time just after an epileptic seizure; and interictal or interictal interval, which refers to the time period between two epileptic seizures (Novick & Arnold, 1988).

Classification

Seizures are typically classified according to location of seizure onset in the brain, semiology, etiology, and syndrome (CEP/ILAE, 1993; Hagar, 2008; Hartlage & Hartlage, 1997; Novick & Arnold, 1988; Solomon & Pfeffer, 1996). The most widely accepted classification system (as noted by Hartlage & Hartlage, 1997) is the Commission on Classification and Terminology of the International League Against Epilepsy [CCT/ILAE] (1989), which primarily classifies seizures according to whether the onset of abnormal and excessive neuronal activity is focal (thus involving one hemisphere) or bilateral (thus involving the whole brain from the start). Seizures with focal onset have traditionally been referred to as partial seizures, which will be the term primarily, used in the current paper. More
recently, researchers are using the term focal seizures because partial may inaccurately connote incompleteness.

In generalized seizures, onset is bilateral. Partial and generalized seizures are subclassified according to associated semiology (i.e., clinical signs and symptoms) and neuronal activity (Anderson et al., 2001; CCT/ILAE, 1989; Dreifuss, 1993; Hagar, 2008; Novick & Arnold, 1988; Solomon & Pfeffer, 1996; see Appendix B). Subclassifications of partial and generalized seizures will be explored next.

Partial Seizures

Seizures with focal onset are called partial seizures. There are three main types, all of which commonly occur among children (Novick & Arnold, 1988). Simple partial seizures (also referred to as partial elementary), are characterized primarily by disturbances in sensory-perceptual, motor, and cognitive functioning. Consciousness is preserved. Complex partial seizures are typically characterized by impaired or altered consciousness as well as sensory, motor, and cognitive disturbances (CCT/ILAE, 1989; CEP/ILAE, 1993; Hagar, 2008; National Society for Epilepsy, 2007; Novick & Arnold, 1988; Solomon & Pfeffer, 1996). Simple or complex seizures that begin focally and then spread to involve the whole cortex are described as partial seizures that secondarily generalize. These seizures often generalize into the tonic-clonic subtype (Novick & Arnold, 1988) which is described later. Secondarily generalizing seizures may originate in the brain stem or reticular activating system, which makes sense intuitively. All three partial seizure subtypes are characterized by positive symptoms and/or cessation of sensation, motor output, cognition, and consciousness.

Sensory disturbances are most characteristic of simple partial seizures. Symptoms may include visual, auditory, olfactory, gustatory, or vertiginous misperceptions or hallucinations. The experience of such sensory symptoms is sometimes referred to as an aura, particularly when first experienced as part of simple partial seizure that evolves into a complex partial or generalized seizure. Motor disturbances may include automatisms, stereotyped movements, loss of motor control, or jerking in one part of the body. Cognitive disturbances include, for example, changes in language, attention, and affect. Finally, while children are typically alert during simple partial seizures, consciousness is altered or impaired from the start during complex partial seizures (Novick & Arnold, 1988; Solomon & Pfeffer, 1996). The specific clinical symptoms experienced by the child and observed by others depend largely upon the location of abnormal electrical activity in the brain.
Although partial seizures (all subtypes) often originate in the limbic system or temporal lobe (Solomon & Pfeffer, 1996), focal onset reportedly may occur throughout the brain, with certain semiology associated with location of onset. For example, simple partial seizures arising from the mesial basal limbic or primary rhinencephalic region of the temporal lobe are associated with autonomic and/or perceptual symptoms. Seizures beginning in the uncus may be accompanied by olfactory or gustatory sensations that are often experienced by the child as unpleasant odors and bitter or salty taste (Bennett & Ho, 1997; Solomon & Pfeffer, 1996). Seizures originating from the hippocampus or amygdala may result in a rising sensation felt from the abdomen. Generally, seizures arising in the lateral temporal lobe are characterized by auditory hallucinations or visual-perceptual hallucinations. Auditory misperceptions may be experienced when seizures originate in the anterior temporal lobe, especially in the left hemisphere (Bennett & Ho, 1997). During the ictus, the child may perceive voices or sounds as being too soft or loud in volume or too low or high in pitch. Simple auditory hallucinations such as buzzing, ringing, or hissing noises may also be experienced, particularly when the seizure focus is in the primary auditory zone. Visual misperceptions are common when seizure focus is in the posterior temporal lobe. In these cases, objects may appear much smaller or larger than they actually are. As would be expected given the functional aspects of association cortex zones, complex visual hallucinations appear to arise from the temporal-parietal-occipital junction (Bennett & Ho, 1997; Solomon & Pfeffer, 1996). Other temporal lobe-related simple partial seizures include affective-perceptual symptoms such as déjà-vu (familiarity of unknown people, places, objects, or experiences), jamais-vu (unfamiliarity of known people, places, objects, or experiences), or overwhelming fear (Solomon & Pfeffer, 1996).

According to Task Force on Classification and Terminology, ILAE (2001), seizures originating in the frontal lobe feature prominent autonomic vocalizations (e.g., repetitive grunts, shrieks, or other nonlanguage utterances), and motor responses (e.g., stereotyped movements such as pelvic thrusts other repetitive body movements). Urinary incontinence and drop attacks may occur as well. When seizure focus is in the motor cortex, there may be sudden, involuntary, and repetitive contractions of muscles in a particular muscle group that spread to contiguous muscle groups progressively. This is referred to as a Jacksonian March (Task Force on Classification and Terminology, ILAE, 2001). Frontal lobe seizures may be quick to secondarily generalize (Solomon & Pfeffer, 1996).

When seizures originate in the parietal lobe, they are often accompanied by somatosensory symptoms such as numbness, tingling, or...
the feeling of electricity on one side of the body (Solomon & Pfeffer, 1996). Sometimes the somatosensory symptoms will first be experienced in the hand and then spread like a Jacksonian March through the arm and throughout one side of the body. Finally, simple partial seizures originating in the occipital lobe are accompanied by visual hallucinations, such as colors, flashes, or sparks (Solomon & Pfeffer, 1996).

In contrast to the simple partial variety, complex partial seizures have an absence of aura and instead are characterized by an abrupt loss of consciousness and cessation of ongoing activity. Often, this is followed by speech-related automatisms such as shouting or screaming; affective automatisms such as laughing or crying; simple automatisms such as chewing, lip smacking, spitting, or swallowing; and complex automatisms such as drinking, running in a circle, and undressing (Novick & Arnold, 1988; Solomon & Pfeffer, 1996). Seizure duration is typically about a minute and is followed by postictal amnesia and confusion (Solomon & Pfeffer, 1996). For simple partial seizures that evolve into complex partial seizures, the aura precedes loss of consciousness.

**Generalized Seizures**

Seizures in which onset involves both hemispheres initially are referred to as generalized seizures (CCT/ILAE, 1989; Dreifuss, 1993; Hagar, 2008; Novick & Arnold, 1988; Solomon & Pfeffer, 1996). Consciousness if often impaired and motor symptoms (when they occur) are bilateral. Like partial seizures, generalized seizures are subclassified according to associated semiology and neuronal activity (See Appendix B). Generalized seizures are subclassified as absence, myoclonic, clonic, tonic, tonic-clonic, and atonic.

Of the generalized epilepsies, absence and tonic-clonic subtypes are the most frequently occurring in children (Novick & Arnold, 1988), and are described below. But first, the remaining subtypes are briefly described in order to facilitate understanding terminology and semiology associated with generalized seizures. Definitions and descriptions presented here were explained in detail elsewhere (see Blume, Luders, Mizrahi, Tassinari, van Emde Boas, & Engel, 2001).

**Myoclonic** refers to brief (i.e., < 100 milliseconds) involuntary contractions of muscles or muscle groups. **Clonic** refers to regularly repetitive myoclonic contractions which involve the same muscle groups and occur at a frequency of approximately 2 to 3 seconds. **Tonic** refers to sustained increase in muscle contractions lasting seconds to minutes and is observed as a sudden seizing of muscles or muscle groups. **Tonic-clonic** refers to a sequence of tonic-clonic or sometimes clonic-tonic-clonic phases. **Atonic** refers to a sudden loss of muscle tone without apparent
preceding myoclonic or tonic phases, typically involve muscles of the head, trunk, jaw, or limbs, and last up to 2 seconds (Blume, et al., 2001).

**Absence Seizures**

Unlike most generalized epilepsies, absence seizures (formerly known as petit mal seizures) are nonconvulsive (Hagar, 2008; Novick & Arnold, 1988). Absence seizures are characterized by an abrupt loss of consciousness that are usually brief (e.g., lasting approximately 10-30 seconds), and may occur dozens of times a day (Hagar, 2008; Novick & Arnold, 1988). The symptoms associated with absence seizures are typically subtle, thus the seizure may go unnoticed by others. To the observer, the individual experiencing the seizure may appear to be staring off into space. Others may perceive the child to be daydreaming. During the ictal phase, the child will not respond to the environment. The child will typically resume activities postictus with no memory for the episode. Typically, absence seizure epilepsy first occurs between the ages of 4 and 10 years of age, but may begin in adolescence. Absence seizures tend to disappear when the child reaches adulthood. However, about half of children with absence seizures later develop tonic-clonic seizures (Novick & Arnold, 1988).

**Tonic-Clonic Seizures**

Tonic-clonic seizures (formerly called grand mal seizures) are characterized by abrupt loss of consciousness and convulsive motor activity. During a tonic-clonic seizure, muscles suddenly contract and become rigid (tonic phase) and then jerk and shake violently (clonic phase). Vomiting, urination, and defecation may occur during the ictal period, followed by postictal confusion, unresponsiveness, and amnesia for the seizure (Novick & Arnold, 1988).

While location of onset is the typical classification system, it is important to note that seizures are often a symptom of some other ailment. Sometimes, epileptic seizures may be secondary to disease of the central nervous system (CNS). Seizures may have genetic determinants as well. Most often, however, no specific cause can be identified. Etiology of epilepsy is described next.

**Etiology**

Seizure etiology fall into two main categories: symptomatic and idiopathic. Symptomatic seizures result from known CNS dysfunction (e.g., focal pathology, metabolic abnormalities). That is, they are experienced as symptoms of another diagnosed disorder. Epileptic
seizures may be secondary to hypoglycemia, bacterial or viral infection, brain hemorrhage, brain contusion, or brain tumor. Seizures may result from these disorders because of intracranial pressure or metabolic changes in the surrounding neurons (CEP/ILAE, 1993; Novick & Arnold, 1998; Solomon & Pfeffer, 1996).

*Idiopathic* seizures are seizures with particular clinical signs and symptoms, but have no clear antecedent such as CNS infection or injury (Shinnar & Pellock, 2002). Although there are no detectable causes, undetected metabolic or structural abnormalities are thought to be involved (Novick & Arnold, 1988). The majority of seizures experienced by children are idiopathic.

Sometimes, family patterns can be found among children with epilepsy, thus genetic determinants are thought to be involved (Novick & Arnold, 1988). Genetic etiology appears present in absence and tonic-clonic seizures, for example.

*Cryptogenic* seizures, which have no known etiology, is another term used to classify epilepsy according to etiology. Cryptogenic seizures include both partial and generalized seizures that do not conform to criteria for the symptomatic and idiopathic categories (CEP/ILAE, 1993; Hagar, 2008). Cryptogenic seizures were presumed to be symptomatic, however over time genetic features have been identified in some variants of the subtype (CCT/ILAE, 2008).

**Epileptic Syndromes**

Epilepsy can also be classified according to syndromes, which are epileptic disorders with specific clusters of signs and symptoms that occur together and have several typical features (Solomon & Pfeffer, 1996). Approximately 50% of children with epilepsy can be classified into an epileptic syndrome (Rothner, 1992). Epileptic syndromes share similar onset ages, clinical courses, and responses to treatment, although there may be divergent etiologies. Syndrome classification is useful because it allows providers to better evaluate the patient in terms of illness course and prognosis as well as choose appropriate medication (Solomon & Pfeffer, 1996). An abridged list of epileptic syndromes, which are subclassified according to location of seizure onset and etiology can be found in Appendix C. Onset may be generalized, focal, or undetermined. Etiologies are varied. Those epileptic syndromes commonly occurring among children are described below.

*Generalized Epileptic Syndromes*
Childhood absence epilepsy and juvenile myoclonic epilepsy are generalized, idiopathic epilepsies, both of which have favorable prognoses. *Childhood absence epilepsy* (also known as pyknolepsy) typically occurs in children between 4 and 12 years of age, with the highest rate of onset occurring between 6 and 7 years of age. Childhood absence epilepsy usually remits after adolescence, although tonic-clonic seizures may develop during this time. There is a strong genetic component to this syndrome, as evidenced by EEG patterns. Seizures are characterized by brief staring and eye blinking lasting between 5 and 10 seconds, and occur several times a day. Ictal EEG shows predictable spike and wave activity. No structural lesions are present, medication helps to control seizures, and prognosis is favorable. Sodium valproate is generally prescribed for childhood absence epilepsy with additional tonic-clonic seizures. Otherwise, ethosuximide is the drug of choice (Anderson et al., 2001; Solomon & Pfeffer, 1996).

*Juvenile myoclonic epilepsy* (also known as impulsive petit mal) is characterized by brief myoclonic jerks and absence seizures as well as generalized tonic-clonic seizures that often begin during adolescence. Ictal EEG shows predictable spike and wave patterns. About one-third of patients show a photoparoxysmal response. Seizures are well-controlled with valproate, although relapse is high upon tapering or ceasing the medication (Solomon & Pfeffer, 1996).

In contrast to the prior mentioned syndromes, *Lennox-Gastaut syndrome* is a generalized epileptic syndrome that is symptomatic. Seizures typically begin between 2 and 5 years of age and are characterized by cessation of ongoing motor activity (akineti), loss of muscle tone (atonic), and sustained muscle contractions (tonic). There is also a high incidence of tonic-clonic seizures. Sadly, prognosis of Lennox-Gastaut syndrome is less favorable. Seizures are difficult to control and there is a high incidence of associated cognitive and behavioral problems (e.g., mental retardation). Treatment for Lennox-Gastaut syndrome includes sodium valproate and benzodiazepines, as well as a ketogenic diet (Solomon & Pfeffer, 1996), which is a high fat, adequate protein, low carbohydrate diet (Freeman, Kossoff, & Hartman, 2007).

### Partial Epileptic Syndromes

Similar to those with generalized onset, epileptic syndromes with focal onset may be idiopathic or symptomatic. Focal seizures may be simple or complex. Idiopathic syndromes common among children include benign childhood epilepsy with centrotemporal spikes and
childhood epilepsy with occipital paroxysms; they will be described first. Next, features of partial onset symptomatic syndromes are described.

Benign childhood epilepsy with centrotemporal spikes (also known as benign Rolandic epilepsy of childhood), typically begins in children 3 to 12 years of age. Clinical symptoms are typically atonic and akinetic, and include speech arrest, paresthesias of the mouth, and excessive drooling. Consciousness is typically preserved. There is a strong genetic component, predictable EEG spike patterns during sleep, and no evidence of underlying structural lesions. Seizures typically cease when children reach their teens. Fortunately, children typically go on to have normal intelligence and performance on neurological examinations (Solomon & Pfeffer, 1996).

Childhood epilepsy with occipital paroxysm, another syndrome with idiopathic focal onset, is characterized by visual symptoms such as amblyopia (i.e., blurred vision) and visual hallucinations. Often, there is a family history of epilepsy in children with this syndrome. EEG activity during sleep follows a predictable pattern. Childhood epilepsy with occipital paroxysms is said to be benign, with resolution of seizures and associated EEG abnormalities in the late teenage years (Solomon & Pfeffer, 1996).

Focal onset seizures of the symptomatic variety are classified according to anatomic location of seizure, seizure type (i.e., simple or complex partial), clinical features, and etiological factors if known. Symptomatic focal seizures often originate in the frontal lobe, temporal lobe, or limbic system. Associated ictal and interictal behavioral abnormalities are typically present and specific symptoms vary according to location of onset. Often, seizures occur unpredictably and are followed by postictal confusion. Clinical manifestations may include automatisms and other motor symptoms. If seizures are frequent, there may be associated memory problems. Cognitive and behavioral problems are associated with focal onset symptomatic syndromes. Anticonvulsant medication such as carbamazepine and phenytoin are typically prescribed. Barbiturates have been prescribed but are associated with negative cognitive side effects, thus have fallen out of favor. If medications are not effective and onset is localized to the temporal lobe, children may be good candidates for surgery to reduce or eliminate seizures (Solomon & Pfeffer, 1996).

Sometimes, it cannot be determined whether seizure onset is focal or generalized, as both types are typically present. Acquired epileptic aphasia and acquired epileptic frontal syndrome are examples of this subclass. Acquired epileptic aphasia (also known as Landau-Kleffner syndrome) is typically idiopathic although structural lesions in the temporal lobe have
been found on rare occasions. This syndrome is associated with predictable EEG spike and wave activity in the temporal lobe, with some children displaying continuous spike and wave activity during slow wave sleep. Seizures are often generalized and convulsive, but may also be partial with motor abnormalities. Behavioral and psychomotor problems are present in two-thirds of children. These symptoms usually begin between the ages of 2 and 10. For example, verbal-auditory agnosia and deterioration of spontaneous speech can begin as early as age 2. Seizures often remit before the age of 15, but at least one-third of children continue to have serious language disorders. Some children have responded to treatment with steroids (Solomon & Pfeffer, 1996).

Similarly, acquired epileptic frontal syndrome is also associated with continuous spike waves during slow wave sleep. Intertial EEG of the frontal lobe during both wake and sleep show predictable activity. Seizure onset is also quite early in a child’s life, typically beginning between two and a half and 5 years old. Acquired epileptic frontal syndrome is associated with subsequent deterioration of cognitive abilities and behavior. For example, children typically show impaired reasoning, impaired visual-spatial ability, and disorientation to passage of time. Treatment with ethosuximide, which is often used to treat absence seizures, was associated with improvement in children with acquired epileptic frontal syndrome (Solomon & Pfeffer, 1996).

Non-epilepsy Seizure Disorders

Certain seizures and seizure disorders appear epileptic in nature but are actually not considered as part of the epilepsy family of disorders. Febrile seizures and pseudoseizures are two examples of nonepileptic seizure disorders (CEP/ILAE, 1993; Hagar, 2008; Solomon & Pfeffer, 1996).

Febrile seizures (i.e., fever-related seizures occurring in early childhood) are usually classified as symptomatic (CEP/ILAE, 1993). There are two subtypes: those associated with febrile illnesses that affect the central nervous system (e.g., respiratory illnesses) and those that are not. Febrile seizures typically occur between 6 months to 5 years of age. Febrile seizures are thought to have genetic etiology. Although frequently seen by psychologists and neuropsychologists, probably due to concerned parents, they are often not associated with later learning disorders or mental retardation (Novick & Arnold, 1988).

In contrast to epileptic and febrile seizures, pseudoseizures (also known as psychogenic seizures) are not accompanied by abnormal electrical brain activity (Hagar, 2008). Associated EEG activity appears normal (Solomon & Pfeffer, 1996). Seizures appear epileptic, but etiology is
believed to be related to stress or emotional conflict (Hagar, 2008; Solomon & Pfeffer, 1996). For example, pseudoseizures have been associated with childhood abuse and school problems. Thus, pseudoseizures are more appropriately classified as a conversion disorder (Solomon & Pfeffer, 1996).

Clinical symptoms of pseudoseizures typically include uncontrolled thrashing of the body, although incontinence and injury to the patient are typically absent (Solomon & Pfeffer, 1996). Sometimes, pseudoseizures are accompanied by a dissociative reaction or temporary amnesia which may be an unconscious attempt to "get away." Pseudoseizures are common in the pediatric population and may occur in children and adolescence, and may occur alone or alongside epilepsy (Pakalnis, Paolicchi, & Gilles, 2000; Paolicchi, 2002; Solomon & Pfeffer, 1996), making accurate diagnosis difficult.

As noted by Solomon and Pfeffer (1996), provocative EEG testing has assisted neurologists with diagnosing pseudoseizures. The provocative EEG test entails securing the patient’s permission to induce a seizure using an innocuous method, such as a cold pack placed on the head or an intravenous saline injection, which are essentially placebos. The patient is told the procedure will likely induce a seizure. The procedure was followed by a pseudoseizure response in many patients with uncontrolled seizures (Cohen, 1982). Thus, provocative EEG testing may help, but should not be used exclusively, to differentiate children with pseudoseizure from those with true epilepsy.

Notably, frontal lobe seizures are sometimes confused for pseudoseizures because of the unusual behavioral presentation and short ictal and postictal period (Solomon & Pfeffer, 1996). However, unlike frontal seizures, pseudoseizures do not occur during sleep and they are unresponsive to antiepileptic medication.

**Diagnosis**

Epilepsy is diagnosed and treated primarily by neurologists (Novick & Arnold, 1988). Diagnosis is based on a variety of data, including (1) detailed information about seizure activity; (2) a comprehensive patient history; (3) findings from medical and neurological examinations; and (4) results from laboratory studies (Hagar, 2008; Novick & Arnold, 1988). Tests for metabolic disorders or infections may be included. Electroencephalogram (EEG) is probably the most frequently used technology to aid physicians with diagnosis (National Society for Epilepsy, 2006; Novick & Arnold, 1988; Solomon & Pfeffer, 1996). EEG records alternating excitation and inhibition of neuronal electrical activity, and
assists with identifying the origin of seizures in the brain. However, a negative EEG does not necessarily refute the presence of seizures, as false negative results occur. Other assistive devices include neuroimaging techniques such as computerized transaxial tomography (CT), magnetic resonance imaging (MRI), and positron emission tomography (PET) scanning, which assist in locating lesions in the brain that may be associated with seizure activity (Solomon & Pfeffer, 1996).

In addition to technology-based tests, neuropsychological assessment is an important part of epilepsy diagnosis. Neuropsychological assessment aids in establishing severity of impairment (e.g., cognitive, behavioral, psychosocial) and monitoring the effects of treatment on dysfunction. For example, neuropsychological testing before and after medication treatment or after medication change can assist in finding a practical balance between seizure control and adverse cognitive, behavioral, and psychosocial consequences. Neuropsychological testing can also aid in determining focal onset of seizures, level of cognitive impairment, and whether patients are good candidates for surgery (Bennett & Ho, 1997). Skill in evaluating and tracking the children’s cognitive and psychosocial problems associated with epilepsy is probably the greatest asset of neuropsychologists.

**Dysfunction Associated with Epilepsy**

Children with epilepsy experience a range of problems associated with cognitive and psychosocial functioning (Novick & Arnold, 1988). Cognitive concerns are discussed first.

**Cognitive Concerns**

While cognitive deficits have been reported among some children with epilepsy, not all demonstrate cognitive impairment. Children with epilepsy may in fact have normal or superior intelligence. One study found that the distribution of intelligence scores in children with epilepsy was comparable to that of the general population (Rutter et al., 1970). Lennox and Lennox (1960) indicated that in a study of 1905 patients with epilepsy, two-thirds had normal intelligence while only 14% clearly showed cognitive impairment. Still others suggested that children with epilepsy have mean IQs ranging up to a standard deviation lower than average (Hartlage & Hartlage, 1997). In contrast, Bennet and Ho (1997) noted that most children with epilepsy have normal intelligence, although variance is positively skewed toward the low end of average. Discrepant findings in intellectual ability could be due to uncontrolled variables that may differentially affect cognitive functioning, such as age of onset, duration of
the seizure disorder, seizure type (i.e., focal or generalized), seizure frequency, medication effects, and whether seizures were symptomatic or idiopathic. It has also been noted that the exclusive use of the IQ score as a measure of cognitive function may be inadequate in assessing various cognitive abilities and deficits associated with brain dysfunction (Bennet & Ho, 1997), as IQ is theorized as relatively stable and research suggested it may be insensitive to cognitive changes associated with epilepsy. More recent research has investigated cognitive processes such as sensory processes, attention, concentration, learning, memory, receptive and expressive language ability, reasoning, and motor skills (Bennet & Ho, 1997).

When considering moderator variables, subgroups of epileptic children appear to be more at risk for cognitive impairment. Etiology, onset, and syndrome classifications have been examined in this regard. For example, children with underlying CNS disease (i.e., they have symptomatic epilepsy) performed worse on tests of intelligence, while idiopathic epilepsies were less often associated with intellectual compromises (Solomon & Pfeffer, 1996). For example, IQ was found to be 4-11 points lower in those with symptomatic versus idiopathic epilepsy (Tarter, 1972). Bennet and Ho (1997) reported that children with symptomatic seizures were more likely to be mentally retarded (73%) compared to those with idiopathic seizures (22%).

Seizure frequency was positively correlated with greater intellectual deficit (as noted in Hartlage & Hartlage, 1997), however this finding was inconsistent. In fact, the affects of seizures on intelligence are more homogenous within a given seizure classification than across epilepsies. For example, childhood absence seizures are unlikely to show intellectual deficits despite occurring several times a day (Farwell et al., 1985; Hartlage & Hartlage, 1997). Children with minor motor, atypical absence, or absence plus generalized tonic-clonic seizures showed mild impairments on the age appropriate Halstead-Reitan Neuropsychological Battery (Farwell et al., 1985). Children with minor motor and atypical absence seizures are more likely to show aphasias-related deficits and lower IQ scores compared to children with other types of epilepsies (Bennet & Ho, 1997; Hartlage & Harlage, 1997). Those with generalized seizures in general and tonic-clonic seizures in particular appear to be at higher risk for cognitive impairment compared to those with focal onset, regardless if the seizures were idiopathic or symptomatic (Bennet & Ho, 1997). Finally, Tarter (1972) indicated that individuals with generalized tonic-clonic seizures show the greatest intellectual deficit, those with simple partial seizures showed the least deficit, and those with partial complex seizures had intermediate levels of intellectual impairment.
Epileptic syndromes appear more predictive of cognitive impairment than seizure type. For example, children with benign Rolandic epilepsy and juvenile myoclonic epilepsy rarely show decline in intellectual functioning regardless of the number of seizures (Holmes, 1991). In contrast, progressive mental retardation was observed in 75% to 95% of children with Lennox-Gastaut syndrome (Chevrie & Aicardi, 1972). Differences in IQ are probably related to an interaction of a host of variables. IQ tends to be lower in children with earlier onset and multiple seizure types, longer and more frequent seizures, less seizure control while on medication, toxic drug levels due to medication, and multiple drug toxicity (Solomon & Pfeffer, 1996). Farwell et al. (1985) reported that three variables accounted for the variance in IQ scores, specifically years with seizure disorder (38%), followed by seizure duration (16%) and age of onset (9%).

Other cognitive problems found among children with epilepsy include, for example, problems with information processing speed, sustained and focused attention, motor fluency, vigilance, and alertness. There appears to be different cognitive problems associated with hemispheric location of seizure activity. For example, epilepsy with focal onset in the left hemisphere in general, and more the left temporal lobe specifically, is more often associated with verbal processing and immediate memory problems. In contrast, right hemisphere onset is more often associated with problems with visuospatial reasoning, attention, modulation of affect, paralinguistic aspects of communication, and parallel information processing (Solomon & Pfeffer, 1996). In a small study that compared (right and left) temporal lobe epileptic patients without a history of brain damage or neurological disease with healthy controls, no lateralizing deficits were observed, although there was a trend found for deficits in psychomotor speed, selective attention, and reasoning among the epileptic group (Haynes & Bennett, 1991).

As noted by Bennett and Ho (1997), impaired sustained attention appears related to generalized seizures more so than focal seizures, possibly because generalized seizures are more likely to involve subcortical structures responsible for maintaining attention. In contrast, those with cortically-based focal seizures appear more likely to be impaired on tests of selective attention.

Evidence for memory deficits is strongest in patients with complex partial seizures with temporal lobe foci (Bennett & Ho, 1997). Most research has focused on verbal memory, which is more likely to be impaired in those with seizures originating in the left temporal lobe. Nonverbal deficits have been observed in those with right temporal lobe onset. Long term memory appeared more affected than short term
memory. Results persisted after controlling for age of onset, duration of epilepsy, and seizure frequency. It should be noted that most studies examined surgical candidates with little attention given to patients with complex partial seizures who were not surgical candidates.

Language deficits have also been noted (Bennett & Ho, 1997). Dysnomia was reportedly prominent in patients with complex partial seizures with left temporal lobe foci. Other observed problems included circumstantiality in speech and writing, and hyperplasia (i.e., the tendency toward excessive and compulsive writing). In addition, Bennett and Ho noted that children with epilepsy perform poorer on tests of perceptual-motor skills. Finally, those with epilepsy demonstrated reduced reaction time, processing speed, and psychomotor speed (Bennet & Ho, 1997; Hagar, 2008).

To summarize, the precise cause of cognitive changes is unclear, and a variety of factors appear involved. Those with symptomatic epilepsy, generalized seizures, longer duration or seizure disorder, and certain epilepsy subtypes appear to be at greater risk. Cognitive changes could be due to alterations in the CNS because of recurrent seizure, or due to an underlying degenerative disease of which epileptic seizures are symptom (Bennett & Ho, 1997). Seizures may be secondary to head injury, infectious disease such as encephalitis, brain tumor, or cerebrovascular disease, all of which are associated with cognitive deficits in their own right (Bennett & Ho, 1997). Contributing factors may include physiological abnormalities of the limbic system, brain damage secondary to repeated and uncontrolled seizures, the presence of an underlying degenerative disease that is associated with the epilepsy, effect of the pharmacological treatment, disturbed psychological response of the patient toward societal stigma, and negative reactions by others toward the illness (Solomon & Pfeffer, 1996).

Frequency of seizures was negatively correlated with cognitive ability in adults with tonic-clonic seizures as well as children across seizure classes. At the same time, earlier age of onset and longer duration of the disorder are associated with greater risk for cognitive impairment in children age 9 to 15 as well as adults (Bennett & Ho, 1997). Notably, these findings do not take into account the effects of antiepileptic medication of cognitive dysfunction, which are discussed later. It is important to note that there are no specific cognitive deficits common among across the epilepsies, although children with epilepsy have higher incidence of cognitive problems compared to the general population (Solomon & Pfeffer, 1996).

Associated Psychosocial Problems
Many children with epilepsy experience myriad psychosocial problems. For example, poor academic performance has been observed most notably in arithmetic, followed by spelling, reading comprehension, and word recognition (Hagar, 2008; Novick & Arnold, 1988; Solomon & Pfeffer, 1996). In fact, children with epilepsy have been found to be 12-28 months behind nonepileptic peers in reading and 28 months behind in comprehension (Bennett & Ho, 1997). Learning problems occur in approximately 5-20% of children with epilepsy (Solomon & Pfeffer, 1996). As noted in a review by Hagar (2008), epileptic children are also at risk for vocational difficulties in adulthood, and children frequently present with comorbid depression, anxiety, and suicide ideation. During adolescence, issues related to self-esteem and peer acceptance may arise, and experiencing violent seizures that occur during school may exacerbate such feelings. Epilepsy is often associated with psychosocial problems such as parental over-protection, peer teasing and bullying, and fear of seizures (Solomon & Pfeffer, 1996).

During adolescence, issues related to self-esteem and peer acceptance may arise, and experiencing violent seizures that occur during school may exacerbate such feelings. Epilepsy is often associated with psychosocial problems such as parental over-protection, peer teasing and bullying, and fear of seizures (Solomon & Pfeffer, 1996). Experiencing seizures at school, learning problems, and imposed limitations on participation in sports, playground activities, and driving (a right of passage) may further limit normal peer interaction and social development (Hartlage & Hartlage, 1997).

Psychosocial disturbances are associated with age of onset, type of epilepsy, and EEG patterns. For example, childhood epilepsy is often associated with memory, attentional, and analytic deficits, reading comprehension problems, dyslexia, dyscalculia, and academic underperformance. For some epileptic children, poor reading ability is associated with specific EEG abnormalities. Adolescent onset is often associated with psychological disturbances. Children and adolescents with epilepsy have a higher prevalence of comorbid psychiatric symptoms such as inattention, hyperactivity, aggressiveness, and anxiety compared to children in the general community (Solomon & Pfeffer, 1996). Among epileptic children, 33% had psychiatric disorders, compared to 7% of the general population and 12% of children with physical illness not involving the brain (Rutter et al., 1970). Psychiatric symptoms are most often associated with partial (focal) seizures originating in the left hemisphere (specifically in the temporal lobe), with generalized seizures, with multiple types of seizures, and early age of onset (Solomon & Pfeffer, 1996). Psychosis is often associated with temporal lobe focal onset and with focal seizures that secondarily generalize (Solomon & Pfeffer, 1996).

While data on children was not readily available, adults with epilepsy appear to be at 4 to 5 times higher risk for attempting suicide compared to
the general population (Solomon & Pfeffer, 1996). Suicide attempts were associated with poor seizure control.

Social competence is positively associated with good seizure control. Externalizing behavior involving aggression, hyperactivity, and delinquent antisocial behavior was associated with male gender, disrupted parental marriage, younger age of onset, and poor seizure control. Internalizing behavior problems such as depression and fearful and inhibited behavioral was associated with good seizure control, intact parental marriage, and male gender (Solomon & Pfeffer, 1996). Given the myriad psychological problems associated with epilepsy, it is imperative that neuropsychologists develop appropriate treatment recommendations aimed at reducing or eliminating factors within control of the child, their family, and medical providers. Medical and behavioral treatments are discussed in the next section.

**Treatment**

Treatments for epilepsy mainly include medication, surgery, and diet. Psychotherapy may be indicated to treat associated behavioral problems. Pharmacological treatments are discussed first, followed by surgical treatment. Finally, behavioral techniques are discussed.

**Pharmacological Treatment**

Anticonvulsant medication is the primary treatment for controlling seizures. Commonly prescribed medications include phenytoin, phenobarbital, carbamazepine, primidone, ethosuximide, and valproic acid. Appropriate medication selection can be difficult, as the various seizure disorders respond differentially to different medications (Novick & Arnold, 1988). In addition, there may be individual differences in terms of absorption rates and medication tolerance. Although they differ by medication type, common side effects include drowsiness, ataxia, lethargy, intellectual dulling, nausea, dizziness, headache, tremor, and appetite changes, among others (Novick & Arnold, 1988). There appears to be a relationship between certain medications and performance on specific tests of cognitive abilities (for a review, see Hartlage & Harlage, 1997). Specific medications and their side effects are discussed next.

Phenobarbital was associated with a variety of cognitive problems, such as intellectual, attentional, information processing, and psychomotor speed deficits (Solomon & Pfeffer, 1996). Intellectual deficits were also observed in children using phenobarbital (Hagar, 2008). Concentration and short term memory was also negatively affected (Hartlage & Harlage,
Phenobarbital was also linked to psychological problems such as depression, anxiety, irritability, hyperactivity, aggression, psychosis, and sleep disturbances (Solomon & Pfeffer, 1996). Similarly, primidone was negatively associated with attention, information processing speed, and psychomotor speed (Hartlage & Harlage, 1997).

Phenytoin was associated with similar types of cognitive and psychological disturbances (Solomon & Pfeffer, 1996). For example, phenytoin use was related to intellectual impairment, memory problems, depression, confusion, and psychosis. Phenytoin may also lead to encephalopathy (Solomon & Pfeffer, 1996).

Another commonly used medication, sodium valproate, has been associated with reduced reaction time, encephalopathy, aggression, and drowsiness (Solomon & Pfeffer, 1996). The medication has also been associated with liver toxicity and decreased social competence. Interestingly, research suggested that sodium valproate may also have some positive side effects, such as improved alertness, mood, and sociability, which seem to contradict findings about the negative side effects (Solomon & Pfeffer, 1996). Research by Hartlage and Hartlage (1997) found no significant relationships between use of sodium valproate and performance on several tests of cognition.

Similarly, carbamazepine has been associated with both negative and positive side effects. Negative side effects include aggression, hyperactivity, delinquent antisocial behavior, and in rare cases, psychosis. At the same time, carbamazepine was found to improve reaction time, eye-hand coordination, and manual dexterity (Solomon & Pfeffer, 1996). Another study found no significant effects of carbamazepine on performance on a variety of cognitive tests (Hartlage & Hartlage, 1997).

Benzodiazepines have been used less frequently, probably due to a combination of negative side effects and short duration of therapeutic effectiveness (Solomon & Pfeffer, 1996). Benzodiazepines in general and clonazapam in particular were associated with memory problems and increased likelihood of aggression, irritability, emotional instability, sedation, and disinhibition of behavior. The medicine also has limited utility regarding seizure control. Tolerance builds quickly; it loses its effectiveness after only a few months, after which seizure breakthrough may occur. Finally, ethosuximide may improve cognitive performance but may increase risk for psychotic behavior (Solomon & Pfeffer, 1996).

Another aspect of pharmacological treatment worthy of discussion concerns single versus multiple medication treatment and drug serum levels. In general, a single medication (monotherapy) is preferable to treatment using multiple medications (polypharmacy) in order to reduce the likelihood of toxicity in the liver (Bennett & Ho, 1997; Solomon &
Pfeffer, 1996), in which most drugs are metabolized. Many patients experience good seizure control while on a single antiepileptic medication (Hagar, 2008). However, as many as 25% to 30% of patients may be refractory to drug treatment (Bebin, 2002) and thus may require multiple medications. Unfortunately, polypharmacy increases the risk of toxicity, and this risk is amplified in children (Solomon & Pfeffer, 1996).

In addition to damaging one's organs, toxic levels of antiepileptic drugs have been associated with cognitive and behavioral dysfunction (Bennett & Ho, 1997). Polypharmacy increases the risk of such problems. Particularly concerning is that adverse effects have also been noted even when serum levels were within the therapeutic range. For example, patients with higher serum levels of phenytoin or phenobarbital, compared to patients with lower levels, showed intellectual deterioration, psychomotor slowing, psychiatric illness, and personality change. Serum levels were in the therapeutic range and patients exhibited no cerebral lesions or drug toxicity (Reynolds & Travers, 1974). Similarly, Trimble and Corbett (1980) found that children who experienced a decline in IQ of 10-40 points over the course of a year had higher serum levels of phenytoin and primidone compared to those with lower levels. Moreover, discontinuation of phenytoin was association with improved motor speed, attention, and concentration (Bennett & Ho, 1997). Cessation of other drug use was also correlated with improved cognitive functioning. For example, in a double-blind study, discontinuation of sodium valproate and carbamazepine was associated with improved motor speed.

Finally, the number of drugs discontinued appears to be just as important as drug type. Bennett and Ho (1997) indicated that reducing polytherapy to monotherapy resulted in improvements in alertness, concentration, drive, mood, and sociability in 50% of patients. For most patients, medication treatment effectively controls seizures to the degree that patients are able to function in life. However, approximately 30% of patients continue to have uncontrolled seizures. For these patients, other forms of treatment such as surgery or behavioral interventions may be considered.

**Surgical Treatment**

Surgical treatment for epilepsy has been in existence for over half a century (Hartage & Hartlage, 1997). Children who do not respond to medications and have definable lesions in the anterior temporal lobe or clearly focal onset are potential surgical candidates. Neuroimaging is used to determine focal onset of seizure activity and have improved the accuracy of locating the focus of epileptic seizures in the brain (Bennet
and Ho, 1997). CT, MRI, PET, and SPECT technology if frequently used to aid in determining epileptic focus. Neuropsychological testing, however, remains the gold standard of determining patient functioning and has contributed to improving the efficacy and safety of epilepsy surgery (Hartage & Hartage, 1997). Surgical success rates have been reported as high as 75%, with success defined as remaining seizure free for at least five years post-surgery (Bennett & Ho, 1997). In a 39-year longitudinal study of patients with partial seizures, in which surgical with medically treated patients were compared, seizure frequency was found to be better controlled with surgery. However, neurological deficits were also more frequent. Thus, neurologists and neuropsychologists should work together with patients to determine the most appropriate treatment option to optimize functioning and minimize impairment. The NIH Consensus Development Conference on Surgery for Epilepsy (1990) recommends that, at minimum, specialized epilepsy treatment centers that provide evaluative and treatment services for those with intractable seizures should include both neurologists and neuropsychologists, as well as other medical staff. Moreover, specialized epilepsy treatment centers should minimally include EEG, MRI, and neuropsychological testing to assist with evaluating surgical candidacy.

Behavioral Techniques

The Ketogenic Diet

A treatment option that may sound unorthodox is the ketogenic diet, which involves massive consumption of fats in proportion to calories with minimal intake of protein and carbohydrates (Bennet & Ho, 1997). While it may seem as if such a diet would cause inordinate weight gain, actually the individual’s weight is maintained on the ketogenic diet. Moreover, the diet has consistently been associated with successful control of epileptic seizures. In a study of 58 children with refractory epilepsy and who experienced seizures at least three times per day despite proper medication adherence, 67% demonstrated improved seizure control on the ketogenic diet. Improvement was defined as a 50% or more reduction in seizures for a minimum of four weeks. An additional 28% of the total sample experienced complete seizure control. Sixty-four percent were able to reduce one or more antiepileptic medication while 10% were able to discontinue all medications. Changes occurred quickly, with improvement usually occurring within the first two weeks of starting the diet (Kinsman, Vining, Quaskey, Mellits, & Freeman, 1992).
The ability of the ketogenic diet was commonly used to reduce seizures prior to the 1920s, and while over 70 years of research has shown the diet to be effective, the exact mechanisms of action remain unclear (Bennett & Ho, 1997). Medical research indicates that the ketogenic diet mimics fasting, in which the body first burns up glucose in the bloodstream for energy. Once the glucose is depleted, the body begins to burn fat deposits. The body's ketogenic state (i.e., the depletion of glucose and burning of fat deposits) can be medically monitored via identification of ketone bodies that are present in urine. A major downside to this intervention is that the diet must be followed precisely. Even mild deviations such as not finishing a meal or consuming a few more grams of protein can lead to seizure reoccurrence.

Psychological Treatments

A psychologist may possibly be the first provider to identify potential seizure disorder and then facilitate referral to a neurologist. For example, parents may take their child to a psychologist suspecting that the child is exhibiting a behavioral problem. Thus it is important for psychologists to be familiar with the differential presentations of epilepsy as well as referral sources in the community (Novick & Arnold, 1988).

Psychologists in general and neuropsychologists in particular are called upon to assess the cognitive and emotional problems that are frequently experienced by children with epilepsy. For example, psychologists are asked to conduct differential diagnosis of the child's learning, emotional, and behavioral problems (Novick & Arnold, 1988). Thus, it is imperative that psychologists be familiar with the potential effect of epilepsy on children's cognitive and emotional development, as well as normal growth and development and typical performance on tests of cognitive abilities and personality (Novick & Arnold, 1988).

Psychologists and neuropsychologists also assist children and families in dealing with the emotional and social repercussions of having epilepsy and any associated cognitive and behavioral problems. Psychologists and neuropsychologists are in a position to educate children and families about the disorder and provide counseling for issues regarding, for example, risks and benefits of drug therapy, medication compliance, and adjustment to living with a chronic condition (Solomon & Pfeffer, 1996). Psychologists and neuropsychologists can also provide treatment in the form of traditional group and individual therapy to children and their families as well as serve as an educational resource to help children and families deal with psychosocial stressors, help families and teachers devise ways to manage the disorder, and provide stress management or
biofeedback training as a behavioral method for reducing seizure frequency (Bennett & Ho, 1997).

Finally, psychologists and neuropsychologists recognize that in order to facilitate social development, the epileptic child should be permitted to participate in school-related activities such as class trips and recreational activities. While participation in sports is associated with small risk, children and their parents should weight the risks of feeling restricted and isolated from peers. Seizure control varies across the epilepsies, and decisions and recommendations should be handled on a case-by-case basis. For less controlled seizures, other hobbies can be encouraged such as photography and music (Solomon & Pfeffer, 1996).

RESEARCH IMPLICATIONS

Many clinical concerns have been discussed, such as identification and treatment of epilepsy. The final topic mentioned briefly here concerns research. There are many problems associated with research on epilepsy. Heterogeneity of epileptic disorders make systematic study of associated cognitive and behavioral deficits difficult, and caution should be taken when applying research results across seizure classes. Spurious variables, such as brain injury, CNS disease, seizure type, seizure frequency, duration of the disorder, drug dosages, absorption rates, and compliance should be adequately controlled for in research studies. Also, treatment efficacy and potential harmful side effects of drug treatment must also be carefully considered. For example, after just one year on the market, felbamate was found to cause liver and bone marrow failure, and was subsequently taken off the market. Since that time, guidelines for new drug trials include careful monitoring of cognition and behavior (Commission on Antiepileptic Drugs of the International League Against Epilepsy, 1994). While living with seizures is a huge burden for many patients, epilepsy also remains a challenge for interventionists and researchers working to attenuate the negative effects of this often violent and unpredictable chronic condition.

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Co-occurring Antisocial Personality Disorder and Substance Use Disorder: Treatment Interventions

Joleen M. Haase

Abstract: Substance abuse is highly prevalent among individuals with a personality disorder (Verheul, van den Bosch, & Ball, 2005). About 40% to 50% of individuals with a substance use disorder meet the criteria for antisocial personality disorder (ASPD) and approximately 90% of individuals diagnosed with ASPD also have a co-occurring substance use disorder (Messina, Wish, & Nemes, 1999). Psychotherapy is the treatment of choice for personality disorders; however, various personality disorders are not equally represented in the research, so it is unknown how applicable the research findings on the treatment strategies for personality disorders are to ASPD (Leichsenring & Leibing, 2003). The current essay will give a brief overview of ASPD and substance use disorder and review the latest treatment recommendations.

Research on personality disorders began relatively recently in the 1980’s (Verheul, van den Bosch, & Ball, 2005). The high comorbidity of individuals with a personality disorder and their difficult clinical management has been a foundation for the research (Verheul et al., 2005). Substance abuse is highly prevalent among individuals with a personality disorder (Verheul et al., 2005). The two most common personality disorders associated with substance use disorders are Antisocial Personality Disorder (ASPD) and Borderline Personality Disorder. About 40% to 50% of individuals with a substance use disorder meet the criteria for ASPD and approximately 90% of individuals diagnosed with ASPD also have a co-occurring substance use disorder (Messina, Wish, & Nemes, 1999). There continues to be a widely held belief that personality disorders in general and ASPD in particular, are untreatable (Verheul & Herbrink, 2007). There is also a reluctance to work with this population because of their difficult clinical management. Furthermore, individuals with ASPD are often excluded from substance abuse treatment programs due to the symptoms of their personality disorder. Likewise individuals with a substance use disorder are often excluded from personality pathology treatment because they are often disruptive and uncooperative (Messina et al., 1999). Individuals are often told to leave treatment until they have stopped using or have a certain amount of time abstinent from using. More research is needed to determine appropriate treatment strategies for individuals with co-occurring ASPD and substance use disorder. The current essay will give a brief overview of ASPD and substance use disorder and review the latest treatment recommendations.
The main characteristic of ASPD is a pervasive disregard for the rights of others. This disorder begins in adolescence and continues into adulthood; the individual must be at least 18 years old to qualify for an ASPD diagnosis. ASPD is characterized with deceitful and manipulative behavior. People with ASPD demonstrate impulsive and aggressive behavior, they have a low tolerance for boredom, and they behave irresponsibly. Individuals with ASPD externalize their difficulties; they attribute blame on others and do not want to face the consequences of their actions, they lack empathy. These individuals are typically unable to sustain long-term employment or a monogamous relationship. People with ASPD embrace a deviant lifestyle and often commit criminal acts, which can be demonstrated by their overrepresentation in the criminal justice system (American Psychiatric Association, 2000).

Substance abuse is highly prevalent in people with Axis II disorders. Axis II diagnoses range from 44% among those who abuse alcohol to 79% among those who abuse opiates, with the most prevalent Axis II diagnosis being ASPD (Verheul, et al., 2005). Twin studies have indicated that there may be a genetic factor linking antisocial behavior and substance use disorders (Krueger, Hicks, Patrick, Carlson, Iacono, & McGue, 2002). Therefore the development of antisocial behavior and substance dependence might be traced back to a common genetic factor. A similar study by Krueger and colleagues (2002) also examined a possible genetic factor in the development of these disorders. They surveyed 524 pairs of twins in their late teens. Data analysis indicated that substance dependence and antisocial behaviors commonly co-occur and could be traced back to an externalizing factor, which was said to be highly heritable; however, it did not account for all of the patterns of co-occurrence. Overlapping diagnostic criteria may also be a reason for the high co-occurrence of ASPD and substance use disorders (Verheul, et al., 2005).

Co-occurring Relationship

Further evidence for the relationship between ASPD and substance use disorder is provided by Flory, Lynam, Milich, Leukefeld, and Clayton (2002), who examined the relationship among personality, symptoms of substance abuse, and symptoms of comorbid psychopathology. Data were analyzed from 481 individuals, who were all 21 years old. Seven percent of the sample met adult criteria for ASPD. Thirty percent of the sample met criteria for alcohol abuse, and 24% met criteria for marijuana abuse.
Sixteen percent of the sample qualified for alcohol dependence, and 12% qualified for a diagnosis of marijuana dependence. Data revealed a significant positive correlation among symptoms of alcohol abuse/dependence and symptoms of marijuana abuse/dependence as well as Antisocial Personality Disorder symptoms. Personality remained significantly correlated to substance abuse even after controlling for antisocial symptoms. This may indicate that it is general personality characteristics, rather than antisocial personality characteristics that explain the correlation. This finding may have important implications for theories which posit that it is the antisocial behavior, not personality, which leads to substance use. Furthermore it is also possible that persons with ASPD and those who use substances share common personality characteristics.

Trull, Waudby, and Sher (2004) also assessed substance use disorder symptoms and personality disorder symptoms. They found that personality symptoms from Cluster B personality disorders (including antisocial, borderline, histrionic, and narcissistic) were significantly related to alcohol abuse and dependence as well as drug abuse and dependence. This relationship remained after controlling for personality scores. The highest rates of past year alcohol dependence were found in those with Cluster B disorders. Antisocial symptoms alone were also significantly related to substance use diagnoses. Trull and colleagues (2004) concluded that Cluster B personality symptoms were significant predictors of both alcohol and drug use diagnoses. Additionally, antisocial and borderline symptoms were found to be the strongest independent predictors of alcohol diagnoses. Findings from this study suggest that personality symptoms precede substance use disorders.

Treatment Interventions

The relationship between ASPD and substance use is highly debated. Whether or not a causal relationship exists and the order of onset of the two disorders could have important treatment implications. Despite the severity of personality disorders, programs designed to treat them are rare (McMain & Pos, 2007). Health professionals often lack adequate training in the treatment of these disorders and there is a reluctance to work with this population due to the associated clinical challenges (McMain & Pos, 2007). There is also a continued belief that people with personality disorders do not improve with treatment, due in part to a lack of evidence based treatment data on effective treatment for personality disorders (Verheul et al., 2005). Recent data suggest that psychotherapy is a key
element of effective treatment of personality disorders, including ASPD (McMain & Pos, 2007).

Psychotherapy is the treatment of choice for personality disorders (Leichsenring & Leibing, 2003). One of the few studies addressing ASPD and substance use was conducted by Messina, Farabee, and Rawson (2003). The researchers tested the treatment responsivity of cocaine dependent individuals with ASPD. Four treatment interventions were assessed. Cognitive behavioral treatment (CBT) consisted of 48 - 90 minute group sessions, 3 per week for 16 weeks. This group also was given a workbook that explained or illustrated an aspect of CBT. In the contingency management (CM) condition, participants were required to provide three urine samples per week and meet briefly with a technician. If the urine did not test positive for stimulants, the participant earned a voucher that increased in value with each negative urine sample. The third intervention combined CBT and CM techniques. All conditions received identical methadone maintenance treatment; however, the fourth intervention did not include any additional treatment intervention. Participants with ASPD demonstrated optimal performance in the CM condition, with ASPD participants performing significantly better than non-ASPD participants. Overall, participants with ASPD performed better than participants without ASPD in all conditions except for the methadone maintenance only condition. ASPD was significantly and positively related to treatment outcome. ASPD participants in each treatment condition were more likely to test negative for cocaine at the 17 week, 26 week, and 52 week follow up. Most importantly ASPD participants in the CM condition were twice as likely as non-ASPD participants in the CM condition to test negative for cocaine at all follow up periods. The results of this study demonstrate that individuals with co-occurring ASPD and substance use disorder can be responsive to treatment. More research is needed to determine if other interventions could be effective; however, it appears that contingency management is an effective intervention strategy. Although the results appear promising, this study did not assess improvement in personality pathology.

Research on the treatment of personality disorders alone has focused mainly on psychodynamic and cognitive behavioral therapies. Unfortunately various personality disorders are not equally represented in the research. The most prevalent disorders found in the research are borderline, dependent, and avoidant personality disorders; and the least prevalent disorders found in the research are antisocial, schizoid, narcissistic, and histrionic (Verheul & Herbrink, 2007). For that reason it is unknown how applicable the research findings on the treatment strategies for personality disorders are to ASPD. Leichsenring & Leibing
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(2003) found that both psychodynamic and cognitive behavioral individual therapies are effective treatments for personality disorders. The effects of the psychodynamic and cognitive behavioral treatments involve a reduction of the symptoms of personality pathology as well as improvement in social and occupational functioning (Verheul & Herbrink, 2007). Overall the efficacy of psychodynamic and cognitive behavioral therapies seems to be equal; however, it is important to note that psychodynamic therapy on average has a longer duration than cognitive behavioral therapy (Leichsenring & Leibing, 2003). Additionally the supportive aspect of psychodynamic therapy may lead to a higher retention in treatment (Verheul & Herbrink, 2007). Psychodynamic therapy is also found to be more effective than other techniques for individuals who lack a tolerance for frustration and anxiety, have low impulse control, and are less capable of mentalization (i.e. ASPD) (Verheul & Herbrink, 2007).

Studies have also shown that group psychotherapy can be an effective supplemental treatment for personality disorders, with the average length of participation being two years or more (Verheul & Herbrink, 2007). Individuals with severe Cluster B personality disorders have not been shown to benefit from short term inpatient therapy; however, long term (psychodynamically oriented) inpatient psychotherapy may be effective in reducing personality pathology and improving social functioning (Verheul & Herbrink, 2007). Chiesa, Fonagy, and Holmes (2006) found that a combination of medium term inpatient treatment followed by a long term outpatient program yielded the most symptomatic improvement and the most long term improvement. This combination of therapies resulted in a continuation of symptom improvement or a long term maintenance of reduced symptoms over a four year period. Motivational techniques may also be beneficial to individuals who have a pattern of externalizing behavior (including ASPD) as it may help them become aware of the relationship between their personality and their impairment in functioning (Verheul & Herbrink, 2007).

Current research gives some direction for therapy, with CM, CBT, psychodynamic therapy, and motivational interviewing techniques yielding some improvement in personality pathology and the reduction of substance use. Research has shown that individuals with ASPD may even be more responsive than others to substance abuse treatment. Additionally, longer term psychodynamic therapy may improve personality pathology. Findings of effective treatment for co-occurring ASPD and substance use disorders are encouraging for future research, which should include populations with ASPD adequately represented.
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Dependent Personality Disorder: A Review of Etiology and Treatment
Chasidy Faith

Abstract: Dependent personality disorder (DPD) is one of the most common personality disorders seen in mental health clinics. Those with DPD tend to cling to others and have an extreme need to be taken care of. Many of the diagnostic issues involve the comorbidity of DPD, especially with avoidant personality disorder. There are a wide range of theories that attempt to explain the etiology and treatment of DPD including: biological, environmental, social learning, and cognitive perspectives. Future research in process and outcome would benefit DPD, along with information about the comorbidity and cultural views for DPD. This paper will briefly examine the diagnostic concerns, ideas about etiology and treatment, and some of the historical and contextual issues related to DPD.

We have all been completely dependent on another person during our lifetime, although for many of us this only occurred during our younger years. Bornstein (1992) makes an important statement, “A few life experiences are so widely shared by people of different backgrounds that they transcend the boundaries of culture, gender, and ethnicity” (p. 3). Dependency is one of these experiences. Even when we have grown-up, we still show some degree of dependency on others and have a need for support, guidance, and approval from others, especially during stressful times (Bornstein, 1996). Dependency becomes a form of psychopathology when there is abnormal dependency and it causes personal distress and/or functional impairment (Sperry, 2003).

Personality disorders are enduring patterns in our behaviors and with dependent personality disorder (DPD) this pattern involves submissive, clinging behavior in which a person has an extreme need to be taken care of (American Psychiatric Association [APA], 2000; Perry, 2005). This pattern begins by early adulthood. These individuals may down play their assets and refer to themselves as stupid (APA, 2000). Sperry (2003) comments there is generally a lack of self-confidence, great discomfort in being alone, self-doubting, and approval seeking found with DPD. People with DPD may easily be taken advantage of because they are so compliant, agreeable, and trusting of others (Ansell & Grilo, 2007; Sperry, 2003).

DPD is part of the Cluster C personality disorders, along with avoidant and obsessive-compulsive personality disorders, which are all considered the anxious and fearful type (APA, 2000; Seligman & Reichenberg, 2007). Being among the most commonly diagnosed personality disorder, DPD is found in about 14% of people who have personality disorders and about 2.5% of the general population (Seligman & Reichenberg, 2007; Sperry, 2003). Other estimates have shown a median prevalence rate of 20%, with
a range from 2% to 55% (Fossati, et al., 2006). Although Cluster C personality disorders, including DPD, show high base rates they still have been studied less than other personality disorders (Endler & Kocovski, 2002; Fossati, et al., 2006; Gude, Hoffart, Hedley, & Ro, 2004).

In order to diagnose a person with DPD, they must exhibit five or more of the eight criteria that are listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition Text Revision (DSM-IV-TR, APA, 2000). These criteria include the ideas and concepts to follow. First, making simple everyday decisions is a great challenge, especially when others are not giving advice or reassurance. Second, a person with DPD wants others to be responsible for decisions involving the major areas in his or her life such as what career to follow, where to live, or possibly even when to have children. According to Sperry (2003) this is the optimal criterion, meaning using this criterion in diagnosing DPD has been shown to be the most useful. Third, they may say they agree with others when in reality they do not. The agreement is preferred because of a fear they will otherwise lose peoples’ support. Fourth, due to a great lack in self-confidence it becomes very difficult to begin projects on their own. The fifth criterion states that a person will go to extreme lengths and endure unpleasant events. These events could be minor, such as going to a restaurant they do not particularly care for, or severe such as tolerating physical and/or sexual abuse (APA, 2000). Sixth, many times being alone is just simply not an option and is very uncomfortable. Therefore, the seventh criterion says that when one relationship comes to end another quickly begins. People with DPD believe they cannot function on their own. Finally, the eighth criterion notes that because of a belief that they are dependent on others’ advice and help there is a fear of abandonment which will mean they will have to care for themselves.

Diagnostic issues have been noted, especially involving the comorbidity of DPD. For example, 43% of the people diagnosed with avoidant personality disorder (APD) also met the criteria for DPD; 59% of patients with DPD met criteria for APD (Fossati, et al., 2006). This leaves one to question if these two criteria sets are distinguishable from one another. Fossati et al. (2006) made an important finding regarding criteria 1 thru 5 for DPD and criterion 4 with APD diagnoses. These criteria, “...were not efficient indicators of the respective latent variables” (p. 200). This raises a big issue with DPD because 62.5% of the diagnostic identifiers are involved in criteria 1 thru 5. An example is given comparing criterion 3 for DPD, difficulty expressing disagreement, and criterion 4 for APD, excessive fear of being criticized. The criterion for DPD may be related to either a great need for dependency or to this fear of being
criticized. Therefore, Fossati et al. (2006) argue that the convergent and within-cluster discriminant validity needs further consideration.

DPD has also been shown to be comorbid with mood and anxiety disorders, such as depression, phobias, obsessive-compulsive, and alcohol abuse (APA, 2000; Bornstein, 1992; Ng & Bornstein, 2005). Ansell and Grilo (2007) state that patients have poorer outcomes when they have the combination of mood and/or anxiety disorder along with dependency traits. Since DPD is so often co-occurring with other disorders, it is important to understand what effects comorbidity has on individuals. Yet, there is little known about how comorbidity affects DPD or the treatments that may be more useful for these individuals.

Etiology

Many ideas have been developed about the etiology of DPD. Early studies of dependent personality traits were looked at psychoanalytically (Bornstein, 1992, 1996). These traits were associated with breastfeeding and weaning. Those who became fixated at the oral stage would remain dependent on others for support. It was thought that high levels of dependency came from either frustration or overgratification during the oral stage, although research in this area has shown inconclusive results (Bornstein, 1996).

Studies have determined two parenting styles that lead to high levels of dependency in children (Bornstein, 1996). First, authoritarian parenting may create dependency. This is partly because this style of parenting prevents children from learning through trial-and-error, which is one way children develop autonomy and feelings of self-efficacy. Secondly, overprotective parenting can lead to high levels of dependency. Similar to authoritarian parenting, overprotective parenting makes children believe they cannot function on their own without the help, guidance, and support of others. It is important to note that studies have also shown dependent behaviors in children may encourage and reinforce parents’ overprotectiveness and increase their demandingness (Bornstein, 1992).

In response to these early experiences within the family, cognitive structures are formed (Bornstein, 1992, 1996; Sperry, 2003). Children may develop beliefs and mental representations about their own self-efficacy and the power of others. Perry (2005) noted that a cognitive conceptualization has been created by some people who suggest these individuals first believe they are inadequate and helpless, followed by thinking that the best strategy to fix this is to find someone who may be able to deal with the world and protect them. Therefore, these children may be developing mental representations of themselves being helpless, inadequate, and failing on their own. This then leads them to seek out
other people to depend on in order to survive. Eskedal and Demetri (2006) discuss information on biological issues that may influence the development of DPD. Infants who have fearful, withdrawing, or sad temperaments and those with prolonged health issues during childhood may force parents to become overprotective, which in turn may lead to DPD. Interestingly, endomorphic and ectomorphic body types, which are common for dependent people, may also create more concern from parents (Eskedal & Demetri, 2006). These body types have low energy thresholds, which may create concern in parents.

Another view on the etiology of DPD is from social learning, simply stating people learn to be dependent (Bornstein, 1992). Initially it was believed that dependency was an acquired drive, although the importance of social reinforcement then became evident. People develop DPD because their dependency was or still is rewarded. One of the issues involved in this view is that children are experiencing conflict because they are taught to obey authority figures and to depend on these people for guidance and protection, yet they are also being taught to be creative and autonomous (Bornstein, 1992).

**Historical and Contextual Issues Related to DPD**

While there does not seem to be much research on culture and DPD, it is noted that consideration needs to be made regarding one’s culture (APA, 2000; Perry, 2005). The diagnostic criteria need to be considered in light of the person’s cultural norms because some cultures value characteristics such as passivity. Similarly, diagnosing DPD needs to be used with great caution, and perhaps not at all, with children and adolescents. It is essential to distinguish dependent behaviors that are developmentally appropriate from those that are not (APA, 2000).

More research and time has been spent looking at the differences that genders exhibit with DPD. Usually, DPD has been found to be more prevalent in females, although how much more prevalent is still up for debate (Bornstein, 1992; Eskedal & Demetri, 2006; Fossati, et al., 2006; Klonsky, Jane, Turkheimer, & Oltmanns, 2002; Loranger, 1996; Perry, 2005). Fascinatingly, when using projective measures of dependency, versus self-report, the typical finding is that men and women show similar levels of dependency (Bornstein, 1992; Eskedal & Demetri, 2006).

Bornstein (1992) has postulated a theory about why males and females may show similar findings when the test is projective and not a self-report. In general, self-report measures of dependency will ask direct questions about dependent traits, feelings, and behaviors. Males will be less likely than females to recognize and admit these dependent traits. When using
projective measures, the client is asked to respond to ambiguous stimuli, often being asked to provide open-ended descriptions. The client is unaware of what is exactly being looked for, so they will not distort their responses on the basis of what is socially desirable (Bornstein, 1992).

Another captivating trend regarding gender and prevalence rates is that longitudinal studies show little if any difference during early childhood in boys and girls dependency levels, however there is an increase in dependency differences as a child’s age increases (Bornstein, 1992). This change in the prevalence of dependency may be accounted for by the traditional sex role that socialization practices. In general, boys are discouraged from expressing their feelings and needs of dependency, but girls are usually encouraged to do so (Bornstein, 1992). Role models, such as parents, teachers, siblings, etc. encourage this behavior even through subtle messages. The extent that men and women play out these socialized sex roles may also determine if they will develop psychopathic dependency. It has been shown that married women who follow the traditional sex role receive significantly higher scores on the dependency scale (Dy) for the Minnesota Multiphasic Personality Inventory (MMPI) versus women reporting that they live a reversal of the traditional sex roles in their marriage (Bornstein, 1992). In addition, Klonsky et al. (2002) found that higher femininity and lower masculinity were both associated with dependent traits, regardless of one’s actual gender.

Treatment of DPD

When working with DPD it is important to keep in mind a few things throughout the treatment planning and intervention processes. First, these clients depend on others and therefore may view their therapist as another person to rely on (Seligman & Reichenberg, 2007). This reliance may initially be seen in their lack of communication if the therapist does not direct or ask the client what to discuss (Sperry, 2003). They may work very hard to please the therapist, which can be used to develop rapport and encourage an increased independence. Also, to develop rapport it is important to demonstrate a lot of support and acceptance. It may be helpful to begin in a directive and structured manner in order to give sessions a focus. Seligman and Reichenberg (2007) note the overall goal is to promote a clients’ self-reliance, self-expression, and autonomy in the safety of counseling and to then transfer these characteristics outside of the sessions. Terminations may be difficult and caution needs to be taken so the client does not feel abandoned. Therapists must be aware that clients with DPD, more than any other client, are more apt to develop a
romantic attachment to the therapist (Seligman & Reichenberg, 2007). Therefore, setting clear boundaries are of the utmost importance.

There are a variety of treatment approaches for DPD, although there is concern because few, if any, controlled treatment outcome studies have been completed (Sperry, 2003). Much of the treatment literature contains case descriptions, uncontrolled studies, and some controlled trials that contain a mixture of personality disorders (Perry, 2005). Keeping the lack of research in mind, psychodynamic is one approach that may be used. Psychodynamic therapy attempts to help clients better cope with object losses and/or previous separations (Eskedal & Demetri, 2006; Sperry, 2003). Transference is thus important and the client is allowed to see the therapist as this lost object or relationship. When a good therapeutic relationship has been developed, the transference is recognized and provides insight into the client’s problems while helping resolve the client’s therapeutic issues (Eskedal & Demetri, 2006; Perry, 2005; Sperry, 2003).

Time-limited psychodynamic therapy has been said to be the treatment of choice for clients with DPD (Eskedal & Demetri, 2006; Sperry, 2003). Long-term psychodynamic therapy will allow a greater transference to occur which can be used to promote emotional growth, although this can take three or more years (Sperry, 2003). Today, this amount of time is not likely to be spent in therapy for a variety of reasons. Clients who have limited ego strength or a great degree of separation anxiety may not benefit from either short or long term psychodynamic therapy as much as they would from something else, such as a supportive treatment approach (Eskedal & Demetri, 2006). One last thing to note with psychodynamic therapy is the possibility of countertransference toward the client, often of contempt or disdain because of the dependency the client has on the counselor (Eskedal & Demetri, 2006).

Cognitive-behavioral therapy (CBT) is also used for DPD, with the goal of increasing a person’s autonomy and self-efficacy (Sperry, 2003). Allowing some dependence initially is important so the client becomes engaged. As this relationship is formed, the therapist may challenge dichotomous beliefs, such as the need to either be dependent or independent with no in-between. Therapists should note what triggers a client. For example, situations in which a client faces being alone may trigger the client’s maladaptive patterns, which then causes anxiety (Eskedal & Demetri, 2006; Perry, 2005). Knowing these triggers will allow the client to learn more adaptive ways to deal with difficult situations. The behavioral techniques used involve techniques such as assertiveness training or dating skills, homework, relaxation training, and role playing (Perry, 2005; Sperry, 2003).
Group psychotherapy has also been demonstrated to be successful in treating DPD (Sperry, 2003). However, group therapy is not advised for those with severe impairment or a lack of prosocial behavior. In addition, it should be determined if the client should be placed in a group that only targets dependency issues, or a group with mixed personality disorders (Sperry, 2003). Caution should be used so the client does not become lost in mixed groups. Furthermore, it should be noted that DPD homogeneous groups establish cohesion more quickly, offer instantaneous support, and may provide relief of symptoms at a greater pace (Eskedal & Demetri, 2006). A group setting will allow clients to try out adaptive behaviors while still being in a supportive setting (Eskedal & Demetri, 2006).

Although it may make sense that marital and family therapy may be very helpful, because DPD involves being dependent on someone, professional literature on these interventions is basically nonexistent (Sperry, 2003). Perry (2005) states that there are no studies that examine using only family therapy for DPD. When the dependency involves a family member or members, it may be helpful to include them to facilitate the client’s progress outside of counseling. Doing so may reduce the amount of time it takes to help the client and also give support to the family members (Perry, 2005; Sperry, 2003). The therapist needs to identify what in the family or relationship is encouraging the dependency and help the family develop workable goals (Perry, 2005).

Day and residential therapies are used with clients who require a high level of support and treatment intensity (Perry, 2005). These patients often have other co-occurring Axis I and Axis II disorders. The therapy used with these particular individuals generally includes a mixture of individual and group therapy, and possibly other services such as occupational or expressive therapies (Perry, 2005). The duration for day treatment programs may range from 18 weeks to a year or more, while residential programs are more long term and for those who have not improved or have deteriorated with outpatient therapy or while living on their own (Perry, 2005). Day and residential therapies are said to be helpful, but there are not a great number of studies noted to support this statement.

Medications may be used in combination with therapies, although there are cautions in doing this. Often people diagnosed with DPD also have Axis I diagnoses, such as depression and anxiety, which may benefit from medication (Sperry, 2003). If a client is not diagnosed with an Axis I disorder along with DPD, medication should probably not be used because it may be abused (Eskedal & Demetri, 2006; Sperry, 2003). Interestingly enough, because of dependent client’s help-seeking behaviors, physicians will often prescribe medications because of the
client’s persistent complaints (Eskedal & Demetri, 2006). To support this idea, Eskedal and Demetri (2006) note one study found that DPD patients in a hospital setting received nearly 50% more medications as compared to nondependent patients with similar Axis I diagnoses, possibly due to this help-seeking behavior.

With all of these treatments listed, there still seems to be a need for studies on the effectiveness of each. There is some support for most of the treatments, but the lack of research on effective treatments has been surprising. During this review, there were not any studies found examining what exactly makes therapy work, for example the mediators and moderators of therapy. Dependency itself and the etiology of dependency seem to have a large amount of literature, including perspectives of different theories. However, DPD would benefit from more empirical support for treatments, with a focus on process and outcome research. With that being said, the prognosis for DPD seems to be relatively good (Perry, 2005; Seligman & Reichenberg, 2007; Sperry, 2003). Some reasons for this prognosis include: clients with DPD can form relationships and make commitments, they can ask for help, and they are trusting (Seligman & Reichenberg, 2007). This good prognosis may take a significant amount of time, such as months or years, but it can be reached (Perry, 2005).

During treatment there may be some great obstacles to overcome, which may affect the amount of time therapy will take. One of these obstacles involves the client experiencing a significant loss or separation in their personal support (Perry, 2005). With the need to depend on others, suddenly not having this other person available may overwhelm the client and result in a regression in therapy for the skills that have been learned. Perry (2005) notes that it is important for the therapist in this situation to be supportive, offering some suggestions and direction, while at the same time accepting the interruption or delay in the client’s growth.

Perry (2005) discusses five other challenges that may often arise in treating a client diagnosed with DPD. First, as is characteristic of DPD, a client who begins therapy may make many requests for advice and help that the therapist is unable to give. Second, clients may place the therapist in a role of the dominant person who should take responsibility for decisions and tell the client how to run his or her life. The third challenge entails the client not making changes outside of therapy in order to keep the emotional attachment with the therapist. Fourth, it may be difficult when a client has punitive and unsatisfying relationships. Hearing repeated stories about mistreatment may make a therapist have a desire to either control the client’s self-defeating pattern or punish them, perhaps unknowingly, for not changing. The client may then feel torn between
pleasing the therapist and being punished by his or her partner in the relationship outside of counseling. Finally, there are clients who avoid dealing with their separation issues in therapy. This may lead to difficulties during termination if the therapist does not address this avoidance. All of these issues can produce great obstacles in treatment.

Conclusion

In summary, DPD is a common issue seen in therapy. It is important to be knowledgeable about its etiology and treatment options in order to better serve clients. With the great range of ideas about the etiology and treatment of DPD, along with the lack of research available, there continues to be many unanswered questions. Studies that are better designed and more controlled would benefit the DPD literature, because there is a current lack of evidence-based treatments for this disorder. Fortunately, there seems to be a good prognosis for individuals diagnosed with DPD. Part of this may be because these clients are generally easier to develop a rapport with since they lean on others for support. Therapists can use this to their advantage, as long as they keep clear boundaries and help clients become more independent with time.

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Stress Management Group Counseling for Homeless Women: A Summary and Evaluation of Literature
Chasidy Faith

Abstract: Stress is exceedingly prevalent and affects individuals in a variety of ways; therefore developing skills to combat stress is imperative. Homeless women report greater stress levels than homeless men and may significantly benefit from a stress management group. After completing a literature review, it was discovered that little information on stress management groups for homeless women exists. However, by using the current literature on stress management groups in general, a group can be developed. Completing a psychoeducational group focusing on the most common stressors homeless women experience, and creating a positive community feeling, may help reduce levels of stress.

The purpose of this paper is to examine stressors and stress management, particularly in groups, for homeless women. Many of the stressors homeless women often encounter have been identified and discussed in literature; however, there is a disconnect with what this means in aiding these individuals to overcome these stressors, especially in regards to creating a stress management group. This topic is an important one given that the two most rapidly growing subgroups within the homeless population include women and women with children (Zugazaga, 2004). There are also studies that show homeless women who are single may perceive events as more stressful than either homeless men or homeless women with children (Roll, Toro, & Ortola, 1999; Zugazaga, 2004). The way in which an individual perceives an event will determine if the individual finds the event stressful or not. Knowing this information, it becomes evident that a closer examination of stress and stress management for homeless women is a topic requiring further discussion. Therefore, this paper will look at the types of stress, followed by a brief description of stress management, a discussion about the stress experienced by homeless women in particular, and then end with a review and critique of the existing literature.

OVERVIEW OF STRESS

Even though stress is a part of people’s everyday lives, defining stress can prove to be a challenging task. For the purpose of this article, stress will be defined as “the inability to cope with a perceived (real or imagined) threat to one’s mental, physical, emotional, and spiritual well-being, which results in a series of physiological responses and adaptations” (Seaward, 2004, p. 5). The key part of this definition is the word perceived. An event
one person finds stressful may not be perceived as stressful to another. With such a great variance in what defines stress, and the way in which each person will experience stress, it is beneficial to examine this phenomenon more closely.

There are three different kinds of stress: eustress, neustress, and distress (Seaward, 2004). Eustress is the positive, motivating, and inspiring stress a person may experience. For example, meeting your hero may involve eustress. Another type of stress is neustress, which is not considered good or bad stress. An example is learning about a tornado in a state across the country from a particular individual; it is neither bad nor good, it just is. Finally, distress is usually considered bad stress. There are two types of distress: acute and chronic. Acute distress is quite intense once it is perceived and then quickly disappears, while chronic distress may not seem so intense at first but lasts for long periods of time.

Another way to examine stress is through a complex mixture of six variables: stressors, distorted stressful appraisals, physiological arousal, medical and emotional distress, reduced psychological functioning, and coping deficiencies (Smith, 2002). First, stressors (stress events or situations) are life events where change and readjustment contribute to stress. Distorted stressful appraisals are the second variable. When these appraisals are irrational and maladaptive, it is most likely to be stressful. Appraisals may interfere with utilizing good coping skills because irrational and maladaptive appraisals often contradict facts or reason. The next variable, physiological arousal, involves the great deal of energy it takes to deal with some of the stressful life events people go through. Some symptoms that may be a sign of physiological arousal related to stress include fast and irregular heartbeat, hurried and uneven breathing, tight and tense muscles, dry mouth, backache, and loss of appetite. The fourth variable is medical and emotional distress. Chronic stress arousal is not healthy and can add to dysfunction and problems in the body. This can increase vulnerability to a wide range of illnesses (e.g. allergies, cancer, diabetes, hypertension, sleep disorders, etc.). In addition, negative emotions such as depression and anxiety often indicate psychological distress. The sixth variable, reduced psychological functioning, may occur when people are markedly stressed. They may not be able to do their best at work and in relating to others.

Coping deficiencies involve problem-focused and emotion-focused coping strategies. Problem-focused coping involves trying to change a stressful situation. Emotion-focused coping entails trying to reduce the discomfort involved in a stressful event without trying to change the situation itself. Research on coping has been expanded from this distinction and can be sorted into four categories: actively trying to
change a stressful condition, altering how we realistically appraise or think about the situation, releasing our pent-up emotions or relaxing, and distorting or denying that a problem exists or withdrawing from a problem (Smith, 2002).

Just as the term stress has various definitions, stress management has created an assortment of definitions and techniques (Smith, 2002). The definition for this article is from Smith (2002) stating stress management is, “a set of skills that enable one to anticipate, prevent, manage, and recover from the wear and tear brought on by perceived threats and coping deficiencies” (p. 5). Along with this definition, there are four pillars of stress management that are applicable in most stressful situations: relaxing, planning how to solve the problem, thinking realistically and productively, and reviewing and rehearing.

**HOMELESS WOMEN AND STRESS**

As two of the most rapidly growing subgroups of the homeless population include single women and women with children, it is important to examine stress in homeless women (Zugazaga, 2004). Homeless women are often more likely to have poor physical health, experience victimization, and have drug use and dependency troubles (Nyamathi, Stein, & Bayley, 2000). Stressors, such as housing instability, poverty, and work problems or unemployment, are often the experience for homeless women (Milburn & D’Ercole, 1991; Munoz, Vazquez, Bermejo, & Vazquez, 1999; Zugazaga, 2004). Living in poverty can almost assure that one will live a life with chronic struggles because it is necessary to spend income on necessities and have little or no flexibility in spending any money coming in (Milburn & D’Ercole, 1991). Zugazaga (2004) found the top three most frequently occurring stressors for homeless single men, single women, and women with children were a major financial crisis, followed by breaking off a steady relationship, and finally the death of a close friend or relative.

When comparing homeless women with children, single women, and single men, the women, with and without children, reported having higher depression and anxiety levels than single men (Roll, Toro, & Ortola, 1999). This is important because the women did not differ significantly from the men with regards to diagnosis or hospitalization for mental illnesses, thus women may perceive their current situation as more stressful than men. In a more recent study, it was found that single women had the highest rates of being hospitalized in a psychiatric facility and experienced considerably more stressful life events than either the single men or women with children; yet, there still was not a significant
difference between the three groups when examining the diagnosis of a serious mental illness (Zugazaga, 2004). This may again point to single women perceiving these life events as more stressful.

With homeless people who are single it has been estimated that 22% are considered mentally ill, as compared to only 8% for homeless people who have children (National Coalition for the Homeless, 2008). Women with children still often note feelings of powerlessness and loss, distress, fear, and anxiety (Tischler, Rademeyer, & Vostanis, 2007). Disorders such as depression and anxiety are rather prevalent for homeless women in general, and while social support is a key aspect of coping in stressful situations, women often feel separated from sources of support (Tischler, Rademeyer, & Vostanis, 2007). Diagnoses from the American Psychological Association Diagnostic and Statistical Manual of Mental Disorders Fourth Edition Text Revision (DSM-IV-TR, 2000) that may be more relevant to this population when experiencing stress include depression, anxiety, adjustment disorder, acute stress disorder, and post-traumatic stress disorder. The latter two may be due to trauma and victimization that homeless women often experience (Nyamathi, Stein, & Bayley, 2000). Adjusting to homelessness may lead to depression, anxiety, and adjustment disorders. While these are certainly not the only diagnoses within the homeless population, these may be more prevalent due to the stressors this population experiences in life. Although, the DSM-IV-TR (2000) does not have a diagnosis specifically for stress, the stress may manifest itself into some of the aforementioned diagnoses.

It has been well established, as noted above, that homeless women experience a great deal of stress in their lives. Perceiving events to be so stressful, along with a lack of good coping skills, creates a need for stress management for homeless women. Promoting healthy support networks through a group, providing training and skills to afford and maintain housing, integrating into a positive community setting, and developing higher self esteem are some of the areas pointed out in the existing literature to work on in order to help homeless women (Milburn & D’Ercole, 1991; Nyamathi, Stein, & Bayley, 2000; Tischler, Rademeyer, & Vostanis, 2007). Homeless women need to develop stress management skills to help them cope with being homeless at the current time and to take with them when they leave shelters. Perhaps this will aid in their integration back into society more quickly, smoothly, and less stressful.

REVIEW AND ANALYSIS OF LITERATURE

It is important to note the author was not able to locate any articles examining stress management in group therapy designed specifically for
homeless women. An integrated stress management group for women in general was found which may be applicable to homeless women. This model teaches various relaxation techniques, offers information on nutrition, exercise, and sleep, and encourages the implementation of stress-reducing behavior changes (Ulman, 2000). Cognitive and behavioral interventions are both included in order for clients to become aware of their thoughts and behaviors that affect stress symptoms and help women become more active in their overall health care. Ulman (2000) notes learning new behaviors can feel strange, therefore having a group in which to feel valued, accepted, and validated is important.

In order to understand this integrative group model, Ulman (2000) discusses the composition of the group. It is an eight week group that meets for an hour and a half weekly. Each session has three components: teaching and practicing relaxation techniques, individualized exploration and discussion of the cognitive and behavioral changes needed in order to reduce stress symptoms, and an open-ended discussion of general life situations including the role current relationships play in either helping or hindering the woman to achieve her goals. During relaxation, the women learn how to attain a sense of calmness and stillness and how to differentiate between this calm state and their stressful state. The second component of exploration and discussion is to help the women recognize any resistance and compel the women to think about what has been effective and ineffective in the past when responding to life stressors. The final component is geared towards exploring affect and the development of respect and support.

Ulman (2000) further breaks down the sessions for this group. The beginning sessions (one through three) include major tasks such as getting to know one another, learning relaxation skills, and developing individual goals. The middle sessions (four through six) are considered the working sessions in which group members come together and support each other, while giving evidence of how they took the group with them during the past week. These sessions may involve more unstructured discussion to develop insight into their struggles with making behavior changes. The end sessions (seven and eight) are for saying good-bye and giving examples of how they will take advice and information from other group members with them.

Although this integrated stress management group for women seems well thought out and developed with specific concerns women may have in mind, Ulman (2000) does not have any research data to measure the efficacy of the group model. After conducting fifteen groups using this model, it was observed that most of the women addressed and mastered internal difficulties and felt an increased sense of well-being. There was no
follow-up completed in any of the groups to measure any long-term
effects. Conducting a study to measure the success scientifically, rather
than solely observing it without a research design in mind, would provide
evidence for adopting this model.

The article most closely related to stress management groups for
homeless women involved stress management training for women on
public assistance, although, it is quite dated (Tableman, Marciniak,
Johnson, & Rodgers, 1982). The study involved the Stress Management
Training Project (SMTP) in Michigan, which was designed to reduce poor
mental health and dysfunctional behavior in women on public assistance.
Over two-years, the study examined 65 women in the experimental group
(receiving seven to ten training sessions), and 51 in the control group
(receiving no sessions). Those in the experimental group were to attend
ten weekly sessions lasting from two and a half to three hours. The first
three sessions aimed to improve self-esteem and identify aspects of
personal relationships that induce stress. This involved labeling feelings,
exploring the impact of negative feedback, and practicing to accept and
give positive feedback. Sessions four through eight discussed an
acceptance of responsibility for their behavior and techniques to use in
order to take control. This was completed through clarifying needs and
goals, practicing problem-solving skills, and assessing key relationships in
their lives. The last two sessions were to aid in understanding stress and
stress management strategies. The women reviewed signs of stress and
responses to stress, while also practicing positive self-talk and redefining
the situation.

This study demonstrated that SMTP may have a positive influence on
women’s lives, because significant differences between group means was
found (Tableman et al., 1982). An increase in self-confidence and decrease
in anxiety and depression suggest SMTP may change behaviors that are
associated with the low self-esteem many of these women face. Because
the findings of this study support a group intervention for these women, it
is imperative to further explore and recreate this program to determine
the benefits it can provide women. Learning more about what techniques
or teachings were most beneficial for these women is important in order
to help women in the future.

Another area in literature has reviewed coping, or how a person
responds to situations, and stress management (e.g. Majella de Jong &
Emmelkamp, 2000; Rayburn et al., 2005). Avoidant coping (e.g. hoping for
a miracle, making the self feel better through eating, smoking, or
drinking) was found to be related to physical and mental dysfunction
(Majella de Jong & Emmelkamp, 2000; Rayburn et al., 2005). Furthermore,
experiencing a trauma may contribute to an avoidant coping style, which
may then increase the risk for experiencing depressive symptoms in women residing in shelters (Rayburn, et al., 2005). Another explanation offered by Rayburn et al. for this finding states some behaviors that are inherent in avoidant coping are in essence aspects of depression. On the other hand, active coping (e.g. talking to a professional, becoming informed about the problem) has been shown to be negatively related to dysfunction (Majella de Jong & Emmelkamp, 2000; Rayburn et al., 2005).

In one study that examined more long-lasting effects, participants were recruited through their employment site. They completed an eight week long group of stress management training and then had six months time pass. Improvements were maintained with an increase in problem-focused (active) coping and decrease in psychosomatic complaints (Majella de Jong & Emmelkamp, 2000).

One final area within research that will be reviewed involves stress management in women with breast cancer. In a ten week cognitive-behavioral stress management (CBSM) group, women were exposed to didactic material, experiential exercises, and homework assignments (Antoni et al., 2001). The focus was to learn to cope better with the daily stressors associated with cancer and how to optimize the use of social resources. The group used both problem-focused coping strategies, such as active coping and planning, and emotion focused coping strategies, such as relaxation training and emotional support. The control condition received a one day seminar, although the information covered was not explained. For the experimental group, CBSM affected two measures of well-being: an increase in the reports of experiencing a benefit from having breast cancer and an increase in the levels of general optimism about the future. In a similar study for CBSM with women having breast cancer, evidence was again found to support group based stress management intervention as being effective (Antoni et al., 2006).

Given that no studies were found specifically examining stress management group therapy for homeless women, a review of an article explaining how to structure and design a psychoeducational group may be helpful. Through this article we may learn how to better pull the existing literature together in order to develop a psychoeducational stress management group for homeless women. Furr (2000) notes there are two phases, each with three steps, in developing a psychoeducational group. The first phase is conceptual and involves creating a statement of purpose, establishing goals, and setting objectives. The second phase is operational and includes selecting content, designing experiential activities, and evaluating the group. It is important that goals be focused, a theoretical orientation guides the objectives and content that is selected, and that
activities are well-designed and well-processed. Following these steps gives us a starting place when creating a psychoeducational group.

In analyzing the studies for this literature review, these steps for developing a psychoeducational group were not often noted. Some studies did include a theoretical orientation (Antoni et al., 2001; Antoni et al., 2006; Ulman, 2000). Only one study explained the theoretical approach of CBSM, which suggests that techniques to minimize physical tension and anxiety ridden thoughts can promote fewer negative experiences and more positive experiences (Antoni et al., 2006). As previously described, there were studies which noted general topics or areas to work on for sessions, but no study broke down the group session by session with very detailed descriptions of activities, process goals, and didactic material to be covered in session. Using this model in order to develop a study on stress management groups for homeless women may help create a better, more well-designed, and easily replicated group that can then be applied in practice.

The studies being reviewed would also benefit from further examining multicultural issues within stress management groups for homeless women. While knowing how many people are homeless on average each day is rather difficult, it is estimated that the homeless population is about 42% African American, 39% White, 13% Hispanic, 4% Native American, and 2% Asian (National Coalition for the Homeless, 2008). This is important to know because our research should try to match these percentages when developing studies and gaining participants. With the exception of one study reviewed, studies did not match this ethnic diversity and included mostly Caucasian participants. It may be difficult to generalize the findings of some studies, because multicultural concerns are not made known. For example, two studies did not describe the race or ethnicity of the participants (Majella de Jong & Emmelkamp, 2000; Tableman et al., 1982). However, one study examining trauma, depression, and coping in impoverished women included 61.70% Black/African American, 23.22% Hispanic, and 9.91% White participants (Rayburn et al., 2005). Having such a diverse sample in more studies may help generalize the results from other groups of women to impoverished women.

In addition to knowing the race or ethnicity of participants, it may be helpful to obtain information about items such as education level and relationship status. Noting participant’s highest level of education completed may be beneficial. It may be found that depending on the amount of education people have, help-seeking behaviors, problem solving skills, optimism, or other variables may look different or have a range of effects on stress. There was diversity in the education level in the same study examining trauma, depression, and coping listed above, with
36.02% completing high school and 38.39% more than high school (Rayburn et al., 2005). Furthermore, recording participant’s relationship status may provide valuable information. Many articles discuss the importance of social support, yet some studies did not report participant’s relationship status (Nyamathi, Stein, & Bayley, 2000; Tischler, Rademeyer, & Vostanis, 2007). Again, if participants are married or in a relationship they may look at stressful situations in a different way, possibly with more optimism or comfort in knowing someone is there who can help them get through the tough times.

CONCLUSION

It is obvious that there is still a tremendous amount to be done with future research. The multicultural issues just discussed are only a few. First, while it appears that stress management groups for women are successful in reducing a variety of symptoms we are not sure how long this success lasts. Second, there were no studies found that examine stress management groups for homeless women in particular. While we can take pieces of information from other populations that have been studied, we cannot be certain if there are any significant differences in how homeless women react to stress management groups.

All of this information can be applied in creating a stress management group for homeless women to the best of our ability at this time. It is important to use the advice Furr (2000) gives in how to develop a psychoeducational group in order to insure we have a sound background and reasoning for implementing what we are doing in group. Cognitive-behavioral techniques seem to have been the most common methods used and have been shown to be effective in the studies reviewed. Therefore, using a cognitive-behavioral approach to develop the group activities and assignments may be important. For example, relaxation training seems to be an important component to use in stress management, as most studies utilized this and found it effective (Antoni et al., 2001; Antoni et al., 2006; Majella de Jong & Emmelkamp, 2000; Tableman et al., 1982; Ulman, 2000).

There are many different techniques and skills that can be taught in a stress management group; therefore it is essential to remember the stressors many homeless women have experienced or are experiencing and let it dictate the skills and techniques to cover. As discussed, relaxation techniques help calm the mind and become aware of the difference between our relaxed and stressed states. These techniques have been shown effective and should likely be included in a stress management group for homeless women. Problem solving skills and positive self-talk are also areas that have been found beneficial and may be applicable to
homeless women (Antoni et al., 2001; Antoni et al., 2006; Majella de Jong & Emmelkamp, 2000; Tableman et al., 1982). Teaching and reviewing a variety of techniques within a stress management group offers more choices for women and may increase the likelihood that each woman finds something that is helpful in her situation.

Homeless women are experiencing a great amount of stress, as compared to homeless men, and often lack the coping skills that may be most beneficial for them. Developing a positive community experience through group where the women can acquire support from others may offer the social support necessary to help reduce stressful feelings. Even though no studies were found that specifically looked at stress management groups for homeless women, we can use the information from the existing literature to develop this group to the best of our abilities. Until research is completed for this particular population, we may not know for sure that what we create will be successful. This gives us good reason to be sure we are scientifically evaluating our groups in order to examine what we may need to change in order to best help homeless women manage and reduce their stress.

REFERENCES


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Chasidy Faith received her BA from the University of Wisconsin-Stevens Point, double majoring in Psychology and Spanish. She is currently working on her MA degree in counseling at Marquette University. She plans to continue her education to pursue a PhD in order to be a practicing psychologist and teach at the university level.
Sex Education Groups for Adolescent Girls: A Review of Current Practice and Research
Amy C. Orecchia

Abstract: This paper reviews the literature on the sexual health of adolescent females in the United States and effectiveness of current approaches to sex education with this population. Sex education programs that include group discussion and emphasize peer influence have been found to be effective (Card, Lessard, & Benner, 2007; Sieving, Eisenberg, Pettingell, and Skay, 2006). Research has also demonstrated that psycho-educational groups are especially effective in reducing other risk-taking behaviors among adolescent females (Becky & Farren, 1997; Rosen & Bezold, 1996; Zinck & Littrell, 2000). Therefore, small group psycho-educational interventions are proposed as an effective method of preventing unwanted pregnancies and STDs among teens. Multicultural considerations, specific areas for future research, and application to the real world are also discussed.

Psycho-educational groups are commonly used by both school and community counselors as primary prevention interventions with children and adolescents. An especially relevant concern for professionals working with adolescent females is pregnancy prevention and sexual health (Cairns & Cairns, 1994). Teenage girls often receive mixed messages about sexuality and lack accurate information about relationships, their bodies, contraceptives, STD prevention, and decision-making (Ward, 1995). Therefore, groups aimed at educating adolescent girls about their sexual health may be a welcome and effective intervention for this population (Byers et al., 2003; Card, Lessard, & Benner, 2007). This paper will give a brief overview of current data highlighting the need for sex education among female adolescents and review the literature on group approaches to sex education, including effectiveness, multicultural considerations, specific areas for future research, and application to the real world.

SEX EDUCATION

For professionals who work with youth in schools and community agencies, questions of how and what to teach regarding adolescent sexuality are ever-present and politically charged concerns (Lindbergh, 2006). However, it appears that current approaches may provide teens with too little information too late in their development (Dicenso et al., 2002; Ferguson, 1998). In recent years, some federal and state mandates have limited sex education to abstinence-only programs despite a lack of evidence that they are effective (Alan Guttmacher Institute, 2006b). The effects of these changes can already be seen. In 2002, only 62% of sexually experienced adolescent girls had received instruction about contraception.
before they first had sex, compared with 72% in 1995 (Lindberg, 2006). Additionally, one in five teachers believe that restrictions on sex education are preventing them from meeting their students’ needs (Alan Guttmacher Institute, 2006b). Lack of knowledge about their sexuality is reflected in the sexual health of adolescent females in this country.

Education and Prevention

Statistics on the sexual health of adolescent females in America are consistent with the lack of effective sex education. Teen pregnancy rates are much higher in the United States than in many other developed countries—twice as high as in England and Canada and eight times as high as in the Netherlands or Japan (Alan Guttmacher Institute, 2006a). In addition, American teens (ages 15-24) represent only one-quarter of the sexually active population, but they account for nearly half of all new STDs each year (Weinstock, Berman, & Cates, 2004). Early comprehensive sex education is also important because even though most teens are not cognitively or emotionally ready to have children, they are biologically and physically prepared. A heterosexual adolescent female who is sexually active but does not use contraceptives has a 90% chance of becoming pregnant within a year (Harlap, Kost, & Forrest, 1991). Finally, teenagers themselves view sex education as important and highlight the need for factual information as well as practical skills related to sexual health (Byers et al., 2003). Adolescent girls in the United States both want and need education and information about their sexual health in order to avoid unwanted pregnancies and STDs.

Sex Education Groups for Adolescents

Despite a clear need and desire for accurate and comprehensive sex education, there is currently very little research specifically on psycho-educational small group interventions promoting the sexual health of adolescent females. Most sex education literature focuses on large group classroom interventions and indicates mixed results (Bearinger, Sieving, Ferguson, & Sharma, 2007; DiCenso, Guyatt, Willan, & Griffith, 2002; Kirby, 2002). There is some British research on peer-led interventions that do not appear to be very effective (Harden, Weston, & Oakley, 1999; Kim & Free, 2008). The Program Archive on Sexuality, Health, and Adolescence (PASHA) has published a list of 47 effective teen pregnancy and STI/HIV prevention programs based on outcome research from their Scientist Expert Panel (Card, Lessard, & Benner, 2007). It is unclear if the programs evaluated in PASHA’s research are small group interventions or not.
However, the most commonly used pedagogical technique used in the effective programs was group discussion (Card et al., 2007). This finding suggests that small groups, in which group cohesion and trust facilitate open discussion, are effective formats for such programs. In addition, there is some research on adolescent health and risk behaviors that suggests that small group approaches to sex education are ideal. Sieving, Eisenberg, Pettingell, and Skay (2006) conducted a longitudinal study on adolescents’ first intercourse and concluded that because of peer influence on sexual behavior, sex education interventions must target cohorts and focus on peer group norms and positive relationships rather than exclusively focusing on individual teenagers. While very little research exists on this specific intervention, aforementioned literature indicates that the discussion with peers that is provided in sex education groups are effective in promoting the sexual health of adolescents.

In addition to the above literature, two case studies of specific small group sex education interventions with adolescents show promising results. Blythe, Gilchrist, and Schinke (1981) published a brief article on a pregnancy prevention group they conducted in a high school. This intervention involved 7 male and 12 female participants who were randomly assigned to either the group or a control condition. Participants in both conditions received pretest and posttest measures. The group intervention consisted of fourteen semiweekly one-hour sessions that focused on decision making and interpersonal skills. Teaching techniques used in the groups included didactic presentations, group discussion, experiential exercises, modeling, role-play practice, coaching, feedback, and social reinforcement. Following the intervention, group participants scored significantly higher on posttests concerning reproduction and birth control methods as well as tasks essential to effective decision making in interpersonal relationships than their peers in the control condition. At 3 and 6 month follow-up assessments, responses to a written questionnaire showed that the teenagers who had participated in the group had greater commitment to postponing pregnancy, used birth control more frequently, and had greater reliance on more effective methods of birth control than control students.

Chapman, Vickery, and Joyce (2002) also conducted a psycho-educational sexual health group specifically for teenage girls with mental health problems. The group was incorporated into treatment curriculum on a psychiatric inpatient unit at a hospital and lasted eight weeks. Participants were 7 adolescent females ages 13 to 18. The primary techniques used in the group were handouts with information and resources, group discussions, hands-on activities and demonstrations, and quizzes. Group leaders also had adolescents previously discharged from
the unit who were now teen parents come in and speak about their experiences. Through informal assessment measures such as staff observation, the authors concluded that the group was successful in increasing the girls' knowledge about sexual health issues and improving their respect and self-care of their bodies. These two successful case studies underscore the need for more research specifically on small group sex education interventions.

**Effectiveness of Sex Education Groups**

While there is a marked absence of literature on sex education in a psycho-educational group format, there is quite a bit of research evaluating the outcomes and effectiveness of sex education in general. DiCenso et al. (2002) conducted a meta-analysis of 26 studies of intervention to prevent teen pregnancy (most were large-group classroom interventions). The meta-analysis found that these programs did not delay first sexual intercourse, improve the use of birth control, or reduce pregnancies. Therefore, the authors concluded that current school-based pregnancy prevention programs are not particularly effective. They suggested that to improve effectiveness, programs should start much earlier than high school, include communication and negotiation training, birth control resources, and booster sessions. The authors also suggested that professionals should consult with adolescents about what they think would be helpful (DiCenso et al., 2002). Most other outcome research of pregnancy and HIV/STD prevention programs has found at least some effectiveness in reducing sexual risk behaviors among adolescents (Card et al., 2007; Frost & Forrest, 1995; Kirby, 2002; Kirby et al., 2004). Kirby (2002) found programs to be especially effective if they included activities to address the social pressures that influence sexual behavior and/or provided modeling and practice of communication, negotiation, and refusal skills. Outcome research is mixed in regard to the overall effectiveness of sex education in classroom and school settings. However, there is a growing body of evidence suggesting that programs that include specific formats, content, and/or time-frames can be effective at reducing adolescents’ sexual risk behaviors, unwanted pregnancies, and STDs.

In addition, literature has shown that small group interventions in general can be an effective means of preventing many kinds of risk behaviors among adolescents (Durlak & Wells, 1997; Gerrity & DeLucia-Waack, 2007; Hoag & Burlingame, 1997; Kulic, Horne, & Dagley, 2004). The effects of group therapy are particularly positive with adolescent girls (Erickson & Palmer, 2004). Also, primary prevention and psycho-educational group counseling have been shown to be effective with at-risk
adolescent girls (Becky & Farren, 1997; Rosen & Bezold, 1996; Zinck & Littrell, 2000). These findings may be replicated with female teens considered to be at-risk for pregnancy and/or STDs. Although there is currently no evidence of the effectiveness of small group sex education with adolescent girls, there are convincing bodies of literature suggesting that both sex education and group counseling are effective with this population. Therefore, a next logical step would be to evaluate the effectiveness of sex education groups.

MULTICULTURAL CONSIDERATIONS

There are a myriad of multicultural considerations within this topic and research. Distal statistics show that Latina, Native American, and African American youth have higher teen birth rates than Whites (Alan Guttmacher Institute, 2006a). In addition, black females tend to have an earlier age of first sexual experiences than their white peers (Zabin, Hirsch, & Smith, 1991). This demographic difference is significant because research shows that the younger girls are when they become sexually active, the less likely they are to use protection (Duncan & Hoffman, 1990). Therefore, in a review of culturally tailored interventions with African American girls, Ferguson (1998) concluded that community-based, culturally specific adolescent pregnancy prevention programs need to be implemented earlier than 11 to 12 years of age.

In an attempt to improve culturally-specific programs with Latina youth, Russell and Lee (2004) conducted a qualitative investigation of teen pregnancy prevention practitioners in California. The practitioners’ recommendations for best practices with Latina youth were: to have staff members who understand the Latino culture and/or speak Spanish, emphasize the importance of education for future financial stability, are responsive to subgroup differences such as generation or acculturation level, involve parents, families, and male partners, and recognize Latino cultural values regarding gender roles. Similarly, Garwick, Rhodes, Peterson-Hickey, & Hellerstedt (2008) conducted a community-based action research study with Native American youth, ages 13-18, to determine recommendations for sex education with this population. These youth emphasized the importance of involving trusted Native American family and community leaders in school-based and community education programs. They also suggested that increased access to contraceptives would be helpful in preventing teen pregnancy.

Often overlooked in academic literature, youth who identify as lesbian, gay, or bisexual (LGB) are also considered a more at-risk population than their heterosexual peers. In a study of LGB adolescents,
Blake et al. (2001) found an earlier age at first intercourse, higher number of sexual partners, higher use of alcohol or drugs before sexual activity, and increased pregnancy rates among LGB youth. These youth were also less likely to report having received HIV or STD education than their heterosexual peers. However, in schools where gay-sensitive HIV instruction was provided, LGB youths reported lower sexual risk behaviors. The authors conclude that HIV prevention and sex education programs should be gender-neutral and address the full range of sexual partner relationships that exist. While adolescent girls from minority populations have higher incidences of pregnancy than white females, there is some evidence that culturally sensitive and inclusive interventions may be effective in minimizing this difference.

RECOMMENDATIONS FOR FUTURE RESEARCH

While much more research on sex education in small psycho-educational format in general is needed, there are some areas that are particularly important. First, empirically sound quantitative outcome research is needed in the group literature. Most studies of group effectiveness have serious limitations such as single group designs, small sample sizes, lack of a control group, no checks on treatment validity, and no follow up data (Gerrity & DeLucia-Waack, 2007). Future research on the outcome and effectiveness of sex education groups will be more convincing if it contains these scientific rigors. In addition, future research should be mindful of accurate cultural considerations, instead of assuming that findings apply to all youth. While some recent studies have begun to ask minority youth what is important to them (Garwick et al., 2008), further research is needed to determine what the actual cultural differences regarding sexuality between majority and minority cultures are (Ferguson, 1998). Some well-intentioned practitioners may not have accurate information regarding multicultural issues. For example, a common misperception is that the influence of Catholicism on Latino culture prevents many women from exercising their right to abortions, when in reality abortion rates among Latinas are higher than those among non-Latina white women (Jones, Darroch, & Henshaw, 2002). To promote the sexual health of Latinas, as well as women from other backgrounds, research is needed to examine which cultural differences are myths and which are realities and then provide culturally sensitive and appropriate programs based on findings (Foulkes, Donoso, Fredrick, Frost, Singh, 2005). Specific areas for future research include multicultural considerations as well as research with empirically sound quantitative methodology.
In addition, while some outcome research has indicated that sex education programs are more effective with youth from middle class families than those with low socioeconomic status (SES) (Hoag & Burlingame, 1997), further research is needed to determine what specific aspects of low SES contribute to this difference. Other factors besides poverty, such as different sources of media and peers, have also been shown to influence youths’ sexual behavior (Sieving et al., 2006; Ward, 1995), but little research has been conducted to examine the role of these influences on sex education interventions. Future research should also examine the effects of SES, media, and peers on sex education effectiveness with adolescents.

APPLICATION OF RESEARCH FINDINGS

A common concern regarding all academic research that has direct implications for practice is the applicability of findings to real-world settings. Outcome research on sex education groups and programs may exist. However, if these recommendations are not easily available to the schools and community agencies that run the programs, they have no impact on the sexual education and health of teenage girls. An important resource in bridging this divide between research and practice is the Program Archive on Sexuality, Health, and Adolescence (PASHA). PASHA’s mission is to assemble in one place “all the information that a school, community, or clinic would need to replicate an effective teen pregnancy or STI/HIV prevention program” (Card et al., 2007, p. 2). PASHA first has a panel of experts in the field of sex education research review existing programs to locate the most effective interventions for adolescents. It then assembles together all the necessary materials needed to re-implement and re-evaluate the programs, essentially creating kits that contain specific user’s manuals and program implementation tips. With the availability of actual program packages, implementation of evidence-based sex education becomes realistic for teachers and counselors. PASHA is also dedicated to ongoing field testing investigation of the effective programs and modifying them as needed to different settings and populations (Card et al., 2007). In this way, it is an exciting example of a scientist-practitioner approach and a good model for future research.

CONCLUSIONS

There is a clear need for primary prevention interventions for unwanted pregnancies and STDs among adolescent girls in the United
States. However, there is currently almost no empirical research on psycho-educational groups for healthy sexuality of female teens. Because there is a growing body of evidence suggesting that sex education programs can be effective at reducing adolescents’ sexual risk behaviors, unwanted pregnancies, and STDs, and group counseling has been shown to be particularly effective with adolescent females, future research should examine the effectiveness of sex education groups for teenage girls. Additional considerations for future research include determining accurate multicultural preferences, examining the effects of SES, media, and peers on sex education effectiveness with adolescents, and ensuring that studies have empirically sound quantitative methodologies. Finally, with PASHA providing an exemplary model, future outcome research on sex education groups should be mindful of the practicality and applicability of findings to schools, clinics, and community agencies.

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Grief is the term used to describe the distress or suffering related to loss, particularly death. Everyone experiences grief or bereavement at some point in their life; however, the duration and expression varies among different cultural groups (MacNair-Semands, 2004). The feelings associated with grief often include sadness, anger, helplessness, and despair (Toth, 1997), in addition to denial, disbelief, confusion, shock, guilt, humiliation, and yearning (Mental Health America, 2007). Such feelings may be intense and long lasting, but they are natural and normal reactions to loss. Experiencing grief is necessary to heal and grow emotionally.

Although not everyone experiences loss the same way, it can be helpful to look at grief as a process. A common way of identifying grief is the five-stage model put forth by Kübler-Ross. According to Kübler-Ross (1969), individuals experiencing grief typically follow a pattern of emotions. When first learning of a loss, an individual may go through a period of denial. The person does not want to believe that the loss is real and may try to avoid it. Following the denial stage is the anger stage, during which the individual experiences an intense expression of emotion. Next, the individual begins to bargain in an attempt to prevent the loss. The person is searching for a way to circumvent the loss. After bargaining, the individual enters the depression phase. The person realizes the loss is inevitable and struggles to work through the emotions associated with it. The final stage in Kübler-Ross’ model is acceptance. During this time, the individual acknowledges the loss and begins to move forward with her/his life.

Building upon Kübler-Ross’ work, Lamb (1988) proposed a different model to understand the grief process. In this framework, there are three stages of grieving. During the adjustment stage, a variety of feelings and
thoughts occur. These are the things typically associated with grief, such as sadness and guilt. The purpose of the adjustment stage is to “enable the individual to sustain the impact of the loss without being overwhelmed by the pain and sorrow” (Lamb, 1988, p. 563). It is also a time for the grieving individual to develop coping mechanisms and deal with the meanings and implications of the loss. In the second or intermediate stage, the individual actively experiences the emotional states of grief (e.g., despair, anger, yearning, etc.). It is characterized by an obsessive review of the circumstances surrounding the loss and a search for meaning. It is often during the intermediate stage that individuals seek professional help because they begin to feel isolated. Family and friends typically return to their daily activities and the grieving individual spends more time alone. The third stage, also referred to as the final stage, is marked by a return to activities and behavior that occurred before the loss. Daily functioning increases and they no longer focus on the loss. These models help to elucidate typical grief and bereavement responses.

COMPLICATED GRIEF

Although the frameworks put forward by Kübler-Ross (1969) and Lamb (1988) explain the grief process for many individuals, sometimes people do not progress through these natural stages, and are unable to accept the loss and move forward with their own lives. The grieving process may be disturbed for these individuals. When this process is blocked or disturbed, complicated grief may arise (Piper, McCallum, Joyce, Rosie, & Ogrodniczuk, 2001). Typically, this occurs in people who have experienced a major loss in the last three months and have a prolonged or delayed grief reaction related to the loss (Kipnes, Piper, & Joyce, 2002). The most common types of losses associated with complicated grief are those of a parent, partner, child, sibling, grandparent, or friend (Abouguendia, Joyce, Piper, & Ogrodniczuk, 2004; Ogrodniczuk, Joyce, & Piper, 2003; Piper, et al., 2001). Complicated grief is characterized by a preoccupation with the loss, yearning, disbelief and inability to accept the loss, bitterness or anger about the loss, or avoidance of reminders of the loss (Ogrodniczuk, Piper, Joyce, McCallum & Rosie, 2002). These symptoms are often accompanied by a sustained disruption in social or occupational functioning.

There are three main forms of complicated grief (Bete, 1999). These include absent, delayed or inhibited grief, distorted grief, and chronic grief. Those persons experiencing absent, delayed, or inhibited grief may not show any feelings of grief until two or more weeks after the loss, and the feelings may seem less intense or be unresolved. Distorted grief
manifests itself when one or more grief reactions become very exaggerated. An example of distorted grief may be that the person is only able to show and feel anger for an extended period of time, which blocks out other feelings, such as sadness. Individuals who experience the third type of complicated grief, chronic grief, may never accept the loss. They may stay consumed with the loss for months or years and act as though it just occurred.

Even though there are general patterns of grief and types of complicated grief, there is no standard diagnosis for pathological reactions to loss (Piper, et al., 2001). The DSM-IV-TR (APA, 2000) lists bereavement as a V-code, or “other condition that may be a focus of clinical attention” (p. 740), but typically V-codes are reserved for individuals who do not have a mental disorder. It could be argued that the symptoms associated with complicated grief could classify an individual as having a mental disorder. Indeed, many individuals experiencing complicated grief do receive a diagnosis. The most common diagnoses of complicated grief are depressive disorders (i.e., major depressive disorder and dysthymia), adjustment disorders, post-traumatic stress disorder (PTSD), and personality disorders (i.e., avoidant, dependent, borderline, and obsessive-compulsive) (Abouguendia, et al., 2004; Enright, & Marwit, 2002; Kipnes, et al., 2002; Piper, et al., 2001).

Despite sharing some descriptive features with these diagnoses, none of these completely encompasses complicated grief (Enright & Marwit, 2002). For example, some common core symptoms of PTSD include numbness and disbelief, which are similar to some typical symptoms of complicated grief. However, other core symptoms of complicated grief (such as, yearning, searching, and excessive loneliness related to the loss) are not usually exhibited in individuals suffering from PTSD. Although, people with PTSD may experience complicated grief related to the trauma they have experienced, certainly not all individuals faced with a loss develop PTSD.

In much the same way, depressive disorders cannot completely account for all the individuals with complicated grief. It may be true that most symptoms of complicated grief are similar to those of depressive disorders, particularly Major Depressive Disorder, though not all individuals will meet the criteria for such diagnoses (Enright & Marwit, 2002; Piper, Ogrodniczuk, McCallum, Joyce, & Rosie, 2003). A final example involves the diagnosis of an adjustment disorder. By definition, the symptoms related to adjustment disorders must occur “within three months of the onset of the stressor(s)” and do not last for more than six months after the stressor has ended (American Psychiatric Association, 2000, p.683). Most theorists agree that grief lasts longer than six months,
and the complicated form does not present until after three months after the loss (Enright & Marwit, 2002). Thus, adjustment disorders (and other DSM-IV-TR diagnoses) cannot completely account for all individuals experiencing complicated grief.

Despite a lack of consensus regarding definitions and diagnoses of complicated grief, it clearly interferes with an individual’s ability to function and can lead to other serious problems. The prevalence rates for complicated grief are relatively high, ranging from 15-33% in psychiatric outpatient groups (Ogrodniczuk, Piper, Joyce, et al., 2002), and approximately 20% of all acutely bereaved individuals (Piper, et al., 2001). As may be inferred by the typical diagnoses associated with complicated grief, many individuals develop additional physical and mental health problems. Such concerns include depression, anxiety, sleep difficulties, alcohol and other drug problems, physical illnesses, and increased risk of suicide in addition to their symptoms of complicated grief (Ogrodniczuk, Piper, Joyce, et al., 2002; Ogrodniczuk, Piper, McCallum, Joyce, & Rosie, et al., 2002; Piper, et al., 2001; Sikkema, et al., 2006). Such impairments make it clear that therapeutic intervention is especially important for individuals experiencing complicated grief.

GROUP COUNSELING FOR COMPLICATED GRIEF

One type of counseling that has been theorized to be beneficial to individuals suffering from complicated grief is group counseling. Grief and loss typically cause people to feel isolated, because complicated grief reactions may directly affect social support (Ogrodniczuk, Joyce, Piper, 2003). In the event of a loss, family and friends typically express concern for and assist the grieving individual. However, those experiencing complicated grief may place excessive demands on their social support groups. The stress may alienate the social network and isolate the grieving person. Grief counseling groups seem like an appropriate alternative source of social support. In addition, groups can provide a means of catharsis and a place to learn coping skills and stress management techniques (MacNair-Semands, 2004; Piper, et al., 2001; Sikkema, et al., 2006). Furthermore, grief groups are often brief, which may offer some relief to the suffering individual (Toth, 1997). The three theoretical orientations that typically underlie counseling groups for treating complicated grief are psychodynamic, interpersonal and cognitive-behavioral.

Psychodynamic Group Counseling
Of the approaches that focus on grief counseling groups, those utilizing psychodynamic theory have been studied the most (MacNair-Semands, 2004). Psychodynamic group counseling has a strong theoretical base, and it has been investigated intensely by a group of researchers in Canada. Piper and colleagues have implemented many short-term groups for patients suffering from complicated grief since 1986. The purpose of such groups is to understand how underlying unresolved conflicts contribute to current difficulties dealing with loss (Kipnes, et al., 2002; MacNair-Semands, 2004; Piper, et al., 2001). Typically, the groups last for 90 minute weekly sessions over 12 weeks. Most often two types of psychodynamic group therapies are employed: interpretive and supportive groups.

**Interpretive**

The primary objective for interpretive group therapy is to “enhance the patients’ insight about repetitive conflicts (both intrapsychic and interpersonal) and trauma that are associated with the losses and that are assumed to serve as impediments to experiencing a normal mourning process” (Piper, et al., 2001, p. 531). In addition, interpretive therapies seek to help the patients develop a tolerance for ambivalence toward the people they have lost. The role of the therapist is to create an atmosphere in which clients can examine conflicts in a here-and-now experience. The counselor encourages the client to find a balance of tension and comfort, and helps the client to explore uncomfortable emotions (Ogrodniczuk, et al., 2003). Instant praise and gratification are withheld with goal of helping the client to better tolerate anxiety and tension. It is an active, interpretive, and transference-focused approach.

**Supportive**

The primary goal for supportive group therapy is to “improve the patients’ immediate adaptation to their life situation” (Piper, et al., 2001, p. 532). According to this perspective, positive adaptation results from the provision of support and problem solving techniques. The counselor creates a climate of gratification so that clients can share common experiences and feelings, and receive praise for their efforts at coping. The therapist is active, non-interpretive, and focused on the patients’ current interpersonal relationships (Ogrodniczuk, et al., 2003). Supportive therapies typically are less demanding, depriving, and anxiety arousing than interpretive therapies.
Interpersonal Group Counseling

Another popular form of group counseling for the treatment of complicated grief is the interpersonal approach. In this model, the primary goals are to facilitate the mourning process and help the grieving person regain interests and relationships (MacNair-Semands, 2004). Clients are encouraged to think about, discuss the sequence of events and consequences surrounding, and explore feelings and emotions related to the loss. In addition, relationship patterns are examined to develop an understanding of current relationship difficulties. As in psychodynamic group counseling, an important tenant of the grief process in interpersonal group counseling relates to ambivalence toward the lost person. Ambivalence must be shared and explored in order to facilitate change. Interpersonal group techniques often involve establishing norms, encouraging process reviews, and making here-and-now interventions.

Cognitive Behavioral Group Counseling

A final approach to be reviewed in this paper is cognitive behavioral group counseling (CBT). CBT is a structured approach that clearly outlines an agenda and activities for group settings (MacNair-Semands, 2004; Sikkema, et al., 2006). Typically, techniques involve encouraging group members to gain closure through writing, visiting a cemetery, and expressing and reliving painful memories until the distress is reduced. In CBT groups, the counselor and clients choose topics for discussion and identify common themes. The goal is to detect automatic thoughts. Once clients’ become aware of automatic thoughts, they are able to realize the consequences related to them and diminish the power associated with them. Clients are then able to determine alternative ways of thinking and share ideas to reduce the negative thoughts. Other techniques related to CBT grief reduction groups involve stress management and coping skills.

Effectiveness of Group Counseling

Brief Counseling Groups

There seems to be a consensus that brief therapy groups are among the most effective counseling groups for complicated grief (Abouguendia, et al., 2004; MacNair-Semands, 2004; McCallum, Piper, Ogrodniczuk, & Joyce, 2002; Piper, et al., 2001; Ogrodniczuk, Piper, Joyce, et al., 2002; Toth, 1997). According to Toth (1997), brief therapy is an especially good fit for those suffering from grief because the time constraints intensifies group members’ existential anxiety and serves as a reminder of the finite
nature of interpersonal interactions. Among the benefits of short-term counseling groups are increases in self-esteem, mental health, and social functioning and reductions in general symptoms of grief and use of psychotropic medications (Ogrodniczuk, Piper, Joyce, et al., 2002; Toth, 1997).

*Psychodynamic Group Counseling*

As mentioned above, the most extensive research on group counseling for grief has been conducted on psychodynamic groups (MacNair-Semands, 2004). Piper and his colleagues (e.g., Piper, et al., 2001; Piper, et al., 2002; Piper, Ogrodniczuk, Joyce, Weideman, & Rosie, 2007) have demonstrated that short-term psychodynamic groups can help reduce depressive symptoms and target problems, as well as increase self-esteem, life satisfaction, social support, and autonomy. The researchers utilized large sample sizes, actual clinical populations, standard forms of therapy, and random assignment of patients to improve the scientific rigor (MacNair-Semands, 2004).

The two types of psychodynamic group counseling described above, interpretive and supportive, have shown to have different effectiveness rates (Piper, et al., 2001). The average effect size for interpretive psychodynamic groups was .75, a large effect by Cohen's standard d (Cohen, 1988). An effect size of .75 means that the average patient at post-therapy was better off than 77% of the patients at pre-therapy. The average effect size for supportive therapy was .50, a moderate effect according to Cohen. An effect size .50 for this study means that the average patient at post-therapy was better off than 69% of the patients at pre-therapy.

In addition, interpretive and supportive groups may be effective with different types of people (Ogrodniczuk, Piper, McCallum, et al., 2002; Piper, et al., 2001). For example, individuals with a history of more mature, give-and-take interpersonal relationships typically fare better in interpretive groups. They may do better in this type of group because they are better able to “tolerate and work with the demanding, depriving, and anxiety-arousing features of interpretive group therapy, including the examination of painful conflicts and their relationships to the lost persons” (Ogrodniczuk, Piper, McCallum, et al., 2002, p. 528). In addition, people with a history of relatively unsatisfactory relationships may find supportive therapy more beneficial than interpretive therapy. They may be less able to handle conflict in their relationships and are more dependent on others to satisfy their interpersonal needs. Thus, professionals should keep in mind individual differences when considering the type of counseling group for participants.
**Interpersonal Group Counseling**

The empirical support for interpersonal group counseling is scarce despite having a solid theoretical base. The argument could be made that interpersonal theory is ingrained in both psychodynamic and cognitive behavior group counseling, thus providing support for its effectiveness. For example, aspects of supportive psychodynamic group counseling bear resemblance to those of interpersonal group counseling (i.e. the provision of support and focus on interpersonal relationships). In much the same way, part of group CBT for grief is learning coping skills and stress management, which is also a goal of interpersonal group therapy for grieving adults. However, there are distinct differences among the theories; therefore, more empirical research is needed on interpersonal group counseling for complicated grief.

**Cognitive Behavioral Group Counseling**

Group CBT is one of the only empirically supported interventions for grief work (MacNair-Semands, 2004). In addition, group CBT has been shown to reduce symptoms of grief and psychiatric distress significantly more than individual psychotherapy (Sikkema, et al., 2006). In the randomized controlled trial by Sikkema, et al. (2006), women demonstrated higher baseline scores on grief and distress than men, but also showed greater improvements than men did. Despite the rigorous design of the study, the generalizability of these findings is limited. The study looked specifically at adults with HIV who experience AIDS-related bereavement. It could be argued, though, that these individuals provide an accurate representation of complicated grief because they have the double burden of coping with their own illnesses and multiple losses related to AIDS.

**MULTICULTURAL CONSIDERATIONS**

A number of multicultural considerations arise when examining the research on the effectiveness of group counseling aimed at diminishing grief symptoms. Although loss is a universal experience, the reactions to loss are not (MacNair-Semands, 2004). Most of the literature focuses on adult (19-67 years old) Caucasian females, which is quite a specific population. Each sample has distinct characteristics that may or may not apply to other populations. There may be cultural or gender differences in the expression of grief, which may limit the effectiveness of the treatment. Therefore, clinicians must be cautious in generalizing research findings across gender and cultural groups.
In addition, the outcomes assessed may not be endorsed by all populations. For example, studies have shown that psychodynamic groups can increase autonomy. Autonomy is typically considered an important value for people from individualistic societies, but is not necessarily valued by those from collectivistic cultures. Individuals from such cultures may view an increase in autonomy as a setback rather than positive step in the grief process. The outcomes measured may not be valued across cultures, therefore limiting the effectiveness of the intervention in different contexts.

The strict exclusion criteria for most of the studies also limit the generalizability of the findings to other populations, especially those with severe mental illness. For example, several studies excluded individuals with suicidal intent, psychosis, addiction, sexual deviation, sociopathic behavior, or comorbid disorders that may interfere with therapy (Kipnes, et al., 2002; Piper, et al., 2003; Piper, et al., 2007). Arguably, these studies excluded people who may need intervention the most. However, research has shown that individuals with severe mental illness often do not benefit from group therapy and may hinder the progress of others (Yalom, 2005). In any case, it is important to remember that the findings may not apply to all populations.

FUTURE RESEARCH AND CLINICAL IMPLICATIONS

In conclusion, group counseling appears to be a viable option for those experiencing complicated grief. It provides an additional source of social support and a safe place for clients to progress through the grieving process. Brief psychotherapy groups (i.e., those consisting of 6-12 weekly 90 minute sessions) appear to be especially effective.

In general, more research is needed on group counseling for complicated grief. Although, three different counseling groups have strong theoretical foundations, there is little empirical support for the treatments. Additional research on the effectiveness of different theoretical orientations would be beneficial. Furthermore, future research should compare group theoretical models in order to determine the most effective approach for treating complicated grief.

It is interesting that the majority of the work reviewed for this paper used data from one study conducted by Piper, et al. (2001). The study was well designed, and builds upon years of previous work; however, no study is flawless. If most of the current literature regarding group counseling for complicated grief is based on one study, there are significant limitations with regard to generalizability. Professionals should be wary of applying the results to populations that are different from that of the study. In
addition, they should consider possible researcher biases that may influence the interpretation of the data. All researchers bring their own biases to their work, whether they are aware of them or not. It is important to be cautious when such a large portion of the literature is conducted by the same group of researchers.

The research that is available suggests group counseling is effective in treating complicated grief; however, that research is based primarily on a narrow sample, consisting of adult Caucasian females. This group may be representative of the population that experiences complicated grief; however, there may be distinctive traits and values specific to Caucasian females that do not apply to other populations. Future research should include samples that are more diverse in order to increase the generalizability of the results. Professionals need to consider the population of interest, in addition to cultural values, when recommending group counseling for the treatment of complicated grief in order to ensure favorable outcomes.

Despite limitations, all three of the theoretical approaches to group counseling have strong clinical implications. For example, according to the research, professionals should utilize interventions that provide guidance to help clients communicate needs to others, suggest adaptive interpersonal behaviors, and help to clarify expectations for support (Ogrodniczuk, et al., 2003). These techniques are consistent with the goals of interpersonal and cognitive behavioral groups. In addition, clinicians should explore patients’ impressions of what the lost person did and did not provide to understand the reluctance to accept the loss (Ogrodniczuk, Piper, McCallum et al., 2002). As demonstrated by psychodynamic and interpersonal groups, understanding ambivalence is a critical component to facilitate change and growth. These applications help counselors to treat individuals experiencing complicated grief skillfully and effectively.

REFERENCES


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Elizabeth Para obtained her BS degree from the University of Wisconsin-Green Bay and double majored in Psychology and Human Development. She is currently working on her MA degree in counseling at Marquette University with a specialization in community counseling. Upon completion of her MA, she hopes to provide therapeutic services to young adults in a university counseling center.
The Evolution of University Counseling: From Educational Guidance to Multicultural Competence, Severe Mental Illnesses and Crisis Planning
Alison Lafollette

Abstract: The role of university counseling has evolved over time out of an educational and vocational guidance background. The original focus of university counseling on transitional issues has been maintained to a degree but has also developed as the needs and demographics of college students have changed. Currently university counseling centers are handling a mental health crisis and learning how to counsel an increasingly diverse population of students. Furthermore in the wake of September 11, 2001 and the Virginia Tech incident, crisis planning/disaster mental health has also become important. As the institutional workload of university counseling centers continues to grow, the author recommends a more preventative approach to mental illness through the fostering of mental health.

The current status of university counseling is a product of the historical, political and social situations of the past. Thus, first, a brief explanation of the historical and philosophical roots of university counseling will be given. Next, the current role of a university counselor will be discussed based on issues that have come to be of importance today. University counselors have been trying to increase their multicultural competence, adapt to the increasing severity of mental illnesses among college students, and plan for crisis/disaster. Lastly, the author will offer some recommendations that may decrease the institutional workload and pressure that university counseling centers are currently experiencing.

HISTORIC AND PHILOSOPHICAL ROOTS

Historic Roots

University counseling traces its roots back to the early educational guidance movement of the 1930s. Since that time, it has evolved as a consequence of various historical events; in particular the Great Depression, World War II, the Civil Rights and women's movements, and the Cold War. The guidance movement of the 1930s and 40s focused on assisting young people with life changes such as leaving home, succeeding in school, and obtaining employment (Sweeney, 2001). During this time, the Great Depression in the U.S. heightened the need for vocational services for citizens and the first attempt to institutionalize these services
was made (Sweeney, 2001). It is in the context of this early guidance movement that soldiers returning home from the Second World War received counseling in higher education as many pursued this opportunity for the first time under the G.I. Bill (Hodges, 2001). Though the university counseling was originally meant more for vocational services, the personal and social concerns of the soldiers inevitably needed addressing and thus the role of guidance counselors in the university setting adapted to meet these needs (Hodges, 2001).

As counselors were adapting to the needs of the veterans of World War II another war was beginning that would help further the field of counseling yet again, namely the Cold War. The National Defense Education Act (NDEA) of 1958 came out of the Congress’ desire to identify and prepare the gifted for careers that might be important to the space race (Sweeney, 2001). The NDEA provided funds for guidance and counseling institutes, provided funds for fellowships in counseling preparation, and expanded guidance and testing programs in schools (Sweeney, 2001). The provision for funds came at a crucial time as the population of those attending college became increasingly diverse after the Civil Rights and women’s movements. Both movements created a complex social and cultural environment in colleges which led to a need for more counseling professionals with specialized training to keep up with the growing demand for student services (Hodges, 2001). With an emphasis on addressing both personal and vocational needs of students, university counseling began to develop an identity that was separate and distinct from other student affairs units. However, even though university counseling has developed a distinct identity it still has retained an attachment to early educational philosophy (Hodges, 2001).

Philosophical Roots

Early educational philosophy addressed the fact that development occurs along multiple dimensions of the individual during the college years: interpersonal, emotional, physical and spiritual (Hodges, 2001). Before wellness and holistic approaches to helping were popular, university counseling had already begun to emphasize a respect for the student’s worldview, as opposed to directing the student from one’s own sense of expertise (Hodges, 2001). In addition to a developmental approach, the university counseling setting also took up a person-centered approach, specifically the ideas of unconditional positive regard, recognizing and being sensitive to the uniqueness of each person, and focusing on student self-reflection (Hodges, 2001). The aforementioned developmental and humanistic approaches can still be seen in university
counseling today though there has been somewhat of a shift in recent years toward a medical model. The reason for this shift will be explained in the following section as we address issues that affect the current field of university counseling.

CURRENT ROLE OF UNIVERSITY COUNSELING CENTERS

Increase Multicultural Competence

The multicultural movement in counseling, which has accelerated in the current decade, attempts to acknowledge the differences that exist for people of different races, ethnicities, genders, religions, ages, sexual orientations, etc (APA, 2003). An increasing numbers of multiethnic and multicultural students, lifelong learners and openly gay and lesbian students, among others, are highly visible on today’s campus (Hodge, 2001). The ethnic/racial makeup of students currently enrolled is 75.5 percent Caucasian, 5 percent African-American, 6.2 percent Hispanic, 11.6 percent Asian/Pacific Islander, and 1.6 percent American Indian/Alaskan native and the number of minorities enrolled in higher education is on the rise (American College Health Association, 2009). The increasing diversity of the student population is one factor that university counseling centers are beginning to address. In addition, social justice is closely related to multiculturalism as it acknowledges the broad, systematic, societal inequities and oppression that exist while striving to bring equal rights to every individual (Smith, Baluch, Bernabei, Robohm, & Sheehy, 2003).

One of the first recommended guidelines for practicing counseling with regard to multiculturalism and social justice involves becoming self-aware of one’s own world view that includes one’s values and beliefs. Recognizing that all people are multicultural and thus that all interactions are cross-cultural is an important part of this self-awareness (APA, 2003). Another way in which university counselors can work towards practicing with multicultural and social justice in mind is to collaborate with cultural experts and seek out culturally specific info when working with clients from diverse backgrounds (Smith, 2007). In a recent survey of American College Counseling Association members, 44% indicated that their counseling centers were providing workshops or in-service training in efforts to increase multicultural competency and 22% had recently recruited a racial/ethnic minority or hired a staff member with expertise in multicultural issues (Smith, 2007). The aforementioned efforts are being made in an attempt to deliver therapy that recognizes the influence of culture on an individual seeking therapy. In addition to meeting with an
increasingly diverse student population, university counseling centers are also handling an increase in severe client symptoms.

**Treat Mental Illnesses of Increasing Severity**

Although the developmental movement within counseling dominated the first several decades of university counseling, the most recent decade has witnessed a dramatic rise in the use of the medical model (Hodges, 2001). This shift to a medical model in some institutions is a result of the increase in recent years of students entering the university system with severe mental illness. According to the American College Health Association (2009), 14.9 percent of students reported a diagnosis of depression in his or her lifetime and out of these 32 percent had been diagnosed in the past school year. Other reports indicate that between 12-18% of university students have a diagnosable mental illness (Mowbray, Megivern, Mandiberg, Strauss, Stein, Collins, et al., 2006). Additionally 41 percent of college students report drinking five or more alcoholic drinks at least once in the past two weeks (National Institute on Alcohol Abuse and Alcoholism, 2009) that is particularly alarming when taken in consideration with the suicide risk that exists among college students. In the past 60 years, the suicide rate among adolescents has tripled and has become the second leading cause of death in college students (Mowbray et al., 2006).

Some suggest that the pressures of getting into college and staying there and a rise in tuition that has forced many students to work while in school have both had negative effects on students psychological well-being (Mowbray et al., 2006) while others suggest it is related to parental hyper-concern that is making kids, and later young adults, more fragile (Cooper, Resnick, Rodolfa, & Douce, 2008). A variety of methods are currently being recommended and put into practice in an attempt to address what some are calling a mental health crisis on university campuses. College centers have implemented various procedures such as session limits, waiting lists, and psychiatric consultation in order to meet the growing demand for services (Smith, Dean, Floyd, Silva, Yamashita, Durtschi, et. al., 2007).

**Develop Crisis/Disaster Plans**

In the aftermath of events such as the terrorist attacks of September 11, 2001 and the shooting of 32 students at Virginia Tech University there has been an increase in attention to crisis management and disaster mental health on university campuses. One requirement for accreditation is that
counseling services must provide crisis intervention and emergency coverage either directly or through cooperative arrangements (Boyd, Hattauer, Brandel, Buckles, Davidshofer, Deakin, et al., 2003). Furthermore, counseling services should provide emergency services for students who are experiencing acute emotional distress, are a danger to self or others, or are in need of immediate hospitalization (Boyd et al., 2003). However, with the increase in severity of client symptoms it is important that all university counseling services have some plan of action for addressing violence and student suicide. Stone (2008) recommends creating an educational partnership to ensure an accurate understanding on college mental health. The aforementioned need for crisis planning along with an increase in severity of client symptoms and in the diversity of students has placed a great deal of pressure on university counseling centers.

Handle Increasing Institutional Pressures/Workload

In addition to the recent development of the roles discussed above, university counseling centers are still expected to maintain previous roles/functions such as consultation services, outreach, training, individual/group counseling, and evaluation/accountability research on the effectiveness of services (Boyd et al., 2003). Though there is an increase in the demand for services, a recent survey reports that only 5% of university counseling directors say that their current resources are “adequate” (Bishop, 2006). To stay ahead of the growing demand, university counseling centers have had to implement a variety of techniques in an attempt to see as many students as possible, which may or may not sufficiently meet the individual’s needs. Strategies include offering briefer therapies, managing waiting lists, increasing group treatment options, instituting automatic termination policies and having referral sources outside of the institution where students can receive services (Bishop, 2006). Furthermore, another survey indicates that counselors are also spending more than ten hours a week on administrative duties (Smith, 2007) which takes time away from giving students treatment.

FUTURE RECOMMENDATIONS

Given the aforementioned growing demands being placed on university counseling centers, it seems that institutional funding for university counseling centers may need to become more of a priority. The author recommends two ways in which funding may be used by university
counseling centers to adequately fulfill their roles. First, one intuitive way that funding could be used would be to hire a larger staff consisting of more counselors/psychiatrists and/or of more administrative assistants. Increasing the staff size would disperse the workload so that more time could be spent treating students’ mental illness, increasing multicultural competency, and developing crisis/disaster plans. Second, additional funding could also be used directly for preventative efforts. One requirement for university counseling center’s accreditation already speaks to the importance of preventative efforts. University counseling centers should help students acquire new knowledge, skills, and behavior; encourage, positive and realistic self-appraisal and enhance the ability to relate mutually and meaningfully with others (Boyd et al., 2003). With additional funding university counseling centers would be able to provide more workshops designed to promote the mental health of students. These workshops might focus on things such as interpersonal skill training or might help students identify their strengths and offer suggestions on how students can use their strengths.

CONCLUSION

The role of university counseling centers today now supersedes the original role of providing educational/career guidance and now includes the roles of gaining multicultural competency, treating increasingly severe mental illness, and developing crisis/disaster plans. With the increase of pressure and workload on university counseling centers, either the increase of funding and/or a focus on preventative measures seem to be two probable directions in which these counseling centers may turn. As the college student population transforms so must the field of university counseling to meet the needs of the students and the university as a whole.

REFERENCES


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Counseling Psychology Within the University: A Study of Roles and Functions
Justin T. Sokol

Abstract: The purpose of the current article is to review the roles and functions of counseling psychologists who provide services within college and university counseling centers. The philosophy and definition of counseling psychology are provided, followed by a chronological review which traces the evolution of campus counseling centers over time. The article concludes with a description of current issues and challenges facing campus clinics. Roles and functions have evolved in many ways over the last fifty years and in order to remain effective, counseling psychologists must continue adapting to the changing dynamics of the college student population.

Counseling psychologists are involved with a wide variety of practices and function within a number of settings. New professional roles have emerged over the course of time, typically as a direct result of changing societal needs. One constant has been the employment of psychologists within college and university counseling centers, the practice setting that will be the focus of this paper. Before examining this venue, a general description of the philosophical approach and definition of counseling psychology will be provided to help understand how practice at the university level fits into the larger mission of the field. Next will be a review of the roles and functions for psychologists who practice within campus clinics. Finally, the paper will conclude with a discussion of current issues and challenges university counseling centers face, followed by a short summary.

PHILOSOPHY AND DEFINITION

To understand the roles and functions of psychologists who operate at the university level, it is important to recognize the larger scope of the profession as a whole. Murdock, Alcorn, Heesacker, and Stoltenberg (1998) identified the following philosophical perspectives that set counseling psychology apart from other specialty areas of psychology: (1) an emphasis on working within a developmental perspective across the full range of psychological functioning, (2) working with assets and strengths across all levels of functioning, (3) use of relatively brief counseling and treatment interventions, (4) a broad focus on person-environment interactions, as opposed to exclusive attention to either the person or environment, (5) an emphasis on educational, vocational and career development, (6) a stress on prevention and psycho-educational interventions, (7) an essential commitment and valuing of the integration of individual and cultural diversity and the vital importance of
multiculturalism within US society today, and (8) an essential attitude of critical and scientific inquiry accentuating the importance of evaluating and improving services and emphasizing the integration of science and practice. In summary, the philosophy of counseling psychology comes from a strength-based approach which emphasizes prevention, brief treatment, and the recognition of multicultural issues. This philosophy clearly influences how counseling psychology is currently defined.

According to Division 17 (Society of Counseling Psychology) of the American Psychological Association (APA), the most recent definition of counseling psychology (APA, 1999) is as follows:

Counseling psychology is a general practice and health service-provider specialty in professional psychology. It focuses on personal and interpersonal functioning across the life span and on emotional, social, vocational, educational, health-related, developmental, and organizational concerns. Counseling psychology centers on typical or normal developmental issues as well as atypical or disordered development as it applies to human experience from individual, family, group, systems, and organizational perspectives. Counseling psychologists help people with physical, emotional, and mental disorders improve well-being, alleviate distress and maladjustment, and resolve crises. In addition, practitioners in this professional specialty provide assessment, diagnosis, and treatment of psychopathology. (APA, 1999, p. 589)

This statement reflects an ambitious specialty that offers a wide range of services (e.g. psychotherapy, research, education, supervision, etc.) to a variety of populations (Baker & Subvich, 2008). Counseling psychologists operate in a number of settings including universities, community mental health centers, Veterans Administration clinics, hospitals, independent practice, business organizations, and consulting firms. Surveys of Division 17 members consistently show that the largest number (roughly 40%) of counseling psychologists are employed at the university level (APA, 2000; Fitzgerald & Osipow, 1986; Gelso & Fretz, 2001; Watkins, Lopez, Campbell, & Himmell, 1986). Although many serve as professors and researchers, others are direct providers of counseling services. Before focusing on such providers, a brief discussion of the history behind college counseling centers is in order.
In 1951, the term “counseling psychology” was introduced at the first national conference hosted by Division 17 (Super, 1955). It is no coincidence that university counseling centers were founded shortly thereafter. Inspired by the guidance movement of the early 20th century, the end of World War II, and funding from Veterans Administration, campus clinics provided career and vocational counseling to returning veterans and students (Cooper, Resnick, Rodolfa, & Douce, 2008). By this point in time, psychometric tests of vocational interest, aptitude, and ability were well developed (Baker & Subvich, 2008). However, career concerns were not the only issues facing veterans; many experienced difficulty transitioning from war to civilian life. Counseling psychologists were required to expand their focus beyond vocational guidance.

During the 1960’s, counseling psychology continued to develop as a profession. Leaders from Division 17 gathered again in 1964 for a second national conference (Munley, Duncan, McDonnell, & Sauer, 2004). Among the topics of discussion were training issues, practicum/internship sites, and required coursework curriculum for doctoral studies. As university counseling centers became more involved with training and supervision, the number of sites increased. It was around this same time period that new counseling methods and theories gained momentum (Baker & Subvich, 2008). Up until this point, counseling was primarily focused on matching skills and interests with careers (i.e. career and vocational guidance). Nondirective approaches (e.g. Carl Rogers) became popular, as they attempted to account for the adjustment of the whole person (Cooper et al., 2008). Such approaches were very different because the client was in charge rather than the counselor. Although vocational guidance was still the primary focus at this time, personal counseling emerged.

The 1970’s and 1980’s were viewed as a period of time when university counseling centers became broader in scope (Cooper et al., 2008). Psychologists began to work with clients experiencing interpersonal difficulties rather than focusing solely on career counseling. Doctoral programs continued to be established throughout the US as psychotherapy services improved. At the same time, the number of campus clinics grew and took on new roles including outreach/prevention programs and campus consultation. Advances in psychometric tools also led to the expansion of diagnosis and assessment.

Demand for services continued to rise during the 1980’s and 1990’s as students began paying more attention to their own mental health concerns (Gallagher & Bruner, 1994; Stone & Archer, 1990). Changing attitudes and perceptions towards mental health from society at large was
likely a contributing factor. Unfortunately, resources were limited (Stone, Vespia, & Kanz, 2000) and university counseling centers faced constricted budgets (Cooper et al., 2008). Thus, brief therapeutic models and group therapy were introduced. Psychologists began to consult with agencies outside the university (e.g. community mental health clinics) for additional support due to the high volume of clients that appeared. Referrals became yet another important function of campus clinics.

Today, university counseling centers take on many of the roles previously mentioned. In summary, these include career/vocational counseling, individual/group psychotherapy, training and supervision, outreach/prevention, consultation, and referrals. Different programs operate on different models and size (both of the university and the counseling center) typically has an impact on the amount of resources available (Bishop, 2006; Stone, Vespia, & Kanz, 2000). Although considerable variation exists among college counseling centers, there is no question that many currently face a host of challenging issues (Benton & Benton, 2006; Cooper, 2004; Cooper et al. 2008; Grayson & Meilman; 2006; Kadison & DiGeronimo, 2004). It is worth taking a brief look at what these issues are and how campus clinics are dealing with them.

**ISSUES AND CHALLENGES**

By its very nature, college represents a time of tremendous change for students. Each semester brings with it new classes and teachers, friends and lovers (Grayson & Meilman, 2006). Roommates come and go as students move from one housing location to the next. It is also a time in students’ lives when a series of normal developmental changes are underway including identity formation, the establishment of intimate relationships, and the selection of a career path, just to name a few. While some adjust well, others struggle with all that is “college life.” Fortunately, counseling services are available to those who experience difficulties. As mentioned previously, today’s college students are more likely to seek out mental health resources than they were in years past (Bishop, 2006). This could be due to a number of factors including the destigmatization of mental health concerns and an increase in outreach and prevention programs provided on campus.

For today’s college students, developmental issues are still germane but clinicians must also brace themselves for a variety of other issues. Depression, sleep disorders, substance abuse, anxiety disorders, eating disorders, impulsive behaviors (including sexual promiscuity and self-mutilation), psychotic breaks, and even suicide are no longer anomalies;
they are a part of college life (Grayson & Meilman, 2006; Kadison & DiGeronimo, 2004). Research findings appear to support this belief.

Benton, Robertson, Tseng, Newton, and Benton (2003) conducted a study to explore the severity of problems among counseling center clients across a span of 13 years. They found that from 1988 to 2001, the number of students seen for depression doubled, the number of suicidal students tripled, and the number of students seen following a sexual assault quadrupled. Even before results of this study were published, staffs and directors of college counseling centers reported seeing clients who were more distressed and disturbed than in years prior (O’Malley, Wheeler, Murphey, O’Connell, & Walso, 1990; Robbins, May, & Corrazini, 1985). A more recent poll found that 85% of directors reported seeing an increased number of clients with severe psychological problems compared to previous years (Gallagher, 2004). Findings such as these have led researchers to further investigate causes for the rise in psychological disturbances among college students.

Are today’s college students experiencing more severe forms of psychopathology or are the observed findings a byproduct of a changing college student population? Rudd (2004) believes the latter has contributed to observed trends. First, not only has the sheer number of college students increased, today’s students are more likely to seek out mental health services (Bishop, 2006). If there are more students seeking counseling, it seems logical that the number of students seen for depression, suicidal ideation, and sexual assault has increased. Additionally, advancement in medicine has made it possible for many students to manage mental health problems and do well enough to attend college (Kadison, 2006). Because of these factors, it makes sense that the number of students appearing in campus clinics is on the rise.

Unfortunately, as the demand for services and volume of clients has increased, the amount of available resources has not changed (Archer & Cooper, 1998; Bishop, 1995; Cooper et al., 2008). University counseling centers are often asked to do “more with less” which has led to variations in policies and procedures. For instance, the use of brief therapies and group counseling are two methods employed to offset the increased number of clients (Murphy & Martin, 2004). However, many students need more assistance than traditional counseling services can provide (Medalie, 1987). Thus, the utilization of referral sources outside the institution is another way services are delivered to students in need (Cornish, Kominars, Riva, McIntosh, & Henderson, 2000).
CONCLUSION

In conclusion, counseling psychologists practice in a number of different settings and provide a vast array of services. A high percentage of counseling psychologists operate at the university level by providing direct counseling services to students. Roles and functions have evolved over the course of time to meet changing needs of the clients served. Today's counseling psychologists must be prepared to work with students experiencing severe psychological disturbances in addition to those experiencing normal developmental difficulties and vocational concerns. Limited resources and increased demands require practitioners to balance a busy schedule, become more efficient, and utilize brief forms of treatment. Just as they have in the past, campus clinics must continue to be flexible in adapting to with the changing dynamics of the student population and society at large.

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Positive Psychology and Cultural Sensitivity: A Review of the Literature
Amanda Kubokawa & Amber Ottaway

Abstract: This paper aims to address the cultural sensitivity of positive psychology. In 2000, Seligman and Csikszentmihalyi (2000) developed positive psychology, which focuses on individuals' strengths, in an attempt to move away from the emphasis on pathology within psychology. While the field attempts to capitalize on people's strong points, it does not portray all definitions of happiness and well-being that vary across cultures. A review of the literature shows that cultural differences exist in terms of peoples' values, emotions, and how they define the self. Careful review of the literature has provided evidence to support the lack of culturally based content within the field. As a result, the authors conclude that positive psychology is not culturally sensitive.

Within the field of psychology, it is imperative for professionals to be knowledgeable of individuals' cultural backgrounds in order to fully understand the sources of people's behaviors and worldviews. The lack of understanding of others' backgrounds may lead to misconceptions about the causes of their behaviors. In a society where the ideology of individualism prevails, it is only logical for professionals within the field to have a tendency toward attributing the responsibility of behavior to the individual, without fully taking into account the effects of the environment surrounding them. Therefore, individuals who do not subscribe to an individualistic framework may be negatively affected by theories that are based on such ideology. One consequence may be the unintended labeling of those individuals as possessing characteristics that are less than desirable, and engaging in behaviors that are deemed unproductive, and possibly unhealthy.

One new discipline within psychology that takes the overarching focus off of emphasizing people's weaknesses and treating psychopathology is referred to as positive psychology. In general, positive psychology aims to study individuals' strong points, and their attainment of happiness and well-being (Seligman & Csikszentmihalyi, 2000). Although one may view this new field as opening up the possibility to cross-culturally address the positive characteristics of all individuals, positive psychology has been accused of upholding an individualistic framework, which has effected how researchers study well-being in all persons. In order to assess whether positive psychology is culturally sensitive, it is necessary to define the concept of cultural sensitivity.
CULTURAL SENSITIVITY

The aspects of cultural sensitivity consist of knowledge, consideration, understanding, respect, and tailoring (Foronda, 2008). In order for one to be culturally sensitive, one must have knowledge of cultural differences and values of other individuals (Center For Effective Collaboration and Practice, 2002). Cultural sensitivity also comes from the understanding that one’s background, values, and biases must be initially considered so one is able to recognize how these may affect their perceptions of others (Al-Krenaw & Graham, 2000). The third essential aspect of cultural sensitivity is that an individual must understand the importance of another’s beliefs and experiences (Guberman & Maheu, 2004). Respect refers to the appreciation and regard that one shows for the experiences and values of another human being. The last attribute of cultural sensitivity is tailoring, which encompasses the idea that a change or adaptation of one’s worldviews to consider another person’s or to meet someone else’s needs is essential in becoming culturally sensitive. In other words, one may have to tailor his or her own beliefs in order to see the perspective of another’s (Foronda, 2008).

FRAMEWORK OF POSITIVE PSYCHOLOGY

Positive psychology, founded by Martin E. P. Seligman and Mihaly Csikszentmihalyi, is a relatively new field that has emerged with the focus of emphasizing the strengths of individuals (Seligman & Csikszentmihalyi, 2000). This perspective aims to shift away from the disease model, which has dominated the field of psychology since the end of World War II. The disease model concentrates on treating pathologies within human functioning rather than acknowledging positive characteristics that individuals possess. Within positive psychology, it is just as vital to ask “What is right about people?” as it is to ask “What is wrong with people?” (Snyder & Lopez, 2007).

Within the field, four basic personal traits are recognized as contributing to positive psychology: subjective well-being, happiness, optimism, and self-determination (Seligman & Csikszentmihalyi, 2000). Subjective well-being refers to what people think and feel about their lives. Subjective well-being is a scientific term for what people typically refer to as happiness. Optimism is seen as a character trait that mediates between external events and people’s perceptions of them. Individuals high in optimism have been found to have better moods and be more physically healthy. Self-determination applies to the need for individuals to feel competent, to feel that they belong, and to be autonomous. Furthermore,
positive psychology seeks to explore valued experiences on the subjective level encompassing an individual’s past, present, and future (Seligman & Csikszentmihalyi, 2000).

Positive psychology breaks down subjective experiences and assesses: well-being, contentment, and satisfaction in the past; flow and happiness in the present; and hope and optimism for the future (Seligman & Csikszentmihalyi, 2000). The founders of positive psychology identified specific positive traits within individuals which include: "the capacity for love and vocation, courage, interpersonal skill, aesthetic sensibility, perseverance, forgiveness, originality, future mindedness, spirituality, high talent, and wisdom" (Seligman & Csikszentmihalyi, 2000, p.5). Another aspect of positive psychology places individuals in a societal context and focuses on their position within the community. These desirable traits include: "responsibility, nurturance, altruism, civility, moderation, tolerance, and work ethic" (Seligman & Csikszentmihalyi, 2000, p.5).

After addressing the main concepts within the field, it is apparent that the framework is based on strengthening the self. Although this seems like a groundbreaking and necessary addition to the field of psychology, it has arrived with mixed reactions. The main criticism of the discipline is that it does not take into account how the self is defined in other cultures. If people from all backgrounds are to benefit from the findings in the field, then the structure of the field cannot be built upon theories that are only supported within European American culture. This is just one of the criticisms that will be addressed in the following paragraphs.

MULTICULTURAL IMPLICATIONS FOR POSITIVE PSYCHOLOGY

Christopher and Hickinbottom (2008) scrutinized positive psychology, stating it was founded on ethnocentric ideals and an individualistic framework. There are many aspects that appear to contribute to the framework of positive psychology, such as promoting the independent self, happiness and positive emotions, and core values. The overarching problem of this foundation is that not every culture views these facets of life with the same perspective. The entire structure of positive psychology is founded on Western assumptions that are thought to lead to a better life. Therefore, if one does not embody the characteristics of individualism and self-efficacy, he or she may not meet our Western conceptualization of happiness.
The Self across Cultures

Positive psychology is based on the issue of developing the self, but the self does not hold the same meaning across cultures. In Western societies, the self is seen as independent and autonomous; whereas the self in collectivistic cultures is seen as interdependent and dutiful. For example, a revered individual in East Asian societies would be dutiful to their parents and elders, which would show that he or she possessed a high level of maturity and good character (Hoshmand & Ho, 1995). On the other hand, an individual from Western societies would view duty and obedience as a restraint to reaching one’s potential (Christopher & Hickinbottom, 2008). The ideology of individualism is so engrained in the minds of Westerners that it is assumed that other nations idealize independence and autonomy as well. In fact, individualistic societies only account for about 30 percent of the world’s population (Triandis, 1989). Reaching self-efficacy in Western cultures is seen as a pathway to the fundamental goal of happiness (Christopher & Hickinbottom, 2008).

Emotions across Cultures

Delving deeper into happiness and what it means, it is not only important to ask how one attains happiness, it is necessary to ponder if happiness is a priority in every culture (Snyder & Lopez, 2007). In Western cultures it is implied that everyone is in the pursuit of happiness, but this goal is not culturally universal. Ahuvia (2001) posited that “Westerners tend to see individual happiness as the ultimate motivation underlying all action” (p.77). In fact, most citizens of collectivistic cultures value and act in accordance to social expectations and honor to their elders more than they seek individual happiness (Ahuvia, 2001).

Along with the emotion of happiness, individualistic and collectivistic cultures differ in their views of positive and negative emotions (Christopher & Hickinbottom, 2008). For example, Western cultures view self-criticism in a negative light, while several collectivistic cultures use self-criticism positively to strengthen character and align with societal expectations (Heine et al., 2001). Chang (1996) conducted a study that examined optimism and pessimism in Asian Americans and Caucasians. In the study, the results showed that Asian Americans were significantly more pessimistic than Caucasians, but there was no difference between levels of depressive symptoms. Therefore, the author concluded that pessimism does not necessarily relate to depression in Asian cultures as it does the Caucasian culture. Overall, a number of negative emotions in Western cultures are perceived positively in East Asian cultures; these
emotions are viewed as a catalyst for improvement and growth (Christopher & Hickinbottom, 2008). It is evident that emotions are not universally positive or negative, which leads to strong implications for the utilization of positive psychology across cultures.

Values across Cultures

It is clear that emotions do not have the same universal meanings, and the same argument can be made for valued personal traits. According to Peterson & Seligman (2004), there are six universal virtues that all cultures hold in high regard: courage, justice, humanity, temperance, wisdom, and transcendence. Of these six virtues, the authors created a subset composed of 24 sought after strengths, known as the Values in Action (VIA) Classification of Strengths. Christopher and Hickinbottom (2008) questioned these “universal” strengths by positing that commonalities can be found if that is what one is seeking. They criticized the fact that Peterson and Seligman only looked for commonalities – the creators of the VIA Classification of Strengths identified common values, but ignored the understanding of the values. Christopher and Hickinbottom (2008) conclude that instead of providing a better understanding of different cultures, Peterson and Seligman oversimplified them. They stated that the 24 desirable strengths may include other cultures, but the meanings of the strengths are still Western-oriented.

MULTICULTURAL IMPLICATIONS OF POSITIVE PSYCHOLOGY

Christopher and Hickinbottom (2008) made the bold statement that “positive psychology is doomed to being narrow and ethnocentric as long as its researchers remain unaware of the cultural assumptions underlying their work” (p.565). To attend to this issue, researchers and practitioners are slowly making shifts in order to decrease the egocentrism of the positive psychology approach and develop a more culturally sensitive model (Snyder & Lopez, 2007). The theory of positive psychology is inherently based on Western views and ideologies, which is a problem needing to be addressed. However, as Christopher and Hickinbottom (2008) stated, a deeper problem lies within the researchers (and practitioners) themselves. The people that embody the field of positive psychology need to be put under a microscope just as much as the theory itself does.

Taking a closer look into the approaches of positive psychologists, it is vital to examine how the professionals view culture in relation to positive
psychology research and practice. Snyder and Lopez (2007) described an ongoing debate among positive psychology professionals that has yet to be resolved. The debate surrounding culture asks the question if positive psychology is culture-free or culturally embedded. Professionals supporting the culture-free mentality believe that positive psychology is objective and universal. Therefore, culture is not seen as an issue and it does not play a role in their research or practice. Positive psychologists subscribing to this approach consider happiness as the guiding force in the lives of people everywhere. While many positive psychologists are advocates of this model, there are many other professionals that think otherwise.

Professionals guided by the culturally embedded perspective believe that it is unwise to ignore cultural influences and values (Snyder & Lopez, 2007). The culturally embedded approach takes into account that not every culture values the same strengths or follows the pursuit of happiness. Also, professionals following this model realize that researchers and practitioners conduct their work based on cultural values and assumptions. Christopher and Hickinbottom (2008) exemplified this point by stating that no form of psychology is free of either culture or values. Christopher (2005) insists that ethnocentric conclusions can be prevented if professionals think in a culturally sensitive manner, instead of denying the existence of cultural differences. Christopher also stresses that professionals in the field of positive psychology should recognize their own values and moral visions in order to understand perspectives from other cultures. Suggestions for positive psychologists, researchers, and practitioners to become more culturally sensitive are stated a great deal in many forms of literature, but it is necessary to examine whether these suggestions are being utilized.

CONCLUSION

While it is clear that the theory of positive psychology is innovative and ground-breaking, the values and ideologies of the field need to be examined more closely. Western ideologies and assumptions underlie the entire foundation of positive psychology, which makes research and practice almost impossible to transcend to non-Western cultures. Different cultures define the self in various ways, experience emotions differently, and have an array of diverse values. Positive psychologists have attempted to put the field in a multicultural context, but the field is still far from attaining cultural sensitivity. There are aspects within the field of positive psychology that can be adjusted to include non-Western cultures, but the main problem of cultural sensitivity lies within the positive psychology professionals.
While there are many professionals in the field of positive psychology that consider culture when they are in practice or conducting research, there are a significant number of professionals that subscribe to a culture-free approach. Denying cultural perspectives can be detrimental; it is ignorant to think that culture does not play a role in values or ideologies. The field needs to implement aspects of cultural sensitivity, but this sensitivity needs to start with the professionals first. As stated earlier, Christopher and Hickinbottom (2008) emphasized that researchers are at the heart of the cultural sensitivity issue. Professionals need to be aware of their cultural assumptions, because ultimately those assumptions will influence their work. Furthermore, if individuals from all cultures are able to benefit from the findings of this field, professionals are obligated to alter the framework in order to incorporate all cultures’ viewpoints on happiness and well-being.

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Identity Development Throughout the Lifetime: 
An Examination of Eriksonian Theory
Justin T. Sokol

Abstract: The purpose of the current article is to review identity development from a lifespan perspective. To accomplish this task, identity development is examined at various developmental stages including childhood, adolescence, and adulthood. The article utilizes Erik Erikson’s psychosocial theory of development to investigate identity development throughout the lifespan. Research findings from empirical studies are included within this discussion. It appears that for many individuals, identity development is a lifelong process that extends well beyond the years of adolescence.

The influential writings of Erik Erikson (1902-1994) have stimulated over 50 years of social science literature (Schwartz, 2001). His theories on development have inspired countless research studies making him an especially relevant figure in the field (Kroger, 2007). Erikson wrote at length about identity, focusing mainly on the period of adolescence. However, he did offer insights on identity during both childhood and adulthood. Traces of his theories can be found in almost all forms of identity research. Therefore, it is appropriate to investigate this topic from his perspective.

The purpose of this study is to examine identity development from a life-span perspective. The article will begin with a description of Erikson’s psychosocial theory of development. Next, attention will be given to identity development during childhood, adolescence, and adulthood. Each of these three sections will include a description of Erikson’s theories; empirical studies will also be presented to help illustrate the process of identity development. Finally the article will close with a brief evaluation of Erikson’s identity theory and comments will be offered for future research. Before starting, a few words are in order regarding terminology.

In reviewing the literature on identity, there is very little agreement on how identity is defined (Bosma, Graaësma, Grotevant, & de Levita, 1994). Erikson alone used a variety of identity related terms (identification, identity formation, identity development, identity consolidation, identity foreclosure, and identity resolution) without providing a great deal of explanation (Hoare, 2002). As a result, he has been heavily criticized for his ambiguous style of writing. The current article will utilize fewer terms in an effort to convey a clear message. Therefore, “identity development” will describe the overarching process of development, particularly during the adulthood years. “Identification” will be used to describe development during childhood and “identity formation” will apply to development during adolescence.
ERIKSON’S PSYCHOSOCIAL THEORY

Erik Erikson’s psychosocial theory revolutionized developmental thought (Hoare, 2002). He was one of the first to propose a life-span model of human development which included eight successive psychosocial stages. Each stage is associated with an inherent conflict or crisis that the individual must encounter and successfully resolve to proceed with development. It is worth noting that Erikson (1968) used the term crisis “in a developmental sense to connote not a threat of catastrophe, but a turning point, a crucial period of increased vulnerability and heightened potential” (p. 96). The assumption is that each psychosocial stage has both a successful and unsuccessful outcome (e.g. trust versus mistrust, initiative versus guilt, intimacy versus isolation). Resolution of earlier stages is believed to directly affect the resolution of later stages (Marcia, 1993). Erikson (1968) summarizes with the following statement:

I shall present human growth from the point of view of the conflicts, inner and outer, which the vital personality weathers, re-emerging from each crisis with an increased sense of inner unity, with an increase of good judgment, and an increase in the capacity ‘to do well’ according to his own standards and to the standards of those who are significant to him. (pp. 91-92)

Erikson goes on to say “The use of the words ‘to do well’ of course points up the whole question of cultural relativity” (p. 92) which highlights the emphasis he placed on sociocultural factors.

Erikson continues to receive a great deal of credit for recognizing the influence of culture on development (Hoare, 2002). He was the first to illustrate how the social world exists within the psychological makeup of each individual. Erikson (1959) believed that the individual cannot be understood apart from his or her social context. “Individual and society are intricately woven, dynamically related in continual change” (p. 114). This is a theme that permeates throughout all of Erikson’s eight developmental stages and is especially relevant to the fifth psychosocial stage (identity versus role confusion) which occurs during adolescence. Before examining this developmental task, it is important to recognize what Erikson meant when he used the term “adolescence.”

Erikson (1968) considered adolescence to be a transitional period of development following childhood and leading into adulthood. Unfortunately, he never defined a range of chronological ages for adolescence or other periods of life such as childhood and adulthood (Waterman, 1993). He also wrote in an era when attending college was less common than it is today; this has direct implications because of the
emphasis he placed on vocational identity. It can be hypothesized that Erikson’s version of adolescence refers to an age period roughly associated with middle and high school: ages 12 through 18. Arnett (2000) has since proposed a period of development referred to as emerging adulthood which encompasses the years beyond high school: ages 18 through 25. Identity development is an inherent component of emerging adulthood and there appears to be considerable overlap with the social tasks of adolescence that Erikson describes. Because this stage may be more relevant to what Erikson initially termed adolescence, it will be integrated with the hypothesized age ranges. Thus, adolescence will refer to the large span of ages 12 through 24 for the current study. It is equally important to operationalize age ranges for the other developmental periods that will be discussed. Childhood will include ages 6 through 11, young adulthood will include ages 25 through 39, middle adulthood will include ages 40 through 65, and late adulthood will consist of the years beyond age 65. Although Erikson (1968) believed identity formation is the focal point of adolescence, it seems logical to begin from the start with a discussion of childhood development and then proceed through both adolescence and adulthood.

**Identification in Childhood (Ages 6-11)**

The process of identity development begins much earlier than adolescence. Erikson (1968) believed that seeds of identity are planted at a young age when the child recognizes himself/herself as a unique being, separate from his/her parents. As maturation occurs, the child takes on characteristics and admired features of parents or significant others. Erikson called this process identification. Identification allows the child to build a set of expectations about what he or she wishes to be and do. However, the child eventually loses interest in merely adopting the roles and personality attributes of parents or significant others; it is at this point that the process of identity formation is set in motion.

According to Erikson (1968), identity formation begins when the usefulness of identification ends. Taking on characteristics of others no longer provides satisfaction; the individual experiences a desire to shape his or her world in unique ways. Identity formation begins with a synthesis of childhood skills, beliefs, and identifications into a coherent, unique whole that provides continuity with the past and direction for the future (Marcia, 1993). Erikson did not discuss identity development during childhood at great length. Alternatively, he offered great detail about the process of identity formation during adolescence.
Identity Formation in Adolescence (Ages 12-24)

Erikson (1968) believed the primary psychosocial task of adolescence is the formation of identity. Therefore, he called the developmental conflict identity versus role confusion. There are several contributing factors to the formation of identity. The onset of puberty during adolescence leads to newfound cognitive skills and physical abilities (Kroger, 2004). In addition, increased independence and autonomy leads to greater interactions with neighborhoods, communities, and schools. According to Erikson (1968), this allows the individual to explore vocations, ideologies, and relationships. He gave particular attention to the career domain, stating “In general, it is the inability to settle on an occupational identity which disturbs most young people” (Erikson, 1968, p. 135). New expectations of adult responsibilities are gradually assumed as the adolescent matures. With adulthood on the horizon, eventually the twin identity questions emerge: “Who am I?” and “What is my place in this world?” (McAdams, Josselson, & Lieblich, 2006). When the individual is able to assess their personal attributes and match these with outlets for expression available in the environment, Erikson (1963) would say identity has been formed. However, when the individual is unable to manage this developmental task, role confusion occurs.

From Erikson’s perspective, identity refers to a sense of who one is as a person and as a contributor to society (Hoare, 2002). It is personal coherence or self-sameness through evolving time, social change, and altered role requirements. The formation of identity is a major event in the development of personality and associates with positive outcomes (Marcia, 1993). Identity provides a deep sense of ideological commitment and allows the individual to know his or her place in the world (Hoare, 2002). It provides one with a sense of well-being, a sense of being at home in one’s body, a sense of direction in one’s life, and a sense of mattering to those who count (Erikson, 1968). Identity is what makes one move with direction; it is what gives one reason to be. Erikson clearly believed that having a solid sense of identity is crucial to further development. However, not all people successfully resolve this developmental task.

Role confusion can lead to a very different human experience. It causes the individual to seriously question one’s essential personality characteristics, one’s view of oneself, and the perceived views of others (Bosma et al., 1994). Consequently, the individual experiences extreme doubt regarding the meaning and purpose of their existence, leading to a sense of loss and confusion. Due to changing physical, cognitive, and social factors, nearly all adolescents experience some form of role
confusion (Kroger, 2004). However, most actively resolve these issues and progress towards later developmental stages.

In summary, Erikson (1968) believed that adolescence is a time in which identity normally becomes the focus of concern. Research appears to support this notion by indicating that the most extensive advances in identity development occur during the college years (Waterman, 1985). Major gains are expected during college as students make important decisions that pertain to various life domains including occupation, friendship, romantic relationships, and religious or political beliefs (Waterman & Archer, 1990). “College environments provide a diversity of experiences that can both trigger considerations of identity issues and suggest alternative resolutions for identity concerns” (Waterman, 1993, p. 53-54); Erikson would certainly agree. However, not all individuals attend college and have the opportunity to explore the aforementioned identity domains. Even for those who do, is it realistic to think that they will make commitments in these areas that will remain unchanged throughout life? It is for these reasons that identity development beyond adolescence will now be discussed.

Identity Development in Adulthood (Ages 25 and Beyond)

Erikson held that identity development does not end with its formation (Hoare, 2002). He viewed it as an ongoing process that captures one’s investments throughout the long years of adulthood. Thus, identity development is both a normative period of adolescence and an evolving aspect of adulthood. In contrast to Erikson’s extensive writings on the adolescent identity formation process, he did not offer detailed comments regarding identity’s evolution throughout the adult life (Kroger, 2007). As a result, he has been criticized for extending his theory beyond adolescence without providing much detail. To complicate matters further, Erikson conveys contradictory messages speaking on identity development beyond adolescence. According to Erikson (1968), the final identity is “fixed at the end of adolescence” (p. 161). He suggests that identity concerns fade as issues of intimacy (followed by generativity and ego integrity) become the main focus. Alternatively, Erikson proposed that identity-defining issues of adolescence do not remain fixed; they retain flexibility for modification throughout the adulthood years due to new life experiences. Clearly these two statements appear contradictory; this is why it is difficult to assess identity development beyond adolescence from his perspective. Thankfully, others have picked up where Erikson left off.

There appears to be a considerable scope for identity development beyond adolescence (Kroger, 2007). The identity-defining domains of
meaningful vocational, political, religious, interpersonal, and sexual choices remain key foundational issues during young adulthood (ages 25-39). Vaillant and Milofsky (1980) suggest that young adulthood is a time of developing and consolidating goals, particularly in the areas of career and family. On top of implementing a vocational pathway, the demands of partnering (and possibly parenting) raise new issues for many young adults. Research has indicated that in transitioning from young to middle adulthood, both men and women frequently change their values, goals, what they find important in life, and what they are generally striving towards (Harker & Solomon, 1996).

Identity related issues continue to emerge during middle adulthood (ages 40-65). During this time period, individuals begin to reclaim opposite-sex qualities and experience a shift in perspective on time (Kotre & Hall, 1990). Women tend to take on more masculine characteristics while men take on more feminine characteristics (Huyck, 1990; James, Lewkowicz, Libhaber, & Lachman, 1995); in addition, the reality that life is “half finished” begins to sink in. It is not uncommon for individuals to reevaluate, refine, and readjust vocational and social roles during middle adulthood (Kroger, 2007). Changes in life circumstances can also cause a reexamination of identity issues (Waterman, 1993). Midlife career changes, geographic relocations, resuming one’s education, divorce, remarriage, death of loved ones, and adoption are all viable possibilities for middle adulthood. Finally, the commonly used phrase “midlife crisis” is often associated with identity related issues, although research indicates that this is an infrequently occurring event (Berk, 2007).

Examination and evaluation are two words synonymous with continued identity development in late adulthood (ages 65 and beyond). Retirement allows the individual to reflect upon the choices that have been made throughout the course of life. Reviewing one’s life in a positive manner allows the individual to experience satisfaction. Alternatively, a negative life review can leave the individual with feelings of regret. Kroger (2002) conducted one of the few studies on identity revision and maintenance processes during late adulthood. Results showed that important identity processes included reintegrating important identity elements from younger years, rebalancing relationships and other social roles, readjusting to loss and diminished physical capacities, and finding life meanings. The argument could be made that identity development is still just as much an issue in late adulthood as it is earlier in life.
CONCLUSION

In summary, Erikson’s psychosocial theory is composed of eight developmental stages which span throughout the course of life. Each stage presents the individual with an inherent task or conflict that they must successfully resolve to proceed with development. Erikson placed a great deal of emphasis on sociocultural factors because he believed these strongly influence development. Such factors are especially relevant in the process of identity formation. Erikson believed that childhood identifications lay the groundwork for identity formation in adolescence. The process of forming an identity involves creating a coherent sense of self and who one is in relation to the world. Adolescence represents an optimal time for identity development due to a variety of physical, cognitive, and social factors. Although Erikson believed identity was largely “fixed” by the end of adolescence, he did suggest that identity continues to evolve throughout adulthood. Unfortunately, he did not give great detail on what this process looks like. Research shows that identity development continues to be an ongoing process throughout adulthood. Just as in adolescence, vocations, ideologies, and relationships continue to remain important identity issues. Several studies have been presented to support this notion.

Much like forming an identity, reviewing the literature on this nebulous topic is no small task. As discussed earlier, researchers use a variety of terms and phrases when describing the process of identity development. It is also difficult to find continuity with regards to developmental periods and associated ages. A strong effort has been made to use terminology that connects Erikson’s work with more recent empirical studies in a manner that is understandable and coherent. It would be wise for future researchers to use agreed upon terms and definitions so as not to confuse readers and fellow colleagues. No matter what you call it, identity development is a major psychosocial task and one that appears during many phases of life. Although Erikson may not have been clear regarding identity development beyond adolescence, we will always be indebted to him for the great deal of discussion and conversation he has stimulated on this intriguing topic.

REFERENCES


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