

Content

- 3 Letter from the Student Editors
- 4 Letter from the Faculty Editorial Supervisor
- 5 The Psychology of Immigration: Mental and Behavioral Needs of Immigrant Families With Deaf Children
Hannah A. Joharchi, Carolyn A. Corbett, and Caroline M. Kobek Pezzarossi
- 10 Social Perception Toward Deafness: How May it Influence Deaf Identity Development and the Deaf Community
Gregory Farber
- 14 The Artist - Painting the Destruction of Love and Lost. A Case Conceptualization
Amarilys Galloza-Carrero
- 20 Resilience as a Verb or a Noun: A Literature Review
Heather G. Zimmerman
- 27 Psychological Adaptation and Identity Change After the Acquisition of a Physical Disability in Adulthood, a Critical Analysis of an Autobiography
Joanna Dziura
- 38 Trauma-Focused Cognitive Behavioral Therapy: An Evidence Based Practice Applicable With Minority Children
Amanda Strasser
- 43 Influence of Post-Formal Thought on Intellectual Testing
Kaitlin Brown
- 46 A Proposed Model for the Construction of Higher Order Cognitive Processing and Application to the Development of Anxiety Disorders
Nicholas M. Gala
- 51 Editorial Staff
- 52 Our Reviewers
- 53 Instructions to Authors

Letter from the Student Editors:

We are happy to announce that after several months of hard work, we can finally welcome you to the third edition of the *Gallaudet Chronicles of Psychology*. Originally, this journal was created in 2007 by two graduate students, **Elisabeth Adams** and **Melissa Anderson** as well as Professor **Patrick J. Brice**, who served as Faculty Editorial Supervisor. The *Chronicles* was created as a place where students can share their ideas, both research and theoretically oriented, with the Gallaudet community. The creators of the *Chronicles* hoped that it would become a journal reflecting the uniqueness of work, life, and learning that happens here at Gallaudet University and within the Deaf Community at large.

After two successful publications, the *Chronicles* became inactive for several years. Today, we finally see it reactivated and we hope that it will become an important part of the Department of Psychology for years to come. As we worked on this issue, we tried to stay true to the visions set upon by the first Student Editors, Elisabeth Adams and Melissa Anderson, now both alumnae of the Clinical Psychology PhD program. Our intention was to provide a learning forum where students would publish their conventional and creative work in relation to the field of psychology. While many of the writings reflect and parallel the research interests of the authors, some others may result of more subtle passions that are not as often pursued or published in professional journals. We feel that many of the wonderful ideas and works which are developed during the years of graduate study are becoming lost due to a lack of platform where they can be shared. We are hoping that reactivation of the *Chronicles* will irreversibly change that.

During the summer of 2014, the process of creating the third edition began. We sent our first call for articles asking our fellow students to submit a variety of writings related to psychology. We decided to seek any works that would fulfill the requirements of a professional publication regardless of its form. In addition, we started the search for the peer-reviewers. The results exceeded our most optimistic expectations - many students wanted to serve as reviewers and many others decided to send us their works. From the submitted articles, with the immense help of our invaluable reviewers, we decided to accept eight very diverse works. Thus, in this issue, you will find a varied range of styles from theoretical essays and case studies to a critique. First, the article of Ms. **Hannah Joharchi**, Professor **Carolyn Corbett**, and Professor **Caroline Kobek Pezzarossi** provides an intimate insight into the experiences of an immigrant mother with a deaf daughter and her struggles with the system and access to resources. Mr. **Gregory Farber** explores the influence of social perception towards the Deaf community and D/deaf individuals on the development of Deaf identity. Ms. **Heather Zimmerman** analyzes current research on resilience and the systemic influences on the resilience development in deaf and hard of hearing students. Ms. **Joanna Dziura** investigates the psychological struggles of people with late acquisition of disability. Ms. **Amarilys Galloza-Carrero** discusses the process and the challenges of clinical work faced by new therapists. Ms. **Amanda Strasser** examines the adaptations of Trauma-Focused Cognitive Behavioral Therapy to diverse populations. Ms. **Kaitlin Brown** discusses the impact of the Post-Formal Thought theory on intellectual assessment. Finally, Mr. **Nicholas Gala** presents his theoretical model of cognitive processing in anxiety disorders.

In our final words, we would like to thank those who contributed to the development of the third edition of the *Chronicles*. We could not have succeeded in accomplishing this task without the tremendous work of the authors and reviewers. We also want to give a very special thanks to Dr. Lori Day who has overseen this project since its beginning. We hope that you will find this issue interesting and that future issues will continue to present the fascinating works of our students.

Sincerely,

Joanna Dziura & Gregory Farber,
Student Editors-in-Chief

Letter from the Faculty Editorial Supervisor:

It has been my pleasure to be part of the newest edition of the *Gallaudet Chronicles of Psychology*. It has truly been a student-led effort from the beginning- starting with a student inquiry about reactivating this publication- and ending with student co-editors seeing it through to print. Part of the mission of the Department of Psychology at Gallaudet University is to instill in students a scholarly understanding of psychology and its application to the lives of deaf and hard of hearing persons through the production of scholarly works. The *Chronicles* is one avenue through which students can get hands-on experience with the process of producing scholarly works.

In my experience with talking to graduate students about research, the thought of publishing their work often feels overwhelming. While it is true that the publication process can often be laborious, like most things in life, the best practice is to dive in and get experience early in one's training. The aim of the *Chronicles* is to provide such an opportunity, while supporting the dissemination of both conventional and creative work that is so often budding in graduate students. The *Chronicles* aims to provide an atmosphere of collegial and supportive feedback to often first-time authors to orient them to the process of peer review and revising and resubmitting their work. Reviewers are provided with clear instructions and guidance on completing a peer review, giving them a critical lens through which they can then apply to their own research.

The publication of this third edition of the *Chronicles* was indeed a collaborative effort, including authors, student reviewers, and student co-editors. The co-editors, Ms. Joanna Dziura and Mr. Gregory Farber, deserve special recognition as they have been true leaders throughout this process. They have set the stage for the continued success of this publication. I encourage all psychology graduate students to consider getting involved in some aspect of future editions of the *Chronicles*, and I look forward to reading editions to come!

Sincerely,

Lori Day, PhD
Faculty Editorial Supervisor

The Psychology of Immigration: Mental and Behavioral Needs of Immigrant Families with Deaf Children

Hannah A. Joharchi, M.A.
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Department of Psychology

Access to mental health, medical, and educational resources for immigrant families with d/Deaf and hard of hearing children is becoming ever more important. The immigrant population in the United States has increased and is predicted to continue increasing in the near future (Bhaskar, Arenas-Germosen, & Dick, 2013; Pitkin & Myers, 2011). In 2011, parents who immigrated and children with recent immigrant roots consisted of 22.5% of the total population in the United States. Parents and children with recent immigrant roots are projected to be 30.5% of the total United States population in 2040. Moreover, the number of D/deaf and hard of hearing (DHH) children with recent immigrant roots is expected to increase (Gerner de Garcia, 1995). Currently, there is no research about how these families access medical, academic, and mental health resources. There is also no research exploring potential discrepancies in access to resources by immigrants compared to their American born peers. In 2011 the American Psychology Association (APA) Presidential Task Force on Immigration made a call for an evidence-based report. Subsequently, *Crossroads: The psychology of immigration in the new century* (2011) was developed to disseminate information regarding immigrants' health needs in the way of awareness, recommendations for improvements in policy and resources, etc. The following review of literature uses a social psychology lens to inform service providers (i.e. healthcare professionals, teachers, psychologists, etc.) how to best support deaf people from an immigrant background and their various experiences.

Keywords: Deaf, hard of hearing, immigrants, resources, access

American Families and Their Access to Resources

Information about hearing families and their access to resources with and for their D/deaf and hard of hearing children (DHH) is minimal. Research shows that parents want more opportunities to connect with professionals involved in their child's life and that they value and want more support from said professionals (Hintermair, 2006; Jackson, 2011; Jamieson, Zaidman-Zait & Poon, 2011). Moreover, research regarding minorities in the Deaf community indicates there may be a discrepancy in access to resources in comparison to their White counterparts (Rodda & Eleweke, 2002). The small amount of research that is available on this topic indicates that parents are open to more support from and contact with professionals. Finally, underserved populations within the Deaf community may face additional barriers when accessing resources making it

ever more pertinent for practitioners to become more aware.

Social Influence and Persuasion

When directed to follow instruction of individuals who seem like they are in power (e.g. someone wearing a lab coat) people typically obey (Milgram, 1963). Milgram's obedience study gives insight to how families might feel when consulting with professionals in a position of power. Immigrant families with DHH children may feel influenced by more than one social group and possibly overlapping or integrating social groups. For example, these families may belong to their Armenian social group, a Greek Orthodox group, and the Deaf community. These multiple societies have specific, and sometimes contradictory, rules, which members are required to follow, conform, or obey. In

addition, those in positions of power may not be knowledgeable about the options these families have or may not know how to best deliver these resources.

One transformative study exploring advocacy and American Sign Language (ASL) classes further researched this topic. The study included six parents all of which had recently emigrated from Mexico (five years or less) and had a deaf child (Balcazar et. al, 2011). The participants were taught ASL and training sessions concerning how to access resources and advocate for their deaf child. The training and advocacy sessions were taught in Spanish. Researchers conducted an interview and document review where they explored families' experiences in the advocacy sessions and at the service center. Furthermore, after one year of participating in the group at the service center, parents realized that they reached the maximum ASL level that the center offered.

Interviews revealed that parents were eager to continue in the ASL program and study, but the director of the center would not allow participants to continue in a higher level ASL course. Qualitative findings indicate that the director refused to match his center's services with their progression and did not believe they could continue learning a higher level of ASL because of their limited command of English. Moreover, the director threatened to tell the participants' employers and the United States Immigration and Naturalization Services (INS) that they were undocumented. Researchers found that participants' children experienced isolation from sports and activities at the service center. These findings highlight the struggles and complications multi-lingual families with DHH children might endure in the pursuit of access to resources and services for their deaf child. The director likely expected that participants would obey. Likewise, other health care and service providers may not be mindful of their power and people's obedience.

Additionally, research has shown that people who are given more time to develop a counterargument are typically more confident with their perspective (Tormala, Clarkson, & Petty, 2006). However, participants who had more time to think thought that they were right. When some of the participants were told that their argument was weak, they became less confident in their argument and were more vulnerable to subsequent persuasive attacks. The director's persistent denial of services may have made them doubt their attitude and become more vulnerable to persuasion. The resistance of persuasion can result in reduced strength of their initial stance on continuing to learn how to communicate with and support their child. Social influence is a powerful phenomenon especially when threats are made to inform INS of a family's non-legal status. While it was quite an unfortunate experience, the findings of this study illuminate barriers, prejudice,

misuse of power, and oppression that some immigrant families with deaf children experience.

Choice

Families with DHH children must often make multiple important decisions within a short period of time. For example, many families are prompted to get their child fitted with a cochlear implant. Service providers such as doctors and audiologists may present the cochlear implant as if it is the only choice. However, some families may feel bombarded with so many choices that it becomes overwhelming. Schwartz explained that too many choices tend to overwhelm people and that a choice between a few options is typically less overwhelming (2004). While a few options may be presented to families, it is those in power, usually physicians, who decide which one to present. Joharchi (2013) analyzed the impact of a limited amount of polarizing options on an immigrant parent with a Deaf daughter. The participant shared her experience and feelings about her access to resources and stories of her Deaf child. Moreover, she shared her experiences regarding cochlear implants. The mother opted toward providing her daughter with a cochlear implant, while her daughter refused.

This mother felt there were two polarizing and mutually exclusive options: using ASL or receiving an implant. Moreover, the participant reflected that she did not feel that doctors understood the meaning of this decision for her and her daughter or impact it will have on their lives. The mother stated that after her daughter refused to attend a consultation with the doctor, she understood her daughter that has decided against attempts to make her a "hearing person" and pro Deaf culture. The participant expressed that since then, she fought many battles with her daughter's school regarding speech therapy sessions. Their final choice against the cochlear implant made the participant feel that speech therapy was something she also did not want. As a result, the mother felt that she and her daughter had only two choices – cochlear implant or ASL, but she also felt that the school limited her daughter's choices as well.

Attitudes and Beliefs

The participant in this case study also raised a novel concern. Rather than facing barriers to access resources due to language differences (which was expected based on previous studies) the mother discussed cultural differences. She admitted that for some immigrants language barriers may be important, but that in the case of her family, it was cultural differences that made it difficult to access resources with both the medical doctors and the school. One of the goals of the evidence-based report, *Crossroads: The psychology of immigration in the new century* was to increase

practitioners' awareness regarding the cultural differences. However, to this date, there is no research analyzing the relationship between medical doctors and their awareness or sensitivity towards the needs of DHH immigrants and their families. The case study above suggests that there is a need to further research the discrepancy of beliefs and expectations regarding medical services between professionals and families.

Stereotypes

Although the participant in Joharchi's case study suggested that doctors, teachers, and speech pathologists did not understand her culture and this made adaptation to her daughter's hearing loss much more difficult for her, their issue may be more complicated. Findings from social psychology and social cognitive theories highlight that humans use schemas as a mental model of the world (Piaget, 1932). As such people rely on those schemas to help them to perceive what is experienced. When a new phenomenon does not fit their schema, in most cases people will adjust their previous schema. According to Piaget, the theory of accommodation explains how children seek new knowledge to adjust their understanding when something does not match their current schema. In general, people refer to and rely on their cognitive schemas to process sensory input and social situations. Cognitive schemas may inform people of something derogatory or make people fearful toward someone or some group without just reason.

Schemas and stereotypes are similar in that people automatically refer to them to reduce their cognitive load and optimize processing. The prototype model suggests that people have specific thoughts and beliefs about an out-group's behavior (Zarate & Smith, 1990). People form a conclusion about a person from an out-group based on the person's group membership. Because of that phenomenon, immigrant families may experience attitudes and prejudice from American's stereotyping behaviors. As such, this likely becomes an additional barrier for DHH child as well as their immigrant parents.

When immigrant families feel that their relationship with a service provider is a struggle, one of the reasons may be related with the type of stereotypes held by the provider. Findings from social psychology inform people about the stereotype threat. A parent or caretaker may recognize that they are being perceived according to a stereotype and work to conform or avoid said stereotype. As such, they may become distracted from a task and perform worse than if they would not have felt the need to conform to a stereotype. Perhaps the best way to reduce stereotype threat with service providers is to increase their experience with multicultural families. Service providers may best improve their perception by expanding their limited experience with cultural awareness training.

Exclusion

Society has groups from which they might exclude others or out-group members. Social exclusion is correlated with feelings of loss (Molden, Lucas, Gardner, Dean & Knowles, 2009). Moreover, social exclusion is correlated with diminished defenses or ability to react to future challenges. Actively ensuring that someone does not enter a group or socialize with one's group as well as passively or unintentionally excluding someone are both associated with feeling left out. Some immigrants in the Deaf community express this feeling of loss related with being excluded. Likewise, the participant in the case study also described feeling left out from the group of American parents at school with deaf children. Immigrant families with DHH children may face exclusion. They may feel that they do not belong with their American peers with DHH children or with American peers in general. Moreover, they also may feel that they are no longer part of their home nation. It is important that this feeling of loss is identified.

Close Relationships

In the Joharchi case study, the participant's description of her mother-daughter relationship and her daughter's relationship with their nuclear family involved closeness, emotions, and attachment. Close relationships involve interacting with and influencing one another (Fiske, 2010). A reoccurring theme seen in the participant's transcript was feelings of pride for her daughter. Moreover, the participant asserted that many family members learned some sign language so that they could communicate with the participant's daughter. She expressed looking forward to her daughter's next visit home and shared how the family would prepare for these visits. This participant described their mother-daughter relationship as especially close.

While immigrant families may experience external stressors such as moving, finding employment, etc., there is evidence that these families may in fact be more resilient despite oppression and stressful situations. In the interview with the participant from the case study, she suggested that there were many stressors, but she and her husband created a loving and enriching environment for her daughter despite culturally insensitive care providers.

Prosocial Behavior

Helping others is another aspect to consider when evaluating immigrants' access to resources for and with their DHH children. Findings suggest that people have more empathy for those they perceive as within their group (Sturmer, Snyder, & Omoto, 2005). This could be used to benefit families with DHH children and is often a strategy used by organizations such as Hands and Voices, which created one in-group that aims to include all parents with DHH children. Much of the work that

comes from this group is of the prosocial nature. However, what can groups such as Hands and Voices do to be more welcoming to parents from marginalized backgrounds? Some organizations such as the Clerc Center have made videos with American Sign Language, English captions, and Spanish or Mandarin voice interpretation. Because people have more empathy and a tendency to help those who they perceive as part of their own group the in-group for families seeking resources includes immigrant families. Resource centers such as the Clerc Center recognized that the inclusion of these families is important and that they have unique and different needs such as voice interpretation in a variety of languages. Maintaining and using close relationships and prosocial behaviors within their communities may continue to benefit immigrant families with DHH children. Furthermore, immigrant's resilience may be utilized in practice with psychologists and teachers.

Conclusion

As the immigrant population increases over the next few decades, it is imperative that people become more informed about immigrants and their access to resources. It is likely necessary to assess any potential discrepancies regarding access to resources by immigrants compared to Americans. This paper has been developed to address the growing need for more informed practice with immigrants in the Deaf community. The review of literature from a social psychology lens is intended to provide a comprehensive discussion that is available to a variety of practitioners. To accommodate the general call for more information regarding the psychology of immigration and the increasing number of DHH people with immigrant roots, more research must be conducted.

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Hannah Joharchi, M.A., has Masters of Arts degrees from Pepperdine University's General Psychology program and California State University's Negotiation, Conflict Resolution, and Peacebuilding program. Joharchi is currently a fourth year clinical psychology student at Gallaudet University. She is also a Clinical Extern at Children's National Medical Center where she works with adolescents as their individual therapist and in family and group settings. Joharchi's scholarly work focuses on Deaf immigrants and their children with immigrant roots and sexual wellbeing in the Deaf community (i.e. *Deaf Immigrants and Their Access to Resources* and *A Glimpse at American Deaf Women's Sexuality*). Most recently, Joharchi presented on issues of ontology and neuroethics in the Deaf community at Brain Matters! Vancouver: Brain Science and Social Responsibility.



Carolyn A. Corbett, Ph.D. worked at Gallaudet University since 1988. She was first employed as a psychologist in the University Counseling Center. In 1993, she joined the faculty of the doctoral program in Clinical Psychology. Dr. Corbett's dissertation research was on factors which influenced retention and academic persistence of African American Deaf college students. Her current research interests are in the areas of mental health issues of minority deaf individuals, appropriate psychological assessment of minority Deaf clients, and ethical issues important when conducting research in small communities. Dr. Corbett's research team has projects including high risk behaviors in Deaf adolescents, emotional experiences of Deaf college students, HIV/AIDS in the Deaf community and resiliency in Deaf trauma survivors.



Caroline Kobek Pezzarossi, Ph.D, has worked at the local, state, and federal level in rehabilitation and mental health fields. Her background includes delivery of direct care as a counselor for people who are deaf or hard of hearing. Dr. Kobek Pezzarossi has taught a wide range of individuals. Her strong background in independent living skills as well as psychology has provided her the opportunity to work with individuals in becoming productive members of society. As an Associate Professor of Psychology, she has taught a variety of courses at the undergraduate and graduate level and participated in projects supporting career development, health literacy and diversity initiatives. She has contributed to issues of concern for people with disabilities. Dr. Kobek Pezzarossi's research interests are cultural interactions and communication, intimate partner violence in the Deaf and hard of hearing population and therapeutic interactions.



Social Perception Toward Deafness: How Could it Influence Deaf Identity Development and the Deaf Community

Greg Farber, B.A.

Department of Psychology

Social perception toward the deaf community as well as deaf individuals plays an influential role in a Deaf* individual's identity development. The hearing population's social attitudes and stereotyped views toward the deaf population generally foster a negative bias, causing development of different standards for deaf individuals (McCaughey and Strohmer, 2005). There is also a great deal of diversity of attitudes among the D/deaf population itself. Similarly as their hearing counterparts, D/deaf individuals also have different attitudes toward the Deaf community. This article investigates factors contributing to adaptation and positive Deaf identity development of deaf students who are newly exposed to the Deaf community upon entry to a University with a major deaf student body (e.g., Gallaudet University, Rochester Institute of Technology, and California State University-Northridge).

Keywords: attitudes, deafness, social perception, Deaf community, Deafhood

Research have shown that individuals from minority populations often are faced with the challenge of dealing with their various identities as well as their "multiple-minority statuses and achieving self-actualization in the form of identity" (Leigh, 2009, p. 144). Like individuals from minority populations, deaf individuals are challenged with integrating their deaf identity with their other identities (e.g., ethnicity, sexual orientation, etc.). Research has found that deaf individuals who are "able to come to terms with their double-or triple minority status and find communities of acceptance have a greater chance of ascribing pride to the diverse identities they integrate into themselves" (Leigh, 2009, p. 145). Considering this research, what could the deaf community, a minority population that treasures its cultural heritage and language, American Sign Language (ASL), do to foster and facilitate positive Deaf identity development in deaf children? Furthermore, how may Deaf individuals and the Deaf community adapt to the current social changes threatening their existence, such as rapid development of audiological technology and decrease in number of residential deaf schools due to the implementation of mainstream programs? How can the Deaf community make incoming deaf students with no previous Deaf experiences feel invited and welcomed? The author postulates that the Affect-Behavior-Cognition framework allow us to better understand how one's

social perception comes to be and how it potentially can influence the development of a Deaf identity.

Affect-Behavior-Cognition

What is affect? Affect is the feelings that individuals experience as part of their daily lives, which is experienced in the form of mood and emotions. An individual's mood refers to their positive or negative feelings that are in the background of their everyday experiences. On the other hand, one's emotions are a natural instinctive state of mind deriving from one's circumstances, mood, or relationships with others which involve conscious experience, physiological changes, and expressive behaviors that shows what one's is thinking and feeling (Meyers, 2004). In comparison with moods, emotions are shorter lived, stronger, and more specific forms of affect.

As we interact with other individuals, we learn how to behave around others and in certain situations. In addition, we can develop the ability to behave more efficiently and effectively within our own social interactions. In attempt to do so, we could cooperate with other people to gain outcomes that we could not obtain on our own, and we exchange goods, services, and other benefits with other people, in the form of social exchange. These behaviors are essential for survival in any society (Kameda, Takezawa, & Hastie, 2003; Kameda, Takezawa, Tindale, & Smith, 2002).

Through the experiences with social exchange, people gradually develop their own social cognition, which is a set of social knowledge containing information about ourselves, other people, social relationships, and social groups. Moreover, our social cognition also involves the active interpretation of the surrounding events around us. Interestingly, different people may draw different conclusions about the same events. Two types of knowledge are particularly important to our social cognition: our schemas and attitudes. A schema is a knowledge representation that includes information about a person or group. An attitude is a positive or negative evaluation of people, objects, events, activities, ideas, or just about anything in your environment (Zimbardo et al., 1999). Moreover, attitudes “reflect a predisposition to behave in stereotypical and predictable ways toward, or in presence of, members of a particular group” (Hunt & Hunt, 2000 as cited in McCaughey & Strohmmer, 2005, p. 89). Furthermore, schemas and attitudes are a result of person’s social perception that use “available information to form impressions of other people, to assess what they are like” (Jennifer Tiefert, 2008, pg. 82). Once formed, schemas and attitudes allow people to judge situations and other people quickly and without much conscious thought. Thus, schemas and attitudes have an important influence on people’s social information processing and social behavior.

Thus, to truly understand one’s social perception, it is necessary to understand the factors that can influence an individual’s affect, emotions, and attitudes, and in result, their value system(s) (Kiger, 1997). An individual’s values reflect what an individual was taught to believe in and what they believe is right and wrong. According to Kiger (1997), an individual’s attitudes depends on their values, therefore, if a person possess a specific attitude toward deafness, the favorable or unfavorable expression of this attitude will depend on whether that person’s perception toward deafness facilitates or blocks some cherished values held by that certain person. In addition, a person’s attitudes are influenced by social and situational variables, in which an individual’s perception is influenced by a positive or negative social interaction or situation.

Research have shown that attitudes displayed by hearing and other deaf individuals towards deafness can have a positive or negative impact on the deaf individual’s self-perception and their own attitude towards deafness (Leigh, 2009). According to Robert Rittenhouse (1987), family and school have the most important influence on a deaf child’s social and psychological development. It seems to be justified to assume that family and school will also have the most important impact on a deaf individual’s development of their perception toward deafness.

Family

Azar Hadadian and Susan Rose (1991) found that the parental interaction with deaf child is instrumental in shaping their perception towards their own deafness and deafness in general. Hadadian and Rose (1991) suggested that “the parents’ attitudes toward deafness and how they accept certain alternative modes communication to communicate with their deaf child” (p. 273) and that those two are the two of the most influential factors in shaping a deaf child’s perception towards deafness. Meadow and Schlesinger (1971) found that hearing parents who struggle with the ability to communicate with their deaf child often reported feeling frustrated. Moreover, Meadow and Schlesinger (1971) found that recurrent frustration and inability to communicate with their deaf child decreased the parents’ positive affect toward their child and resulted in becoming less caring. Parental frustration might cause them to act more leniently towards their deaf child, which in result may negatively impact the child’s perception of deafness. Therefore, the child’s perception of his/her parents’ feelings and behaviors toward deafness can have a significant impact toward the child’s attitude toward deafness as well as the type and quality of interactions with their parents.

Academic and Social Influence

Rittenhouse (1987) found that there are certain factors within the school environment that affect the way a deaf individual develops self-perception of deafness. He suggested that three factors; the teachers’ attitudes toward the deaf individual, peers’ attitudes toward deafness, and the child’s social development have the most significant impact on their perception toward deafness. Several studies have indicated that the hearing population’s social perceptions toward deafness are varied, but mostly negatively biased (Bat-Chava, 1993). Interestingly, even exposure to the Deaf culture does not mitigate this attitude. According to Paula Brown and Susan Foster’s (1991) study, hearing college students from Rochester Institute of Technology (i.e., which features a large presence of deaf and hard-of-hearing students annually) reported mostly negative perceptions toward deaf students. The analysis of the results of this study showed that when evaluating whether or not a behavior of a deaf person was appropriate, the hearing individuals’ were looking thorough the lenses of their own cultural and social norms.

In addition, Brown and Foster (1991) found that perceived differences between deaf and hearing student’s often interfered with the ability to develop relationships with each other. Most of the hearing students perceived deaf individuals “as rude, inconsiderate and immature” (Brown & Foster, 1991, pg. 26) and reported being “put off” by their behaviors

and attitudes. A significant factor in determining whether or not hearing individuals responded negatively toward deaf people was the degree to which they knew and/or had any contact with deaf people in general. Harlan Lane (1992) postulated that the hearing population's perception of the deaf as egocentric and defective can cause them to act paternalistic, ignorant, and lenient toward deaf people.

In addition to social attitudes, current social and technological changes also significantly influence the Deaf community. The rise of technological advancements in audiological devices (e.g., cochlear implantation devices), the promotion of early auditory training interventions, the rising expansion and implementation of main-stream education programs for deaf individuals, and the growing decline of residential schools for the deaf all result in increased diversification of Deaf community. With the glitz and glamor of the audiological devices (e.g., bone conduction implants, waterproof implants/hearing aid devices, flashy accessories), auditory verbal training, and the increasing popularity of mainstream programs, it is more likely that deaf children of hearing parents will have minimal access to the Deaf culture, Deaf community, and American Sign Language while growing up.

On the other hand, ASL has become increasingly popular within the hearing population. As more and more states in the United States are recognizing ASL as a foreign language (Laurent Clerc National Deaf Education Center, 2004), more high schools are accepting and implementing it to their foreign language programs. In addition, ASL has become a popular form of communication between hearing parents and their hearing infants. According to Pizer, Walters, & Meier (2007), there are many benefits from the incorporation of signing as a mode of communication between hearing parents and their hearing infant. Researchers suggested that signing with the infant reduces frustration related with inability to communicate, accelerates the learning of spoken language, increases parent-child interaction, increases the possibility of future academic advantage(s), creates deeper family bonds, calms sibling rivalry, and provides hope to improve deaf-hearing relations (Pizer, Walters, & Meier, 2007). The proliferation and popularity of ASL, creates the impression that the notion of decline of ASL and Deaf culture are unfounded. However, the author postulates that it makes the threat to the Deaf community less-straightforward. Paradoxically, the popularity of the ASL and Deaf culture in hearing population goes hand in hand with the increasing lack of access to the Deaf community and Deaf culture by deaf children. Such isolation often impacts a deaf child's identity development and their perception of themselves and other hearing, deaf, and hard-of-hearing individuals. It can also influence how they perceive the Deaf

community when they go to college or enter the workforce. Finally, it may impact how they present themselves toward hearing, deaf, and hard-of-hearing individuals outside of and within the Deaf community. Furthermore, a deaf individual's identity development is changing over life, similarly to hearing person's identity. However, contrary to hearing people, deaf person's identity can be influenced and alternated at any point of time in their lives.

Identity Development in College

When a deaf high school graduate enters college, especially a university with large D/deaf student body (e.g., Gallaudet University, Rochester Institute of Technology, California State University-Northridge), some deaf students often go through identity change(s). In the process of figuring out one's identity and finding their place within the deaf community, some deaf college students may feel externally oppressed by their fellow peers and professors, regardless of their hearing status. For example, some deaf students may face social rejection from social cliques within the deaf student community due to language barrier(s). Some deaf students or hard-of-hearing students may feel excluded from conversations using only ASL, because they are new signers.

Experiencing external oppression may in turn cause deaf students to internalize this oppression. According to Leigh (2009), an internalized oppression is a feeling of shame about oneself due to a negative external social experience, in this case due to hearing differences, feelings that they are not deaf enough to fit in, or feelings of in-competency toward ASL use. On the other hand, some deaf students may unintentionally become oppressors towards other deaf and hard-of-hearing individuals themselves. The reasons behind the actions of oppression may vary (i.e., fear of losing their culture, trying to appear cool in front of their friends, etc.). Regardless of the rationale, their actions may have negative consequences as it may cause their victims to develop or strengthen negative perceptions toward D/deaf individuals and possibly the whole Deaf community.

Search for Deafhood in fostering a positive Deaf Identity

For a deaf individual to achieve a healthy and positive Deaf identity formation, one must search for their 'Deafhood'. Deafhood is a term that was coined by Paddy Ladd (2003) which is not seen as a fixed condition, but a process, in which Deaf individuals come to find their own Deaf identity. Deaf people construct their identity around their variable priorities and principles related with their nationality, their culture, the era they were raised in, and their socio-economic class. According to Leigh (2009), Deafhood is a "deaf

consciousness concept that involves process and reconstruction of Deaf traditions related to becoming and maintaining deaf” (p. 19). This term encompasses the “ongoing discourse of Deaf individuals who value sign language in the journey to elucidate individual and collective shared beliefs, values, a sense of normality, pride, and confidence in the face of an oppressive society that holds on to the demeaning construct of a people who need to have their hearing fixed in order to be normal” (Leigh, 2009, p. 19). Leigh (2009) also pointed out that Ladd appears to be calling for a “distance from essentialist and potentially exclusionary boundaries that implicitly oppress those who appear not to meet specific Deaf criteria while simultaneously scrutinizing which aspects of essential Deaf identity constitute Deafhood” (p. 19). The authors point out that the experiences with the Deaf community heavily influence the deaf person’s ability to achieve a healthy and positive Deaf identity formation and perception towards both, the hearing and deaf communities. With that said, in attempt to facilitate and foster positive Deaf identity formation within young deaf adults (e.g., deaf college students), individuals within the Deaf community should be accepting of all incoming deaf college students, regardless of their hearing status and the level of Deaf acculturation. The Deaf community should be understanding of their possible identity struggles related to deafness, and optimistic in one’s progress in forming their Deaf identity.

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The Artist: Painting the Destruction of Love and Loss. A Case Conceptualization

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The case to be discussed is the one of a of the 24-year-old Latina painter. Five sessions are analyses during the current conceptualization from a psychoanalytical approach. Different from other approaches, the psychoanalytic perspective is based on the “talking cure.” Is not about leading the subject’s therapeutic process or telling her what to do, it is about allowing and facilitating the client to find their journey. Under the psychoanalytic approach, the therapist provides space for active listening, and the client finds a cure through his or her own words. The Artist is a case were issues related to love, death, and lost are address. Though the case conceptualization discussion about transference, contra-transference, the place of the therapist and issues related to the clinical work are presented. As conclusion for the case it can be said that there are no simple cases, and that Freud was right when he said that the word was the clinical cure.

Keywords: Psychoanalytic approach, transference, grief, depression, Lacan

According to the APA Dictionary of Clinical Psychology, a conceptualization is “the process of forming concepts or ideas, particularly those of an abstract nature, out of experience, or learned material using thought process and verbalization” (p.129, 2012). Through this process, a clinician examines the case at hand, applies theory, and plans for the next session. Being able to conceptualize a case allows us to evaluate our work as clinicians as well as our involvement in the case. Sometimes cases reach beyond abstract theory and into real life and those cases need to be conceptualized as well. The purpose of this conceptualization is to discuss the clinical process of a particular case, and the challenges and questions that surfaced during the clinical work. As clinical psychology students, each case assigned to us becomes part of our growth as future clinical psychologists. As part of my first clinical practice, the complexity of the case presented here generated the following questions for me; “What should I do? What should I say? Am I ready?” Just as children learn to walk by walking, we learn by doing in the field of psychology, with the added step of reflecting deeply on each case. In this basic way, the case presented here is no different from the scores of cases every psychologist hears every year, but then again, it seemed to hold surprises at every turn.

The case to be discussed is the one of a of a 24-year-old Latina painter, who I called the “Artist”. She was

treated from a psychoanalytical approach. Different from other approaches, the psychoanalytic perspective is based on the “talking cure.” This theoretical approach takes the subject out of the normal distribution where many others would have labeled it as an “outlier” case. Is not about where in the Diagnostic and Statistical Manual of Mental Disorders the client might be found, is all about where the client positions itself (Chiavaro, 2007).

While with other therapeutic approaches, the client may sometimes be given homework, or may be told what to do. The psychoanalytical approach is not about leading the subject’s therapeutic process or telling her what to do, it is about allowing and facilitating the client to find her journey. Even though other therapeutic approaches are based on removing or extinguishing the subject’s pain that is not how the therapeutic process works in psychoanalysis. Under the psychoanalytic approach, the therapist provides space for active listening, and the client finds a cure through his or her own words. Freud said in this respect that words are, indeed, the essential instrument of the psychic treatment, and they will become the truth balm (Freud, 1980). Our work is to provide the space where the client will put words to their pain. Under the psychoanalytical approach, the subject is not removed from her own pain and suffering, because while it is true that she suffers, she will be ultimately the one who decides what to do

with that suffering (Hassan, 2003). Then, if a therapist utilizing the psychoanalytical approach does not tell their patient what to do, or take out their pain, what they do?

As for the Artist, I received the referral form for psychological services for her, stating that her primary complaint was the loss of employment, which created dependency on her parents. I remember thinking to myself “This is not so complicated”. Now I laugh at my ignorant way of thinking — typical of a therapist in an early stage of training. That was one of the most important lessons I learned from this case: no matter how simple it may sound from the outset, each case brings complexity to play in the therapeutic setting; another lesson was that we do not know what will happen in therapy. As Nazario (2001) wrote, the therapeutic space is not a place one who thinks he knows everything; it is defined in a structural way and is the place of listening. In fact, it is in the therapeutic space that active listening is so crucial.

After reading the referral form, I arranged my first meeting with the Artist. This first appointment would be the beginning of a therapeutic process that would last six meetings, but would be inconclusive, as the process was interrupted by the end of the spring semester, with the hope of continuing in August.

At our first meeting, the Artist showed up at the time that we agreed upon, and we started discussing the reason that had brought her to psychotherapy. She began to cry inconsolably, explaining tearfully that she had unfairly lost her job in a clothing store, and that she felt frustrated about it. She also stated being “depressed” for days, only thinking of what had happened, and that at this point, everyone around her was tired of hearing the same story over and over again. A friend ultimately recommended that she go to the university’s counseling center. The Artist said she felt betrayed because she was a good employee, and her boss whom she had considered a person of trust had cheated her. She said “I’m confused, wondering if I did something that bothered him.”

The Artist thought she was indispensable in her job. She expressed being more upset with the situation, because her boss and other employees knew her situation as being someone who was alone, since she lived far away from her family. She initially had two jobs, and had left the other to keep working in the clothing store, and now, she “had nothing left.” She commented that before, she did not feel safe, and had no friends, but all of that changed when she started working. Now, because of the loss of her job, the Artist said, “I’m in shock! Everything is a disaster.”

After our first session, I had more questions than answers: What had the Artist lost? What implication had her loss played in her psyche? How did she signify and

interpret her lost? Why did she have so much guilt? Ultimately, what does she want to get out of herself so much that she needs to constantly repeat what happened? What was so unbearable about losing her job?

Price, Choi, & Vinokur (2002) said that the loss of a job may generate different feelings, such as low self-esteem, deception, and disappointment. A loss is without any doubt a difficult event to tolerate, because it makes reference to some extent to our inability to have it all. Losing something plays a significant part in our lives. The loss of a job can be experienced in the human being as a traumatic experience for the implications that it has, both social and personal (Classen & Dunn, 2012). The Artist projects herself as helpless. She also seems to be in deep pain. Taking into account her situation, I started to ask the wrong question, “What should I do?” Then I realized, this is not about me, it’s about the Artist.

She pointed out that she was “depressed,” and I wondered, “Is she telling me her diagnosis? Why is she labeling herself?” Depression can be defined in different ways. Depression has become the word that explains everything and nothing at the same time. As clinicians, we cannot assume our perspective of what depression is resembles the one our client has. In other words, despite the Artist’s bringing up depression to explain her emotions, it does not mean that as a clinician I assume the label (depression) explained anything.

Psychoanalyst Jacques Lacan (1977) points out that depression is not a state of the soul, but simply a moral failure. As expressed by Dante or even Spinoza, it is a sin, which means a moral cowardice, that ultimately relates to our thought - in other words, it’s part of the unconscious part of the psychic structure. When Lacan mentions “self-cowardice” he defines it as a betrayal of the self, not recognized in the unconscious (Bertholet, 2012). Depression, as defined by Gerardo R. Herreros (1999), is the sad passion of the soul where the subjects get arrest in relation to the desire, and is different from the melancholia, whereas Freud (1917) said that with depression, not only the world loses its meaning, but also the self.

It is important to consider that in terms of depression from a psychoanalytic perspective, there are two signs that are present: sadness and inhibition. Freud in “Inhibition, symptom and anguish” (1989) expressed that inhibition is common symptom of the depressive state, like resignation. Resignation ultimately limits the functioning of I. Even more, Lacan (1993) stressed the ethical aspect of the sadness. According to him depression is the result of a symbolic desolation, is located in the field of the other. It would be difficult to determine whether the Artist’s self-diagnosis of depression is accurate without numerous sessions.

Nevertheless it is important to have in mind her perspective at the time of therapy.

In that first meeting, I identified some things that I would have in mind throughout my therapeutic work with the Artist. She was 24 years old, and was from a small town, currently living in an unfamiliar city away from family; at the time, the exact same description could have been made of me. More than once in training to become a clinical psychologist, professors mentioned the inevitable fact that at some point, the psychologist will see him- or herself in a patient. It could be assumed that it will produce transference and counter-transference. Transference is seen to occur as “a result of unsatisfied libidinal need, which compels the patient to seek attachment on the analyst” (Bauer, 1994). The transference phenomenon can be difficult for a therapist. While difficult, it can be a vehicle for the client cure as it develops through the therapeutic relationship and it takes time. During that process, the therapist can feel closer to the patient. These cases present challenges in terms of maintaining one’s place as a therapist; on more than one occasion with the Artist, recognizing that it was not my therapeutic process was crucial.

The Artist arrived to our second meeting, and began talking about her relationships. The Artist described her relationships as unsatisfactory. She expressed having problems with her boyfriend and said she believed he was “speaking bad” about her and her friend. Her boyfriend was an “ignorant man” who did not understand nor take care of her. He just mainly thought about “that” (referring to sexual intercourse) and did not worry about how she felt. He often chastised the Artist for her unwillingness to be with him sexually. According to the Artist, they are not compatible and her boyfriend was ignorant due to his age. However, she was with him, because she did not want to be alone and that she needed someone to drive her around since she does not have a car. The Artist complained continually about being misunderstood by others around her and the fact that she does not have anyone to talk to. She said she did not trust anyone, because everyone wanted to hurt her. At that moment, I wondered to myself, “Does this include me?”

From there, it was clinically important to ask, “What is the Artist is afraid of?” “What causes her mistrust?” “What is the basis of the claim that she is being misunderstood by others?” “Where does she position herself?” Apparently, her love for her boyfriend is conditional and she is searching for protection, but protection from what? Her love is conditioned upon the car, but what does the car represent?

During our third session, the Artist said it had become difficult not to talk to anyone about what happened. She expressed feeling alone and that she

could not make decisions for herself, because she needed to consult with others about seemingly everything. She stated that “It is my fault. Every time I need to make a decision, I call someone for advice so they can tell me what to do.” After hearing her statement, I asked myself, “Why does she need reassurance to make a decision? Why (or for what) does she fear being blamed? Is it fear of failure? What does her infant position say about her?”

Ironically, this occurred when the Artist started talking about her mother, a woman who did not finish school and more importantly, did not drive. The Artist commented that her mother was stuck in the same place and dependent on others. Although the Artist was studying at the University in Puerto Rico, she did not drive and also relied on others, just like her mother. She said, “I don’t want to be like my mother [but] I’m afraid to drive — my first boyfriend died in a car accident.”

After the Artist mentioned the death of her boyfriend, she began to speak about it with no apparent affect as if the situation did not bother her. The death of her boyfriend occurred when she was 16. The Artist described him as a beautiful person who cared about her and was always there for her. She also said that after she lost everything in a hurricane, “he was there for me and even bought food for me”. The hurricane the Artist was referring to occur in 1998, named George. Hurricane George was a category fourth, and damaged 72,605 houses and destroyed 28,005 homes in Puerto Rico (National Hurricane Center, 1999). There were 602 direct deaths attributed to George across the Caribbean (National Hurricane Center, 1999). Considering the impact George had in the Island it is understandable the “Artist” remembers the help she received in such a difficult time.

After she recover from the hurricane suddenly her boyfriend died. The Artist expressed, “someone communicated with me saying he had a car accident and later he died in the hospital.” Although he died when she was 16 years old, the Artist commented that a boyfriend who broke up with her when she was 23 said she was still thinking of her first boyfriend. She explained that the reason for the break up was that her boyfriend felt he had to compete with a dead person, because he would never be able to be as good as her first boyfriend, because — for the Artist — he was perfect. The Artist felt different, saying the break-up was not because of her first boyfriend, but because she was unable, for some reason, to commit to the relationship.

At the end of this session, I was puzzled on how it was possible for her to speak in an outwardly unemotional way on the unexpected loss of a loved one when she had not been able to resolve her grief and talk about the unexpected loss of her job in a clothing store in an emotionally exaggerated reaction. Her reactions begged many questions - Had she detached her affect

from the memory of her lost boyfriend? Does the Artist suffer from complicated grief? What does her lack of commitment reveal? What did the ex-boyfriend mean by “competing” with the dead boyfriend? What place did her first boyfriend hold in the life of the Artist?

Although other approaches indicate that the grief process depends on the conditions under which the loss may have occurred, such as whether it was a sudden versus an expected loss (Howard, 2011). From the psychoanalytic approach, it is considered more than that. Even though the conditions of the death of a loved one can have an impact on those left behind, the way a person grieves depends on the individuals, themselves. Freud (1917) noted that the level of intensity of one’s sorrow and the reaction to the loss of a loved one can translate to the loss of interest in the outside world, in everything that reminds us the deceased, as well as the loss of the ability to choose a new love object to replace the lost loved one. Freud (1917) also mentioned that the inhibition and the sorrow of I shows an “in-conditional” commitment to the grief. When a person experiences profound grief, the world becomes dark and empty. The goal of the grief is to make unbearable the bearable, allowing the client to regain his or her energy and interest in the world through word elaboration (e.g., the talking cure).

The Artist’s telling of that fairly recent break-up gave rise to another issue that needed to be addressed; her denial. She refused to consider that the death of her boyfriend could be the cause of her lack of commitment in her later relationships. Freud (1925) noted in his work on denial: “To deny something in judgment means deeply, ‘that’s something I will prefer to suppress.’ The adverse judgment, ‘Verurteilung,’ is the intellectual substitute of repression; the ‘no,’ is a mark of its existence, a certificate of origin, like ‘Made in Germany.’ Through the symbol of negation, the thought process breaks free from the repression and it is enriched by the indispensable contents of its operation.”

In our fourth session, the Artist brought up that she had found a new job and had left her boyfriend. She said it felt very good to make a decision on her own, but she felt lonely in the moments where she was not busy. The loneliness brought a lot of memories from high school and she expressed how she was “nobody” until she started dating her first boyfriend. She stated that “It felt good, because my boyfriend was very popular and everybody knew me.” The Artist wrote many letters to her boyfriend after he died, asking him why he had left her. She brought up what I thought was an attempt at a grief resolution, but at the end she turned. She said “But we fought on Friday, and on Saturday, he had the accident, and died on Sunday.” Following her statement, she had a sudden breakthrough as she stated “I do not

want to live like I did before.” From that point, the Artist started raising important questions such as why she needed to be with someone not to feel alone? At this stage, the Artist recognized that our sessions were a time for reflection where she was responsible for making sense of her own life.

In the end, we are essentially full of desires, and an important part of our therapeutic process is to reestablish some of the dimension of the desire. With that understanding, the patient can start to see what happened from a different context — not as a victim of her sickness, but as an active participant in treating it, and as a subject with desires (Chervocer, 2000).

The contribution that psychoanalysis made in this context was to allow the subject to change his/her position, assuming the role of an active agent in his or her own treatment, following the theory that the patient and only the patient must find the reason for his or her suffering.

At our last meeting, the Artist honored her pseudonym and brought two pieces of art that she made. She started talking about her relationships, commenting that love was something spontaneous and it was she who got tired of her previous relationship for several reasons: the “emotions,” as she described them, just lasted two to three weeks, and she tended to create high expectations that no one could reach. Love was painful (Figure 1).



Figure 1. LOVE. The painting “LOVE” was the pictorial representation of the Artist’s perspective of love. It is important to notice that the letters L-O-V-E are branded into her back of the woman, whose face is wounded: her lips are sealed and her head shaved. Even though the Artist painted a bride (a classically happy visage), her veil is made of cyclone wire.

The Artist said she did not know what she was looking for in romantic relationships, but then she commented she wanted balance (Figure 2). The Artist was able to describe balance by explaining the opposite of what she was looking for: balance was not an

unbalanced person or a person who was thrown to the floor from exhaustion or injury. She made a representation of happiness as a fish, a fish that, until this point, she was not able to become.



Figure 2. Balance. This is the pictorial representation of the Artist on her perspective on balance

Before leaving the therapy room at the conclusion of the semester, the artist told me, “I feel better, let’s see what the summer brings to me, although I have many things to think about.”

And so did I. Seeing the Artist’s love representation was difficult and that her pain was vividly represented. The woman in her representation did not possess the usual cultural attributes that are associated with Latino women. She was a bride that did not have hair, she was beaten up, but most importantly her lips were sealed. The Artist represented the consequences of love. Considering her perception, how did love need to be addressed in therapy?

Love has the power to flood repression and restore perversions, raise the sexual object to an ideal sexual object, and have it support on the grounds of childish fulfillment of love (Freud, 1905). Love is defined as the “attachment of a person to another, often profound, sometimes violent, but it can be mark by ambivalence, and does not exclude narcissism” (Laplanche, 1996). Narcissism is characterized by the choosing his object of love based on self; the subject searches for him- or herself in the love object (Freud, 1920). The narcissistic love searching among other things, what the person would like to have but at this point does not. It should be noted that choosing the love object is not at random. Something that the clinical work can prove is that the subject is the creator of his own destiny. The destiny is moved by the repetition and drive. Freud (1920) states that “there are individuals who every human relationships leads to the same outcome. This ‘eternal return to the same’ is not surprising to us, when we realize that there are some character traits that remains the same, creating the externalizing conditions for the repetition and them, necessarily externalized in the repetition of identical experiences.”

Did the patient search in the repetition a justification of her position as a victim? Did she want to

assume a place of entrapment? While these questions are complex, it is clear that the Artist started moving through our six sessions. There will always be some questions that may never be answered, such as: Where is her father? What was so perfect in her first boyfriend? Likewise, there are other questions that will remain unknown due to the short time of therapy, such as the transfer and contra-transference between the Artist and me, probably pointing to the substantial changes that had occurred in the short duration of therapy.

Even though some of the questions remain, I look to this process with new eyes. I can see myself as a young therapist at the time, and the marked improvement additional training has provided me. But even though this was one of my first clinical experiences, I can see how the Artist decided to take an opportunity to examine old wounds and fresh wounds, and she gave much needed color to what used to be her colorless life. As for the young therapist, she started to learn that there are no simple cases, and that Freud was right when he said that the word was the clinical cure.

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Resilience as a Verb or a Noun: A Literature Review

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This review describes the implications of defining and applying resilience as either a noun or a verb within the context of people who are deaf and hard of hearing and provides an overview of internal and external factors that hinder or promote resilience. The review describes the conclusions that can be reached and studies features, including international and indigenous marginalized and/or at-risk populations of deaf, hard of hearing, and hearing children and young adults.

Keywords: resilience, adversity, internal factors, external factors, indigenous, deaf

People who are deaf or hard of hearing are perceived to be vulnerable to social, academic, and professional failure throughout literature related to deaf and hard of hearing people (Anita et al., 2008; Meadow, 1980; Wang & Haertel, 1995; Zand & Pierce, 2011). Some argue that deafness should not be labeled as a risk factor; yet these articles do not fully articulate the internal and external assets of deaf people and resilience (e.g. Young, Green, & Rogers, 2008; Zand & Pierce, 2011). Speculation remains as to what assets promote resilience and how this strength can improve educational and supportive practices for people who are deaf and hard of hearing. Here we will identify perspectives on resilience and the systematic limitations impacting the resilience of people who are deaf and hard of hearing. We will present the argument regarding whether or not resilience changes, depending on whether or not it is perceived as a verb or a noun. A strength-based method of inquiry into resilience will be used to highlight indigenous studies that demonstrate protective strategies of resilience and offers a greater understanding of resilience in people who are deaf and hard of hearing.

Perspectives and Limitations

Past research has discussed both operational and conceptual definitions of resilience (Young et al, 2008; Zand & Pierce, 2011). Clarifying resilience as a noun or a verb helps capture distinctions. On one hand, Young et al. (2008), specifically defined resilience of children and youth who are deaf and hard of hearing as a protective factor, which is a collective noun. Zand and Pierce (2011) based their research on Young et al. (2008)'s perspective. While the research contributes to

our understanding of resilience as a protective factor, we do not know much about how children who are deaf can be actively resilient in their everyday life. We can identify the barriers and the potential dangers that impact their lives. The problem here is that it can unintentionally imply that the experience of being deaf or hard of hearing as one of overwhelming adversities, riddled with risk and vulnerability, and not much can be practically done about the barriers. In other words few proactive prescriptive measures or solutions have been offered. Moreover, this view unintentionally absolves people who are deaf and hard of hearing from their personal responsibility to be resilient.

On the other hand, as a verb, resilience is defined as the capacity to adapt to or master adversity (American Psychological Association, 2014). Resilience has been defined as a verb by researchers of children and adolescents at risk for adverse outcomes (Ungar, 2008), learning disabilities (Reiff, Ginsberg, & Gerber, 1995), and deafness (Jacobs, 2010; 2012; Jacobs, Brown, & Paatsch, 2012). Jacobs (2010; 2012) used Reiff et al.'s (1995) research to define a framework of proactive life skills for dealing with deaf-specific psychological and social challenges. These researchers view resilience as both a psychological attribute and as an outcome regarding using social strategies during adverse circumstances. Ungar (2008) further stated that resilience is both the individual's ability to successfully navigate their way to the psychological, social, cultural, and physical resources that sustain their well-being. Resilience, Ungar (2008) continued, is also the capacity of the individual and the group to collectively negotiate and acquire resources in culturally meaningful ways.

In contrast to Young et al., (2008) and Zand and Pierce (2011), Ungar (2008) clearly emphasizes resiliency as a verb, not a noun. Resilience is not an abstract concept but an action. Ungar (2008), Reiff et al. (1995), Jacobs (2010; 2012) and Jacobs et al. (2012) underscore the everyday practical meaning and application of resilience. Perceiving resiliency as a noun provides insufficient practical methods that deaf and hard of hearing people can employ to address the challenges they face. The advantage of using the concept of resilience as verb is that we can identify and operationalize skills related to resilience. This in turn may have significant benefits to educational and social services. With the understanding of resilience as both a noun and a verb, we can now complete a critique of the internal and external protective factors that influences young people's success.

Internal and External Protective Factors

Protective factors of resilience include both internal and external skills—both of which mutually impact the individual. Internal factors include, but are not limited to; performing well academically, confidence, positive self-concept or identity, a sense of belonging, independence, an internal locus of control, self-regulatory behaviors, goal orientation, and creativity (Feinstein, Driving-Hawk, & Bartman, 2009; Grotberg, 1995; Richard, 2012; Stanley, 2011; Ungar, et al., 2007; World Bank, 2013b). On the other hand, protective external factors that promote or foster resilience include, adult-child relationships (e.g., mentors, family, teachers), academic support programs (e.g., tutoring), extra-curricular activities, culture, faith or spirituality, access to material resources like social institutions and finances as well as community and social policies that collaborate to promote resilience (Feinstein, Driving-Hawk, & Bartman, 2009; Grotberg, 1995; Richard, 2012; Stanley, 2011; Ungar, et al., 2007; World Bank, 2013a). Next, we will highlight studies that identify internal and external factors of resilience.

According to Ungar et al. (2007), internal factors contribute to resilience regardless of the individual's nationality. Based on Stanley's (2011) longitudinal study of at-risk New Zealanders and Richard's (2012) study with indigenous university students, they both found that developing social-emotional skills such as self-regulatory behavior and an internal locus of control, are critical resilience factors. Research suggested that these skills and attributes should be intentionally taught in educational settings (Jacobs et al., 2012; Richard, 2012; Stanley, 2011; Ungar, Russell, & Connelly, 2014).

Grotberg's (1995) international resilience study demonstrated the importance of internal and external factors in promoting resilience. Participants included 589 children and their caregivers from Lithuania,

Russia, Costa Rica, the Czech Republic, Brazil, Thailand, Vietnam, Hungary, Taiwan, Namibia, Sudan, Canada, South Africa, and Japan. Skills necessary for resilience are categorized as "I HAVE" external support, "I AM" internal supports, and "I CAN" social supports. Grotberg separated the internal protective factors into two categories "I AM", which includes psychological skills and "I CAN", which are social-emotional skills. I HAVE external supports include; trusting relationships, structure and rules at home, parental encouragement of autonomy, access to material resources (e.g., health, education, welfare and security services), emotional support outside the family, a stable home and school environment, role models, and finally a sense of morality or religious affiliation. Examples of I AM internal supports include personal strengths, autonomy, having an easy temperament, being goal oriented, positive self-esteem, hope, faith, a belief in God, a sense of being loved, an internal locus of control, trust, empathy altruism, and morality. Finally, I CAN social-emotional skills include communication and problem solving skills, creative, persistence, humor, impulse control, seeking trusting relationships, intellectual, and social skills.

Resilience is developed externally first then it is internalized later through a dialectic relationship. External factors are learned and internalized through a shared language and culture. Grotberg (1995) found that able-bodied hearing children are unable to promote their own resilience until at least nine years of age. External protective factors can be understood as inter-relational. This external-internal inter-relational aspect can be seen in Feinstein et al.'s (2009) who investigated indigenous youth of the Lakota Sioux society. From his study, results suggest that the cultural values (i.e., belonging, mastery, independence, and generosity) the group practices fosters and maintains the well-being for the youth in the Lakota Sioux society. Moreover, Feinstein et al. (2009)'s findings highlight the bidirectional relationship of external and internal protective factors. Of note, the students were resilient despite not having approval from the mainstream culture. Feinstein et al. (2009) recommended that academic curriculum in general should be culturally relevant and support the development of practical and applied knowledge.

Literature has suggested that individuals develop resilience by using coping skills through adversity (Feinstein, et al., 2009; Richard, 2012; Stanley, 2011; Ungar, et al., 2007; World Bank, 2013a). Extra-curricular activities such as athletics, culture, and spirituality are important in promoting resilience (Feinstein, et al., 2009; Richard, 2012; Stanley, 2011; Ungar, et al., 2014; World Bank, 2013a). Ungar et al., (2014) emphasizes the important role that education plays developing resilient life skills in children. With that said, schools need to consider and address the

structural disadvantages in order to optimize the social and cultural influences as well as personal attributes in the child (Richard, 2012). Feinstein et al. (2009), pointed out that the value of providing extra-curricular activities and a cultural-context curriculum can be two ways that schools can foster resilience in students.

The aforesaid indigenous and international studies do help clarify the factors individuals and communities need to promote resilience. Research provides realistic examples of how education can be employed in fostering social and academic success within the students. However, the question still remains, what are the internal and external factors resilient deaf students have available to them?

Resilience in deaf students

Researchers have found that specific personal, communal, and cultural factors help deaf individuals identify, circumvent, or master adverse circumstances (Ahlert & Greeff, 2012; Charlson, Bird, & Strong, 1999; Jacobs, Brown, & Paatsch, 2012; Larew, 2010; Moore & Mertens, in press; Paris, 2012; Rogers, Muir, & Christine, 2003; Williamson, 2007). As previously argued, researchers should be cautioned not to place all of the responsibility on external factors. Yet, Zand and Pierce (2011) suggested that resilience is co-constructed through a dynamic relationship between the deaf individual and the hearing world. In light of contrasting arguments it is critical to consider the bidirectional relationship between external factors and resilient deaf students.

Studies with both deaf and hearing participants find that social and emotional skills are important internal factors in resilience for constructing both academic and social success. Among these factors are positive self-concept and identity, a sense of belonging, an internal locus of control, well developed self-regulatory behavior, being comfortable with solitude, engaging in service to one's community, and the ability to communicate with both hearing and deaf people (Ahlert & Greeff, 2012; Charlson et al., 1999; Jacobs et al., 2012; Larew, 2010; Luckner & Muir, 2001; Moore & Mertens, in press; Paris, 2012; Rogers et al., 2003). Larew (2010) found that deaf female leaders were determined to succeed regardless of the circumstances. Similarly, Luckner and Muir (2001) found that resilient deaf children were self-determined and advocated for their needs. Such suggests that resilient people have a strong internal locus of control (Ungar et al., 2007). Language ability is fundamental to one's social-emotional skills.

Research has shown that communication skills contribute to deaf people's resilience (Charlson et al., 1999; Jacobs et al., 2012; Larew, 2010; Luckner & Muir, 2001; Paris, 2012; Rogers et al., 2003). Deaf people employ language in different ways by using assistive

technology, interpreters, speech reading, speaking, and signing (Moore & Mertens, in press). Deaf individuals are also creative in how they endure and negotiate communication barriers (Jacobs et al., 2012). Thus, the key factor here is that resilient deaf people know how to communicate effectively in a variety of settings.

Evidence points to the significance of relationships as a key factor in resilience. For instance, parent-child attachment establishes communication skills and develops social and emotional skills necessary for deaf children to realize resilience (Leigh, Brice, & Meadow-Orlans, 2004; Nowakowski, Tasker, & Schmidt, 2009). Similarly, Ahlert and Greeff (2012) studied protective and supportive resilience factors in South African families with deaf children. They found that parents were critical in developing resilient families and maintaining a sense of well-being. Ahlert and Greeff (2012) also found that resilient families spent time together, had routines, used affirmative communication with one another, had access to social support systems, were creative in problem solving, practiced a religion, and accepted their deaf child. The insights of a resilient family might explain the practical ways in how families can foster and raise resilient deaf children.

Many studies point to the fact that resilient people who are deaf or hard of hearing have a positive relationship with an adult or peer role model or mentor (Ahlert & Greeff, 2012; Anita et al., 2008; Charlson et al., 1999; Jacobs, 2010; 2012; Jacobs et al., 2012; Larew, 2010; Luckner & Muir, 2001; Paris, 2012; Rogers et al., 2003; Williamson, 2007). These mentors and role models are more likely to be teachers, but also included family members, interpreters, note takers, peers, employers, and co-workers. These mentors and role models were found to have had high expectations for the deaf child, supported them, and helped them learn to advocate for themselves.

Other studies demonstrated that culture and spirituality might help contribute to resilience for many deaf people (Ahlert & Greeff, 2012; Charlson et al., 1999; Larew, 2010; Luckner & Muir, 2001; Paris, 2012; Rogers et al., 2003; Williamson, 2007). For example, having a strong cultural and belief system helped contribute to a strong sense of identity, sense of belonging, and gave meaning to life.

Ungar et al. (2007) found that resilient people are able to access the necessary material resources. Moore and Mertens (in press) further argue that deaf-specific tools support resilience, such as assistive technology and communication devices, interpreters, accessible educational, medical, and social services, and finances, to satisfy one's basic needs. Studies further found that successful deaf adults not only had access to the material resources that they needed, but also knew how to creatively employ the said tools (Charlson et al., 1999; Jacobs, 2010; 2012, in press; Jacobs et al., 2012; Larew,

2010; Luckner & Muir, 2001; Paris, 2012; Rogers et al., 2003).

Strong evidence suggested that deaf people do actively engage in their surrounding environment to access the psychological, social, and material resources they need to be able to find, sustain, and maintain their wellbeing (Charlson et al., 1999; Jacobs, 2010; 2012, in press; Jacobs et al., 2012; Larew, 2010; Luckner & Muir, 2001; Paris, 2012; Rogers et al., 2003). Wit that said, resilience is therefore a dynamic relationship between the individual and the environment. Whereby the individual is an active agent that is in control of their destiny. Given this interaction, it is helpful to explore the types of adversity encountered by children and adolescents who are deaf and hard of hearing. We now are to critique the educational adverse factors that may have impact on the resilience of students who are deaf and hard of hearing.

Adversity to Resilience

In their review, Zand and Pierce (2011) have found and emphasized that deaf students were at risk for limitations to social and academic success. Zand and Pierce (2011) separated their review article into four stages of human development: infancy and toddlerhood, childhood, adolescence, and emerging adulthood. All of the stages of human development present different challenges that require resilience. Deaf infants and toddlers are at risk for insecure attachment and a lack of communication access, which leads to poor social-emotional skills among other issues. Deaf children are at risk for developing a poor sense of self, effective self-regulation, and executive functioning because of poor parent-child attachment. All of these factors can negatively impact language development including cognitive abilities, social competence, and mental health.

Other studies have identified a link between social-emotional skills and deaf students' potential adverse psychological and social experience. Psychological challenges include communication barriers, isolation and loneliness, learned helplessness, anxiety, timidity, and substance abuse (Coll et al., 2009; Heydebrand et al., 2005; Theunissen et al., 2014). Consequences may include poor academic and social outcomes (Hawthorne & Hogan, 2002; Harris & Bamford, 2001). Those disadvantages may explain why adults who are deaf have been found to have poor mental outcomes and problems with physical health in comparison to population norms (de Graff & Bijl, 2002; Hawthorne & Hogan, 2002; Heydebrand et al., 2005; Hogan et al., 2009b).

These findings suggest that deaf education are facing serious difficulties. A recent report from the Laurent Clerc National Deaf Education Center in Washington D.C. (Szymanski, Lutz, Shahan, & Gala,

2013) identified five barriers to the success of deaf and hard of hearing students within the United States. The five barriers are: (1) A dearth of awareness and education among professionals, caregivers, and mainstream society on deaf and hard of hearing students; (2) A lack of adequate cooperation between service providers, professionals, and mainstream society in serving deaf and hard of hearing students; (3) An absence of qualified professionals and service providers working with deaf and hard of hearing students; (4) A lack of appropriate accommodations in educational settings to meet the mandate of the Least Restrictive Environment; and (5) a greater need for social-emotional child development in deaf education.

Jacobs (in press) argues that the aforementioned barriers are mainly within the deafness related field. The key to addressing such discord, he suggested, is more than to simply provide deaf people access to social services like education, healthcare, and government. However, it depends on when and how access is provided. Access needs to be provided at the appropriate stage of the deaf child's development.

Teacher preparation programs have been slow to address the barriers that deaf and hard of hearing people may experience (Dolman, 2010; Johnson, 2004; Foster & Cue, 2008/2009; Luckner & Howell, 2002). For example, Dolman's (2008) analysis of the training programs for the teachers of the deaf revealed that little has changed between 1986 and 2006. Dolman's investigation revealed that training programs do not educate teachers of the deaf on how to develop the social-emotional skills of their deaf students. In addition, Jacobs (in press) identified a key problem, which is that only a few researchers are interested in studying resilience. These insights are particularly interesting given the psychological, social, educational, and employment issues mentioned previously.

Through deeper analysis of the issues students are potentially at risk to specific challenges, some of which seem to be more potent than others. One of the most significant barriers deaf learners encounter are communication issues with their families, at school, and within their community. In addition, they also have difficulties accessing educational, health, and social services (Charlson et al., 1992; Lytle et al., 2006; Luckner & Muir, 2001; MacDonald, 2007; Ramsey & Padden, 1998; Rogers, et al., 2003; Wilson, 2009). It is important to recognize that communication issues can arise in both signing only and auditory settings. For instance, Ramsey and Padden (1998) conducted a study that demonstrated how fluency in sign language and Deaf acculturation improved academic success in deaf students. One participant, however, was an anomaly. A profoundly deaf boy raised in a Spanish-speaking household did not share the mainstream American language and culture or mainstream Deaf-American

language and culture. He did not succeed academically and was significantly isolated from learning and social participation. The issue here is the inaccessibility to the language or culture of the classroom rather than being able to sign or speak. As Luckner and Muir (2001) discovered, being able to speak or sign does not necessarily determine a deaf students' success. Rather successful at-risk students know how to effectively navigate and negotiate for needed resources (Ungar, 2008). In the spring of 2014, the author, Zimmerman, from Gallaudet University conducted a single case qualitative pilot study. Anecdotal evidence suggests that Deaf education is not adequately preparing students to practically address challenges and engage as equitable members of society. A culturally Deaf international development worker said the following: "Some countries have had education for 100 years but its still (shakes head back and forth)...Yeah like hitting a glass ceiling. They are not working; they are hopeless and overwhelmed with the feeling of not knowing what to do (shakes head)".

This circumstance relates to the theory of cultural capital, understood as the knowledge, skills, and materials that can be shared for the benefit for others and for oneself (Harker, 1990). Given this, cultural capital may be a deciding factor in developing resilience. Ungar (2008) seems to support this critical concept by saying that resilience is the environment's capacity to provide support in culturally relevant ways and the individual's capacity to maintain their well-being by navigating and negotiating for psychological, social, cultural, and physical resources. According to Ciabattari (2011), access to cultural capital determines the quality of a child's educational experiences. It appears that shared cultural capital is a key factor in fostering academic and social success. The question now becomes, how can deaf education foster and teach resilience?

An example may be in preparing the next generation by mentoring current deaf-related educational professionals and service providers to collaborate effectively and to intentionally develop resilience in students. Studies on success and resilience in special education in both South Africa and the United States show that collaboration between educators, service providers, and families are critical to fostering resilience in students (Ahlert & Greeff, 2012; Luckner & Muir, 2001; Zost, 2010). Collaboration helps support student success by developing the specific skills and abilities such as self-advocacy and accountability which are necessary for academic and social success (Luckner & Muir, 2001). Additionally, collaboration has been found to help retain and develop resilience in high burnout professions, such as those in the special education field (Zost, 2010) and create a successful learning environment for students (Ahlert & Greeff, 2012; Luckner & Muir, 2001). Thus, operationalizing

resilience appears to be the most productive when teachers and administrators use schools as a platform for community engagement (Grotberg, 1995; Ungar, Russell, & Connelly, 2014; World Bank, 2013b).

The concept of operationalizing resilience was recently captured in the World Bank's Education Note (2013), a document that synthesized the Education Resilience Approaches Program (ERA) international pilot studies on identifying risks and resiliency assets. The pilot studies in Rwanda, South Sudan, Honduras, and Palestine did not find the same factors. However, the ERA consistently found that collaboration between the school, the families, and the community dynamically contributes to students' resilience by mitigating exposure to risk and creating a culture of learning.

Research about deaf people (Charlson, Bird, Strong, 1999; Larew, 2010; Paris, 2012; Williamson, 2007) and indigenous people (Feinstein, Driving-Hawk, & Bartman, 2009; Richard, 2012) demonstrate that people who are at risk and are resilient have benefited from adult-child mentoring relationships. Mentors were found to help students advocate for themselves, set achievable goals, deal with relational conflicts, and instill cultural mores, values, and beliefs. All of these supportive factors assist students in navigating and negotiating for resources to help them sustain their well-being (Ungar, 2008). Because of the nature of language and communication in the deaf community, teachers and service providers benefit students by creating intentional mentorship programs within school settings.

Conclusion

Approximately 92 percent of deaf children are born to hearing families (Mitchell & Karchmer, 2004). These children are learning language at a different pace, when compared to hearing children. Researchers may therefore benefit from more closely looking at both communication and social-emotional skills in relation to resilience. Many studies define resilience in deaf as the ability to engage effectively in both deaf and hearing settings (Charlson, Bird, Strong, 1999; Jacobs, 2010; 2012, in press; Jacobs, Brown, & Paatsch, 2012; Larew, 2010; Paris, 2012; Rogers, et al., 2003; Williamson, 2007). This implies that communication and social-emotional skills may be a key asset in resilience. Here we identified definitions and perspectives on resilience and the systematic limitations impacting the resilience of deaf students and explained proactive internal and external resilience factors. This review has yet to identify an article that specifically that provides practical knowledge in how deaf education can develop communication and social-emotional skills for effective resilience. Thus, more strength-based investigations should be done to add to our knowledge of resilience in deaf people.

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Psychological Adaptation and Identity Change After the Acquisition of a Physical Disability in Adulthood. A Critical Analysis of an Autobiography

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Contrary to popular belief, the overwhelming majority of disabilities are acquired during a person's lifetime rather than at birth. Research shows that people who acquire physical disability during adulthood are faced with the necessity to redefine their role and place in society and often develop an entirely new identity – the identity of a disabled person. The process of losing the old self, which must precede the development of a new identity, is often described by patients as extremely traumatic. At that moment, the individual is forced to change his or her social affiliation and irreversibly switch teams from “abled” to “dis-abled”. In addition to adapting to physical changes, newly disabled people also face serious psychological challenges. Although some research shows that disabled people do not differ psychologically from the general population, having similar levels of self-esteem and well-being as nondisabled people, other research clearly proves that this is not applicable to newly disabled people. It appears that adults with relatively stable identity and strong expectations related to the future, are the ones who suffer the most after acquiring a disability. This article investigates the major issues related with the development of a new identity presented in the autobiographical book of Simi Linton, who became a paraplegic at age 24.

Keywords: Acquired disability, identity change, disability identity, Reflective Topical Autobiography

Introduction

Disability, “the condition of being unable to do things in the normal way” (according to the Webster dictionary definition, “Disability,” n.d.), is a surprisingly common state of being. The United Nations (UN) assessed that disabled people constitute the world's largest minority, including 10 percent of the world's entire population, approximately 650 million people (United Nations, 2012). In addition, the World Health Organization (WHO) evaluated that this number rises every year due to population growth, increase of survivability due to medical advances, the ageing process of the world population, and an increase in chronic health conditions (“Disability and health,” 2013). Interestingly enough, the overwhelming majority of disabilities are acquired during the lifetime; reports estimate that only 15-20% of all disabled people (with this proportion depending on the country) are born with a disability (“Disability” 2010).

The situation in the US is even more dramatic. The US Census Bureau (Brault, 2012) estimated that nearly one fifth of the entire US population (approximately

56.6 million people) have some form of disability. Americans between the ages of 21 and 64 constitute the largest group of disabled people, accounting for 29.5 million people (or 17% of the US population). Within the last decade, this group significantly increased due to the growing numbers of wounded veterans. As of August 2012, about 3.0 million current veterans (14% of all military retirees) reported having a so-called service-connected disability (acquired in, or aggravated during, military service, “Employment situation of veterans,” 2013). The most current data suggests that in the next few years, these numbers are about to significantly increase due to the inflow of new veterans, those who served in the US military during operations in Iraq and Afghanistan. Recent estimates show that as many as 45% of the 1.6 million newest veterans claim a service-connected disability (Marchione, 2012). In the military, the most common injuries causing disability include amputations, burns, spinal cord injuries, post-traumatic stress disorder (PTSD), hearing loss, and traumatic brain injuries (TBI, “Employment situation of veterans,” 2013). In the general population, arthritis and back and

spine problems (including spine injuries and amputations) are listed between the most common causes of acquired disability, affecting 16.2 million Americans (“47.5 million U.S.,” 2011).

Obviously, disability is not a marginal issue experienced by few. Millions of people with an inborn or acquired disability live and function side by side with the rest of the population. Contrary to popular belief, research shows that most people with disabilities do not differ psychologically from the “normal” population, having similar levels of self-esteem and well-being as nondisabled people (Darling, 2013). However, other studies suggest that psychological well-being largely depends on the age at the time of acquired disability. In general, people with late onset of disability are less happy with their lives and have lower self-esteem than those who became disabled at a younger age (Freedman, 2012). Currently, most researchers agree that the main difference between these two groups is the stability of self-identity, future-self, and identity goals during the time of disability acquisition (Lindgren, 2004). People, who have a relatively stable identity, strong expectations related to their future-self, and already established goals for the future, have major difficulty adjusting to the necessity of changing their lives and selves to “accommodate to bodily losses and limits and resolving the lost unity between body and self” (Charmaz, 1995, p. 657). They are also more likely to accept the medical perspective of their condition, feel excluded from their previous social life, and reject the disability identity (Darling, 2013). The process of losing the old self, which precedes the development of a new identity, is often described as extremely traumatic. Robert Murphy, a man who became quadriplegic in his 40’s, openly admitted hating his new self, “I didn’t ask for this and don’t want it, I hate being SCI (spinal cord injury). [...] I had lost much more than the full use of my legs. I had also lost a part of my self.” (1990, p. 85). Others, like Simi Linton, who became paralyzed from the waist down in a car accident, simply refused to accept the change: “I sought to minimize the outward signs of my impairment, and to downplay its significance. [...] I sought to maintain as much of my individual identity and as much of my former lifestyle as possible.” (Linton, 2007, p. 109).

Reflective Topical Autobiography

The goal of every psychological research is to provide a better understanding of human nature. Currently, quantitative studies are the prevailing and preferred method of scientific analysis in psychological research. Typically, they concentrate on large groups of people and look for correlations, statistical significance, and effect sizes. Although unquestionably this approach provides valuable information, it also appears that, at the same time, in the pursuit of scientific rigors, the spirit of

human experience is sacrificed in favor of numbers. Qualitative studies attempt to restore this lost balance in psychological research by looking at an individual rather than a group and searching for unique, personal meaning. This type of study tries to understand “how people make sense of their world and the experiences they have in the world” (Merriam, 2009, p. 13). Instead of using closed ended questionnaires and tests, typical for quantitative studies, qualitative researchers engage participants in storytelling, encouraging them to share their thoughts, experiences, and beliefs. This way of conducting a study uses the phenomenological approach (Patton, 2002), the assumption that although only the individual himself can really understand what he experiences, every experience has a common core, the essence of shared experience, that is possible to understand by every human being. Following this assumption qualitative researchers believe that although only an individual can feel his own grief, there is an “essence of grief,” which can be studied and compared between individuals.

The autobiography can be seen as a specific form of qualitative interview, since the author shares deeply personal and context-bound knowledge with the reader (Taylor, & Francis, 2013). It can take one of three forms – comprehensive, edited, or topical (Denzin, 1989). A comprehensive autobiography encompasses the whole life of the author, from the earliest memories to the time of writing. An edited autobiography is a short and abridged version of a full life story. Finally, the topical autobiography, often called the Reflective Topical Autobiography (RTA), focuses on one major theme, providing a snap shot of a specific experience and allowing a “comparison with other (like) kinds of lives” (Berg, 1995, p. 45). The book “My body politic” written by Simi Linton is a perfect example of RTA with one main theme – becoming a disabled person. The book begins with the description of the car accident in which, at the age of 24, Linton became paralyzed and it is entirely devoted to her life as a disabled person. Linton rarely mentions any events before the accident. From time to time, we do get small bits and pieces of those times, but they are used only as a background explanation for thoughts, feelings, and behaviors in her life after the accident. Describing her everyday life experiences as a person with a severe physical disability, Linton also paints a moving picture of her struggles to redefine her role and place in society and her reluctant endeavor to develop a new identity – an identity of a disabled woman. She stated, “The injury was a sudden cataclysmic event, and the paralysis in my legs was instant. Becoming disabled took much longer” (Linton, 2007, p. 3). Careful content analysis of this book extracted two major topics – issues related with the psyche (the identity change) and with the body

(attractiveness, womanhood, and sexuality). Both themes will be analyzed in detail in this article.

Self, identity, and identity development

In the literature, the terms self, self-concept, self-view, and self-definition are often used interchangeably by researchers and in general, refer to the ways people think about themselves. Identity, on the other hand, is understood as an “empirically testable form of the self-concept” (Darling, 2013, p. 6). Three theories attempt to explain the identity concept - role identity, personal identity, and social identity.

The role identity theory, developed by McCall and Simmons, defines the person’s identity as an “imaginative view of himself as he likes to think of himself being and acting as an occupant of a particular social position” (McCall & Simmons, 1978; as cited in Burke & Stets, 2009, p. 39). According to McCall and Simmons, the role identity has two distinctive dimensions – conventional, the social expectations related to the role, and idiosyncratic, personal interpretation of the role. Depending on the person, these dimensions might be very closely related or very dissimilar. To maintain the personal concept of self, the person constantly enacts the role performances, real or imagined behaviors that support their role identity. The more behavior is coherent with the conventional dimension of the role, the more the person is viewed by society as constant. The more it is coherent with the idiosyncratic dimension, the more the person feels constant.

According to McCall and Simmons, the multiple role identities are organized into the prominence hierarchy of identities, or ideal self. The place the specific role identity has in the hierarchy depends on three factors – support for the identity (self and social), commitment to the identity, and rewards (intrinsic and/or extrinsic) received from adhering to this identity (Burke & Stets, 2009).

The personal identity theory, developed by Stryker on the basis of the previously described role theory and Mead’s social theory, emphasizes the impact of demographic, social, and cultural factors on the development of identity (Burke & Stets, 2009). Stryker believed that personal identity is what makes a person distinctive from other members of the social group. According to him, this personal uniqueness develops through personal biography (i.e. birthplace, historical time), personal characteristics (i.e. witty), role identities (i.e. mother, student), and a combination of private and public experiences (Andriot & Owens, 2012). Stryker was especially interested in the role identity and in the impact it has on the person’s behavior. More specifically, he was fascinated by the social meaning of specific role identities (for example, the meaning of the role of the mother in Western society). Considering that

every person poses more than one role in society, Stryker postulated that each person also has multiple role identities organized into a salience hierarchy within self (Stryker & Burke, 2000). According to the concept of salience hierarchy, an identity near the top of the hierarchy (more salient identity) has a higher probability to be activated across various situations and directly dictates the choice of behavior, creating a social impression of a stable, predictable personality. Finally, Stryker believed that salient identity is directly related to the personal commitment to this identity. The higher the cost (personal or social) of giving up the identity role, the more the person is committed to maintaining this role (Burke & Stets, 2009).

According to the social identity theory, developed by Tajfel and Turner, a personal sense of self, a sense of belonging to the social world, depends on the membership in the specific social group. Tajfel and Turner suggested that people view the world as divided into two major groups – us (in-groups) and them (out-groups, Cinoğlu & Arıkan, 2012). Tajfel and Turner proposed that three processes are engaged into evaluating others as “us” or “them” – social categorization (assigning a person to a specific group based on some characteristics), social identification (with the specific social group), and social comparison (usually favorable towards the in-group). According to the authors, identity develops through employing these three processes during the lifetime. In order to increase the personal self-image and the sense of uniqueness of the in-group, people tend to consciously or subconsciously exaggerate the differences between the groups and the similarities within the group (Cinoğlu & Arıkan, 2012).

Disability identity

All three major theories of identity agree that the self and identity develop as a result of societal interaction. People gain knowledge about the meaning of the specific role identities and the value associated with them in two ways - directly, through interaction with other members of their social group and indirectly, through media. By the time a person enters adulthood, self is already more or less established and relatively stable, although it is definitely not fixed. Self and identity tend to constantly evolve to incorporate new identities and to redefine the old ones in the new context. These changes are usually gradual and hard to notice in the short term; however, at times they can also be dramatic and sudden. Strauss coined the term turning point (1962, as cited in Darling, 2013) to describe the change of identity as a response to becoming a member of a new social group, such as the moment of entering college. Consequently, the moment of acquisition of a disability can be seen as such a turning point. At that moment, the person is suddenly thrown out from their

previous social group, immediately losing membership in the group of “us –able people” to become one of “them –dis-abled people”. Simi Linton experienced this sudden switch herself:

“Becoming disabled took [me] much longer. I learned along the way how a young woman of privilege, (...), could, by the collision of a tinny Volkswagen bus into cement embankment on Interstate 95, become a marginal citizen, her rights and liberties compromised, and her economic advantage, white skin, and private school education weakened currency in this new world she inhabited. It was, of course, the same world I had always lived in, but when I was a nondisabled person I hadn’t recognized the ways that world had favored me. I had always taken it for granted that if I could go places or get jobs that disabled people couldn’t, it was because I was strong and healthy and they had their deficits and incapacities.” (Linton, 2007, p. 3).

The turning point of acquisition of disability might also mark the beginning of the long journey to developing the disability identity. However, it appears that acceptance of the physical limitations of a disability is easier than the development of the psychological identity of a disabled person. A few months after the accident, Linton was able to accept the fact that she will never be “normal” again:

“More and more I seemed to absorb disability. It’s not that I was at ease. My mind darted about and I was rarely calm, but disability seemed, even in those first few years, a given in my life. I sometimes felt sad not to walk or run or dance, but I did not argue with it, or bemoan my fate, or desperately look for cures. My frenzy, it seemed, was about making it on the road I was on” (Linton, 2007, p. 31).

On the other hand, it took her close to 20 years to acknowledge her new identity: “I have become a disabled woman over time. I certainly would have rejected such a title at the beginning” (Linton, 2007, p. 108). Shakespeare (1996) noted that newly disabled people often try to stay their old self and to feel as ordinary as possible. Linton experienced these feelings herself: “Could I pull it off – being a disabled person in a sea of nondisabled people, asking that nothing much be made of the fact, that we could all just get along and have a jolly time?” (Linton, 2007, p. 32). She accepted that the accident changed her: “Something serious had happen to me, and I was starting to feel like a more substantial person. A woman now, although no longer a

married woman and no longer a walking woman, I was, mercifully, no longer a girl.” (p. 15), but she did not include disability as part of herself for a long time: “I was just feeling my way with the disability thing.” (p. 27).

Undoubtedly, she was not the only one. Research suggests that most newly disabled people reject the idea of disability identity (Darling, 2013). Hughes et al. (2005) argue that the main reason for such a reaction is the way society perceives disability and disabled people. On the other hand, there is a discussion between specialists in the field as to if the single disability identity even exists. Shakespeare (1996) suggests that the disability identity is a complex and fluid concept due to the fact that not all disabled people experience the same degrees of barriers and discrimination. Disabled people create a diverse minority of people of all races, ethnicities, classes, ages, and gender and vary greatly by the visibility of their impairment. All these factors play a major role in the experiences of disability. Linton realizes this fact early:

“People with my brand of disability often encounter fewer social obstacles than others do (...) But what if (...) my disability were a little different; what if my speech were affected, or I drooled a bit, or I used a motorized chair that they couldn’t carry up the steps, or I refused to be carried up the steps into an inaccessible church? What if the local college had a few accessible buildings and provided no accommodations to me? What if landlord refused to rent me an apartment, and no one in town would help me expose him and force his hand? These are threads on which my privilege rests.

I am like the well-heeled, elegantly dressed black man who tries to hail a cab in New York City on a winter’s night. I can encounter good neighbors, as he can encounter a taxi driver who will pick him up right away and take him where he wants to go. But we may both find that our privilege doesn’t help us.” (Linton, 2007, p. 52).

Yet, she also realizes that her social status does allow her to lead a more “normal,” full life as compared to the lives of other disabled people:

“I recognize that I am, of my fellow disabled travelers, enormously privileged. I am privileged by a career, and opportunities most disabled people are denied. [People like me] are the tokens. We can go places that disabled people in institutions and nursing homes, those who get stuck in special ed, those who work in

sheltered workshops, those denied employment, and the many who have inadequate health care and inadequate in-home attendant care cannot. We can go away.” (Linton, 2007, p. 76).

To encompass this enormous diversity of disability minority, with all their differences and similarities, a new definition of disability identity had to be coined. Murugami (2009) proposed that the disabled self should be understood simply as “knowing oneself, accepting oneself with one’s limitations, not being ashamed of the limitations but simply seeing them as part of the reality one is in, and perhaps as a boundary one is challenged to expand” (par. 7). Such understanding of the disabled-self allows us to perceive disability identity as a range of self-concepts, rather than a fixed and static state. This definition allows us to see all variations of identities developed by disabled people as normal and healthy. From this perspective, people who, despite being disabled, never incorporated disability as a part of their identity are seen as simply being on the one extreme of disability identity rather than judged as denying the reality they live in. Watson (2002) argues that some people with disability redefine their identity not by including bodily limitations into self but through a reconstruction of what normalcy is. Those people see themselves as “normal” and believe that the “biological” self is unimportant as long as they are able to fulfill their social roles as much as nondisabled persons. Linton also experienced this state of mind:

“I am more interested in (...) building accessible campuses and laws to insure them, than intrigued by finding a way to get my legs moving. There were things I didn’t like, things I hated about this new state, but there were and are things that work well. My body works well. It gets me places, it affords me and, I dare say, others great pleasure.” (Linton, 2007, p. 69).

Darling (2013) presented a slightly different perspective on disability identity. She believed that the societal perspective on physical or mental disability always influences a person’s self. According to her, disability identity develops in a direct relation to feelings of shame and pride associated with health impairment. While stigmatization of disability in society induces feelings of shame in disabled people, pride is a result of participation in the disability rights movement, rejecting the prevailing societal negative view of disability.

The process of developing a new identity, which is not consciously chosen but imposed upon a person by a quirk of fate and which is so negatively perceived by society is not an easy task. Linton comments, “I crept

toward it, then skittered away. I remained for a long time an eavesdropper, a peeper.” (Linton, 2007, p. 109). The unspoken, yet ever-present, negative societal perception of disability tainted Linton’s view of disability so efficiently that it affected her for years after she herself became disabled. In her book, she openly admits having strong negative feelings toward disabled people:

“The abstract category ‘disabled’, or in those days more likely ‘handicapped,’ that I had grown up with carried over even when I got tagged to be on the team. (...) I thought of them [disabled] to be flat, reluctant people, not the sort to stir up the pot, to be juicy and interesting. I urgently hoped that I was all those things, and standing apart from the group, I reasoned, was my only way to prove it. I was determined to stay myself, this disability thing wouldn’t bleed me dry” (Linton, 2007, p. 47).

She did not want to be associated with disabled people in any way and she refused to admit such an association even to herself: “If I were to say ‘I am handicapped,’ it would be saying, I am one of them, not one of me.” (Linton, 2007, p. 110).

With time, this negativistic attitude slowly shifted toward a more positive view and she was able to see some positives in other disabled people. She started to perceive certain people and groups, such as “(...) the gang on the roof at rehab, the Berkley crew, the [disabled] women I interviewed,” (Linton, 2007, p. 66) in a more positive light, but still did not want to be one of them - “I was afraid to linger too long with them, afraid I would be tainted by disability’s ugliness and shame. I’m not like them, I would think, as I saw one of those vans loaded with tired, sad-looking disabled people go by.” (p. 67).

She became constantly aware of the ways other people perceived her: “People startled at the sight of me. (...) Someone was bound to come up and utter a long sigh, or tell me I was brave, or start pushing my chair across the room, uninvited.” (Linton, 2007, p. 32). In the eyes of society, she stopped being her old self, Simi, and became disabled-Simi, “women-in-wheelchair”: “I knew that few people would see Simi as Simi. (...) In the early years with disability, when shame and denial were at their peak, I doubted that people would pay attention to me in the wheelchair.” (p. 107). She was afraid that being a wheelchair user puts her “lower on the hierarchy” (p. 61). Unfortunately, she was right. In the eyes of society, almost overnight she regressed to not only a dependent, helpless, and tragic figure but also at times to an inanimate being. The accident and physical disability initiated a string of loses. She lost her physical independency: “They [family] did everything for me, and doctors and nurses did everything to me.” (p. 5) and

became a child again: “At twenty-four I was again playing the adolescent games with my mother that I had left home six years before to get away from.” (p.23). She lost feelings of personal importance “I had become an assemblage of body parts, notable only if they worked or not.” (p.6), and at the same time she was treated by everyone as extremely fragile “Everyone had been so nice, so tentative, like maybe I didn’t know what had happen to me” (p.17). She also lost the choice of which social group she could associate with: “We [newly disabled people] had landed in this place with little in common (...) but we had to mingle, there was only one party for us.” (p.11).

Repeatedly, she was treated as a mindless being and talked over: “You can take her down to Gate 14. They will be boarding her in an hour. (...) What will she be having? (...) Oh, you can put her over there. (...) Will she be transferring out of her wheelchair? (...) Ah, yes, we were warned she’d be coming.” (p.71-72). She was defined by her disability: “No matter how I was feeling about life in general or my disability in particular, someone in the course of a day or maybe a week was sure to pronounce it a tragedy.” (p. 33) and other people took ownership of her feelings: “(...) people [were] insisting on telling me what they thought of my sad state or that I was in a sad state and that I was to be commended for my courage in the face of it” (p. 33). When describing these experiences, Linton remarked, “I encountered obstacles every day and new frustrations” (Linton, 2007, p. 33), “I get tired of being talked of in the third person, of being polite in the face of rudeness, and of being ignored.” (p.71).

Research shows, that people who live with a disability long enough to experience years of discrimination and social stigma at some point tend to actively engaged in the disability movement (Schur, 1998). It appears that this is exactly what happened to Linton. Several years after the accident, angry and tired at societal discrimination and prejudice toward disabled people, she attended her first disability movement meeting. She describes it as profound experience:

“I settled toward the back at the meeting, feeling somewhat guarded, still unsure of what this all had to do with me. They spoke of disability rights, and disability pride, power, activism. They said *crip* and *cripple* casually, and with fondness for the person described. I had been so tentative about my disability, and had, up to now, only ascribed a very personal meaning to it—this is what happen to me, this is the effect on me—that their forthright ownership of disability and their drive to take action based on the collective experience set my mind racing. There was a fervor in that room, and I felt illegitimate somehow because I didn’t share

it. (...) The problem, as I came to understand it, was not that I couldn’t walk; it was that the society was configured for those who do walk, see, hear, etc.” (Linton, 2007, p. 53-54).

That experience was literally a Strauss’ turning point for Linton; meeting a new social group and joining in launched her process of mental healing and the integration of physical disability with internal identity –

“That summer I began to recognize the whole me when I looked in the mirror. I was able to see my seated self and the chair I sat in as a unit. I didn’t *divvy* us up, screening out the chair as I had previously done, with the hope that onlookers would do the same.” (Linton, 2007, p. 54).

Her progress toward disability identity was not an easy one, though. It took her over 20 years to become, in her early forties, an involved disability activist:

“I was never a joiner. (...) It took many people to bring me into the fold. To help me move toward disability, carrying myself in the upright posture of a newly enfranchised citizen. My advancement was due to other disabled people and, significantly, to the times we were living in.” (Linton, 2007, p. 108). “I have attended every SDS [Society for Disability Studies] conference since my first in 1990, quickly became active in the organization, and am now on the board.” (p. 138).

One of the more interesting models of disability identity formation is the one created by Gill (1997). Her non-linear model includes four stages of identity development – “coming to feel we belong,” “coming home,” “coming together,” and “coming out.” This model elegantly sums up Linton’s conquest to integrate the old and new elements of self and to become once again a full and complete person. The first stage, coming to feel we belong, focuses on the levels of integration into society and on the experiences of discrimination and oppression – “It was clear from our experience inside the rehab world that people like us were not in charge (...) people like us were largely invisible.” (Linton, 2007, p. 109). The second stage, coming home, concentrated on initial contact with others with disabilities and the first realizations of kinship – “While I initially came to SDS [Society for Disability Studies] for the ideas, I stayed for people.” (p. 139), “Harilyn was the first disabled woman I called friend. We met before I had a sense of why I would want or need a disabled friend, and so I just began to like her.” (p. 148). The third stage, coming together, refers to the process of internal

integration of the shattered self and to the acceptance of physical limitation as a normal part of self –

“I went to a Joan Baez concert (...). I went by myself and sat in the ‘Wheelchair Section.’ I had never before sat side by side in public with the so-called Handicapped. In the previous few years my triumph had been in transferring my body into a regular theater seat, my wheelchair whisked off to a rear closet, made invisible. But here I was, hangin’ with a bunch of other crips. I had by then adopted the word, though not the full swagger that goes with its use.” (Linton, 2007, p. 54-55).

Finally, in the four stage, coming out, a disabled person integrates internal and external presentations of self and becomes proud of who he/she is – “I am a ‘disable woman,’ (...) That means that I identify as a member of the minority group – disabled people – and that is a strong influence on my cultural make-up, who I am, and the way I think.” (Linton, 2007, p. 118).

Disability and Gender and Sexuality

Developing a disability identity might be a long and complicated process; however, we cannot forget that this identity is just one of the multiple identities a disabled person holds. In addition to disability, people are also viewed in the context of their gender, race, ethnicity, and countless other social roles. These characteristics influence disabled people in two major ways. These other identities can multiply the disadvantages experienced by a person with a disability by adding further stigma to their impairment (for example, when the person experiences negative attitudes related with their race and disability). They can also create a completely new construct, holding new meaning and characteristics, and separating people with disabilities from nondisabled persons with the same identity (as is the case in being disabled woman).

When a person holds two or more socially devaluated identities, he/she almost always encounters the “double jeopardy,” “triple disadvantage,” or “simultaneous oppression” (Vernon, 1999) or experiences being a “minority within a minority” (McDonald, Keys, & Balcazar, 2007). McDonald explains this experience using the words of a young disabled African American:

“Whenever the subject of race came up at home, someone would remind me that as a black person who is also disabled, my chances of achieving anything in life were probably less than zero. It was my ‘destiny’ to suffer twice as much discrimination and to miss twice as many opportunities as the person who is ‘only black’

or ‘only disabled.’” (McDonalds, 1991, as cited in Vernon, 1999, p. 387).

Linton observed similar expectations from the nondisabled culture towards disabled people and she writes:

“We learn that we will be accepted and will succeed to the extent that we conform to the style and compartment of majority culture. Don’t act too black, or too gay. Disabled people are expected to mask the behaviors that would disturb the public, and certainly not to exaggerate or call attention to our odd forms or the way our forms function.” (Linton, 2007, p. 153).

Several authors whose work concentrates especially on the experiences of women with disabilities often use the above terms or terms such as “two handicaps plus” (Hanna & Rogovsky, 1991) and “multiple minority group” (Deegan & Brooks, 1985, as cited in Darling, 2013) to describe their disadvantaged status. Disabled women everywhere experience more discrimination when compared with nondisabled women or disabled men. According to Habib (1995), in developing countries, disabled women are much more likely to be poor, have difficulties with obtaining services, and experience physical, sexual, and psychological abuse. Similarly, disabled women in developed countries are less likely to marry, have higher education, or employment (Hanna & Rogovsky, 1991; Darling, 2013).

However, this is not always the case; not all disabled women perceive their gender as an additional complication. For example, Linton did not expect that her gender would be any problem in her life after the accident. She did not believe that being a disabled woman could be any worse than being disabled: “Partly because I was naïve and partly because my mother was a strong businesswoman, I had never seen my gender as an obstacle to anything I might want to do. I was certain that my disability would be.” (Linton, 2007, p. 80). Yet, this belief did not protect her from being affected by the way society views disabled woman. According to Blackwell-Stratton et al. (1988, as cited in Darling, 2013) disabled women experience “rolelessness”, which means that they are not allowed to fulfill the stereotypical womanly roles, such as mother or wife, but instead are seen as “eternal poster child, cute but not sexy, always cared for, never the caring.” (p. 55). Linton experiences exactly that: “(...) my mother called David’s mom, and asked in so many words whether it was OK with her that David would be marrying me – my mother was worried that she would not want her son marrying a disabled woman.” (Linton, 2007, p. 101).

People with disabilities are also not viewed as attractive. In a large survey conducted by Nario-Redmond (2010, as cited in Darling, 2013), disabled people were described by nondisabled ones as “unattractive, dependent, incompetent, and asexual” and “never labeled as feminine” (p. 56). Even more, according to Hahn (1988), nondisabled people experience an “aesthetic anxiety” when confronted with a disability, which results in the rejection of disabled people. Darling (2013) suggests that the stigma of disability is even higher in American society due to prescribing so much value to physical attractiveness, physical abilities, and intelligence. Hanna and Rogovsky’s survey (1991) showed further that the word woman is wildly associated with the term “beauty” while the term disabled woman is associated with words such as “ugly” and “unpleasant.” However, not all women experience this kind of discrimination. In some cases, objectively attractive and young disabled women experience a little different attitude – a surprise. Nondisabled people are surprised by their attractiveness and perceive it as incompatible, as a unique exception from the general rule. Linton recalls experiencing this kind of perspective herself, citing people’s reaction: “Oh, my dear, what a shame, and you’re so pretty, too!” (Linton, 2007, p. 28).

Such experiences are common between disabled women. Fine and Ash (1988) noted that disabled girls are discouraged from being physically and sexually attractive and that they are told instead to concentrate on other areas of life, such as education and career. During her graduate studies, Linton conducted a series of interviews with women who became disabled at a young age as a result of polio. She noted that they all learned exactly what Fine and Ash were talking about. These women were told that a ‘normal life’ is not something they will ever be able to experience: “Parents would often speak to siblings about future romance and marriage, but never mentioned that to their disabled children. Instead, they were told to do well at school and work toward career. Their sister’s clothes were, they remembered, prettier and more feminine than theirs.” (Linton, 2007, p. 66). Their experiences closely resonate with other research. Whitney (2006) who conducted a series of interviews with queer women with disabilities writes, “An individual with a disability was often perceived as a child and treated as such. Individuals with disabilities were assumed to be completely asexual (...) Individuals were categorized as (...) sexually deviant and dangerous if they did express sexual desires.” (p. 39-40).

As was mentioned before, disabled people, women particularly, are perceived as asexual beings and expected to behave accordingly. Yet, research shows that positive sexual identity and body image are very important to the overall psychological well-being and

life satisfaction (Darling, 2013). Howard (2000) defines sexual identity as “awareness of one’s self as sexual being” (p. 377). Moin, Duvdevany, and Mazor (2009) further specified the meaning of sexual identity as a multidimensional concept, which includes sexual self-esteem (self-perception of being a good/bad sexual partner), sexual preoccupation (awareness of the importance of a sex life), and sexual satisfaction. Their study on sexual identity in disabled women showed that although disabled women have similar levels of sexual needs and desires as nondisabled women, they also had lower levels of sexual self-esteem and sexual satisfaction. The authors suggest that the main reason for such results are the experiences of negative attitudes from the nondisabled people and the lack of opportunities to form a sexual relationship due to social isolation. Linton describes her first thoughts and confusions related to sexual life after the accident:

“Our bodies had changed, our lives had changed. Some had partners who wanted them to be the ‘way they were before,’ some didn’t know how their partners felt and were afraid to ask, and some of us, like me, were alone, not knowing how we would meet anyone now. What was clear and uniform across the group was that we had strong desire. We felt lust in our hearts, and our bodies tingled and stretched out toward sex, toward pleasure.” (Linton, 2007, p. 12).

Regardless of the normalcy of sexual desires in disabled people, even medical doctors were not free from social biases mentioned above. Linton recalls multiple situations when her attractiveness and sexuality were denied, for example during the discussion with her psychiatrist when he found out about the homosexuality of one of her male friends (Vic) and decided to ‘fix him’ by finding him a girlfriend:

“I had the sense that the doctor was sizing me up – would I [as a woman] be able to deliver the cure? He didn’t seem to think I could do the job, because he looked me up and down and said, ‘Well, not you, of course,’ but asked if Vic had ever expressed interest in any of my friends.” (Linton, 2007, p. 35).

Linton vividly remembered the first comment after the accident, which maybe she would see as inappropriate in her previous life, that made her feel attractive again: “Charles [physical therapist] came up to me, leaned way down, and, with a sly chuckle in his voice, whispered to me: ‘Been doin’ them horizontal exercises?’ That is the sweetest memory I have of that place. Here was my big brother telling me: ‘You’re OK.

You're attractive. You're going to make it. Go ahead, enjoy your life." (Linton, 2007, p. 14).

Still, disabled women are not expected to marry, and even so, they are not expected to marry nondisabled men, because how "can she minister to his needs when a disabled woman epitomizes all that is needy herself?" (Fine & Ash, 1988, p.17). Thus, Linton heard from one of her doctors "You know," he said, "there are many young men coming back from Vietnam in the same situation as you, and I know you'll find someone really nice to settle down with." (Linton, 2007, p. 4). To Linton, at the beginning of her journey as a disabled person, the idea of being attracted to disabled person was ridiculous: "Did he think that I could now simply be matched with a Vietnam vet, two people with nothing in common but wounds?" (p. 4) and still baffling a few years later: "Meeting a disabled man head-on, and being attracted to him, confused me. I had grown up thinking that disabled people are the unfortunates of the world. (...) Yet Philip couldn't be one of them, he was too much like me, and so I had to exempt him too." (Linton, 2007, p. 49). Nevertheless, Linton admits that the thought of dating a disabled person made her uneasy, "I had a vision of both of our wheelchairs, side by side at the movies, across from each other at the kitchen table, parked at night on either side of a king-size bed. I feared that 'we' would double the jeopardy, and I would lose my footing in the nondisabled world." (p. 49). In her memoir, Linton admits that she dated only nondisabled men and eventually married one. Research suggests that this is not that uncommon. A study conducted by Barron (1997) showed that some disabled women felt "worth something" only when dating nondisabled men. Linton admits that for her, dating nondisabled men was a way of proving to herself that she did not change that much; that she still remained the same attractive woman she was before the accident:

"I had a number of relationships in those years. (...) It was in part, I think, a reaction to my fear that I would not be able to gain the attention of men now that I was disabled (...). And then, with disability in picture, I was also afraid that ultimately my chosen man would reject me, that despite how much I had grown and strengthen myself, I was too small, and I was in disrepair. I could not stand by my man. I could not stand up to his scrutiny. I could not meet his standards." (Linton, 2007, p. 90).

When she started dating her future husband, she was still in the process of accepting her new self. Unsure of her own feelings about disability, Linton was reluctant to let him meet her disabled friends: "I thought that if David saw me with Glenn, and others who are disabled, the reality of my disability would hit him. He

would be scared off." (Linton, 2007, p. 78). Yet, with time and with the acceptance of her new self and her new body, Linton was able to mentally relax and trust that her "chosen man" will also accept her the way she is. She recalls, "Over time, we learned the tricks of my tricky body. (...) I came fully equipped, just powered differently. We grew together. We grew more intimate." (p. 131). After 32 years, they are still married.

Conclusions.

Simi Linton's book, "My Body Politic," is one of those books that brings psychology back to everyday life. Suddenly, a real person emerges from behind the impersonal and abstract numbers and statistics of psychological articles. When we read this intimate story, we do not simply learn about the phases of development of a new identity from Linton, we experience each phase through her. We have a chance to get to know her, feel her, and understand her on a very deep psychological level. Even more, we become more able to understand the experiences of other people with the late acquisition of a disability. We develop a deeper understanding of people's functioning, creating connections between intellectual knowledge and emotional consonance.

To be well equipped to work as a psychologist, we need to possess not only hard factual knowledge but also the ability to "feel" our clients. Thus, psychological research needs to find the right balance between physical and spiritual dimensions. Unfortunately, it seems that in the age when research must be cost-effective and fulfill very specific statistical requirements to be publishable, the human aspect of psychology became underappreciated. Still, we cannot forget that only through intimate conversations with other human beings can we reach a common understanding - find the essence of the shared experience. Books such as "My Body Politic" are a perfect reminder of that fact.

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Trauma-Focused Cognitive Behavioral Therapy: An Evidence Based Practice Applicable with Minority Children

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Today, it is suspected that around 25% of youth experience at least one traumatic event (Woodworth, Black, Tremblay, & Carpenter, 2012). Some children develop post-traumatic stress disorder (PTSD), behavioral disorders, depression, anxiety, shame, cognitive distortions, somatic complaints, concentration difficulties and nightmares as a result of trauma. Trauma Focused Cognitive Behavioral Therapy (TF-CBT), which was originally developed for sexually abused children (Cohen, Deblinger, Mannario, & Steer, 2004), has been adapted to work with children who suffer other types of trauma such as physical and/or emotional abuse, experience of a natural disaster or terrorist attack, witness the death of a loved one, or multiple traumas. TF-CBT is an evidenced based practice (EBP). EBPs are practice and policy guidelines that are based on a review of quality research for specific psychological disorders, bio-psychosocial conditions, and life problems (Spring, 2007). The purpose of this manuscript is to describe how TF-CBT meets the criteria of an EBP, particularly with regards to diversity application.

Keywords: Deaf, hard of hearing, immigrants, resources, access

Introduction

Current estimates predict around 72% of individuals will experience some kind of extreme stressor in their lifetime (Woodworth, Black, Tremblay, & Carpenter, 2012). In the United States, it is suspected that around 25% of youth will experience at least one traumatic event. According to the American Psychological Association (APA), a traumatic event “include[s] the following: a sudden or unexpected event, the shocking nature of an event, death or threat to life or bodily integrity, and/or the subjective feeling of intense horror, or helplessness” (2000). Common examples are: sexual/physical violence, domestic/community violence, neglect, bullying, serious accidents, natural or other disasters, fires, traumatic deaths, war, terrorism, and medical trauma (CATS Consortium, 2010; Woodworth 2012).

The majority of children who experience a traumatic or aversive event do not develop psychological symptoms (Woodworth et al., 2012). Nevertheless, a small subset of children will begin to exhibit a range of biological changes and psychological symptoms characteristic of various disorders (CATS Consortium, 2010). The most common disorders and symptoms for a child to experience after a traumatic event are post-traumatic stress disorder (PTSD), behavioral disorders, depression, anxiety, shame,

cognitive distortions, somatic complaints, concentration difficulties and nightmares (CATS Consortium, 2010; Woodworth 2012; Cohen, Mannario, & Deblinger, 2010).

Research shows that factors such as gender, genetics, length and severity of traumatic experience, parental emotional distress, and social support strongly influence the development of psychological symptoms after trauma (Cohen, Deblinger, & Mannario, 2004; Woodworth et al., 2012; Cohen, Mannario, & Deblinger, 2010). In addition, exposure to one traumatic event increases the likelihood that an individual will experience another such event (Woodworth et al., 2012). These factors make diagnosing and treating children for PTSD very difficult. Currently, Trauma Focused Cognitive Behavioral Therapy (TF-CBT) is the most effective and commonly used therapy to treat the symptoms of PTSD in children.

Trauma-Focused Cognitive Behavioral Therapy

TF-CBT was originally developed to work with children who have been sexually abused (Cohen, Deblinger, Mannario, & Steer, 2004). Over time, TF-CBT has been shown to be effective with other types of traumas, such as natural disasters, terrorism, and repeated trauma (Little & Akins- Little, 2009; CATS Consortium, 2010; Woodworth et al, 2012). The

ultimate goal of TF-CBT is to help children to manage stress and change their reactions to stimuli that remind them of their trauma (Cohen, Mannario, & Deblinger, 2010; Woodworth et al, 2012).

TF-CBT incorporates multiple theories - humanistic, psychodynamic, attachment, and family trauma. The core premise of TF-CBT is that trauma causes a deregulation of affective, behavioral, cognitive and physiological areas (Woodworth et al, 2012). For example, children typically have an egocentric view of the world and as a result, they often blame themselves for the trauma. In situations of abuse, children learn “traumatic bonding” or alignment with the abuser’s beliefs to discourage further mistreatment. TF-CBT states that these maladaptive distortions in one area promote further maladaptation in other areas of life. Similarly, wellness in one domain can increase wellness in another (Cohen, Mannario, & Deblinger, 2010). TF-CBT also suggests fear in one situation can be generalized via reinforcement to other environments where fear behaviors are not effective.

The structure of TF-CBT is very specific, but at the same time endeavors to create flexibility to meet a wide array of client needs. Before the first session, the therapist should conduct an initial intake. During the intake, the therapist collects different information from the parent and child through separate interviews. With the child, the therapist will ask for a positive narrative to evaluate the child’s readiness for therapy and to improve the child’s recall of the traumatic event. During the parental interview, parents are screened for distress and level of involvement in their child’s life, as parental stress responses influence the coping of the child. Moreover, parents will be asked about their child’s prior adjustment, coping styles, their temperament and pre-existing psychopathology. Then the child will be evaluated using psychological measures to assess CRAFTS problems (Cognitive, Relationship, Affective, Family, Traumatic Behavior and Somatic Behavior).

TF-CBT is implemented through 8 phases given the acronym, PRACTICE (Psycho-education/Parenting; Relaxation; Affective Expression; Cognitive Coping Skills; Trauma Narrative and Cognitive Processing; In Vivo Mastery of Trauma Reminders; Conjoint Parent-Child Session; and Enhancing Safety /Development). Completion of all modules takes between 8-20 weekly 90-minute sessions. As not all children require all modules, the therapy may be tailored to suit the specific needs of a child. Most commonly, children with PTSD symptoms just below clinical level will be given only the PRACT modules. After completion of therapy, clients may still need to be referred for further treatment of associated disorders (Cary & McMillen, 2012).

Certain criteria must be met in order administer TF-CBT. One example is age, as TF-CBT is recommended only for children between the ages of 3 and 18. Another

criterion is the clinical level of PTSD symptoms. TF-CBT is not recommended for children below the clinical expression of PTSD (Cohen, Mannario, & Deblinger 2006). Finally, all clients should be screened for suicidal tendencies and hallucinations. Client suicidality frequently prevents conducting TF-CBT; however, if necessary TF-CBT may be modified to provide treatment in more supportive manner, so as not to worsen symptoms. For example, the PRAC sections can be prolonged to emphasize coping techniques. Additionally, the TI components can be addressed in a slower fashion. TF-CBT is not effective with treatment of hallucinations; however, many children experience flashbacks that mimic hallucinations, which can be effectively addressed during TF-CBT. Furthermore, many children treated with TF-CBT have comorbid psychological and psychiatric disorders such as oppositional defiance disorder, depression or anxiety (Cohen, Mannario, & Deblinger 2006). In these cases, the therapist must determine the root cause of comorbid psychological symptoms in order to assess if TF-CBT needs to be altered or if the child needs referral to address emotions/behaviors that would interfere with trauma processing. Lastly, TF-CBT should be used with parents/guardians when possible, but the level of parental involvement may be adapted to best suit the child’s needs.

TF-CBT as an Evidenced Based Practice

Historically, insurance companies have endorsed evidence-based practices (EBP). EBPs are practice and policy guidelines that are based on a review of quality research for specific psychological disorders, biopsychosocial conditions, and life problems (Spring, 2007). In order to be considered an EBP, therapies need to: demonstrate higher effectiveness than at least two other therapies or placebo in a randomized control trial (RCT), have the ability to be replicated (particularly through the use of a manual), meet patient preferences, and cater to a diverse sample (Chambless & Hallon, 1998). TF-CBT is only one of three interventions for child trauma that meets the criteria for an evidenced based practice by Kauffman Best Practices Project (Little & Akin-Little, 2009). In 2007, TF-CBT was the only trauma-informed therapy supported by California Evidenced Based Clearing House for Child Welfare (Woodworth et al, 2012; Little & Akin-Little, 2009).

RCT and placebo trials using a manualized approach provide relatively strong support for TF-CBT. In its infancy, TF-CBT was centered on work with children who had been sexually abused. Numerous studies have shown that TF-CBT with children who have experienced sexual abuse results in a significant reduction of PTSD, depression, behavior problems, shame and abuse-related attributions (Cohen and Mannario, 1996; Cohen and Mannario, 1997; Cohen et

al, 2004). Parents also demonstrate greater improvement in a variety of areas; even they are not the identified patient (Cohen et al. 2004). Furthermore, TF-CBT has been applied to children and adolescents who have experienced other traumatic events. For example, after Hurricane Katrina, 118 children in 4th- 8th grade from New Orleans who screened positive for PTSD symptoms were given Cognitive-Behavioral Intervention for Trauma in Schools (CBITS) and TF-CBT (Jaycox et al., 2010). Although both therapies reduced PTSD symptoms, the TF-CBT was found more effective. Children treated with TF-CBT showed PTSD symptom scores in the normal ranges, while those in the CBITS group scored in the low clinical ranges. Recently, two large meta-analyses of all trauma-focused studies using manuals have been conducted. The results support TF-CBT as the most studied and endorsed therapy (Cary & McMillen, 2012; Sheeringa, 2011; Woodworth et al, 2012). More specifically, the results demonstrated that when treated with TF-CBT children's symptoms of PTSD, depression and behavior problems were significantly reduced (Cary & McMillen, 2012).

TF-CBT has been investigated by a variety of different research groups and shown to be replicable. The CATS Consortium studied the effect of trauma in NYC over about 45 different sites and 700 children (2010). Jaycox and colleagues studied the impact of Hurricane Katrina on children from three separate schools in New Orleans (2010).

Unfortunately, in the area of patient preference and clinical expertise, TF-CBT is not as strong. Only minor modifications, such as parental involvement and cultural relevance, can be made to TF-CBT. Large changes to accommodate patient preferences cannot be made, as a high level of structure is necessary. With regards to clinical experience, TF-CBT is relatively new (the manual was only developed 6 years ago) so there is little research. Furthermore, TF-CBT is frequently implemented into natural disasters where the supervisors who teach it quickly become overshadowed by the their students (Woodworth et al, 2012).

One of the core tenants of TF-CBT is that "effective treatment must be in line with the families' religious, community, and cultural values" (Little & Akin Little, 2009). As such, TF-CBT excels in its application with a diverse population. TF-CBT has been shown to be effective with Native Americans, African-Americans, Latinos, military families, and children with developmental disabilities (Little & Akin Little, 2009; Woodworth et al, 2012). TF-CBT has also been used outside of the country, with individuals from New Zealand and Zambia (Cohen, Mannario, & Deblinger, 2010). Additionally, the materials used in TF-CBT are available in different languages such as Spanish, German, Dutch, and Chinese (Cohen, Mannario, & Deblinger, 2010; Woodworth et al., 2012). As the

domain of diversity is such a strength of this therapy, greater attention and criticism must be given to TF-CBT in order to promote further growth.

Minorities. Over the last couple of years researchers have developed full adaptations for the clients with Latino and Native American origin (Bigfoot & Schmidt, 2010; CATS Consortium, 2010; Kataoka et al., 2003; Woodworth et al, 2010). Latinos are the largest minority group in the US and they also have the greatest amount of diversity. Furthermore, Latinos have some of the highest rates of sexual assault, harassment, and family abduction (Kataoka et al., 2003). Cultural adaptation research with TF-CBT reveals that Latinos require higher warmth, greater psychoeducation, greater inclusion of fathers and the extended family as well as the incorporation of spirituality and conservative beliefs (Cohen, Mannario, Deblinger, 2006). Kataoka and colleagues were the first to pioneer development of a group TF-CBT Latino adaptation catered to immigrants and delivered in Spanish by bicultural social workers. The results revealed the intervention group had significantly greater improvement in depression and PTSD symptoms.

Bigfoot and Schmidt (2010) have adapted TF-CBT for the Native American population and renamed the therapy, Honoring Children, Mending the Circle (HC-MC). Native American children often have a significant amount of trauma exposure that is left untreated (Bigfoot & Schmidt, 2010). In particular, Native American children are more likely to receive mental health treatment through the justice system and inpatient facilities. They also are more likely to receive services from health providers that are poorly trained to work with their culture. The goal of HC-MC is to remove some of these barriers by having therapists consult with the family about the extent and implication of cultural components in therapy (Bigfoot & Schmidt, 2010).

Deaf. TF-CBT has not explored application with a deaf or hard of hearing population despite the fact that this population is at a higher risk for experiencing traumatic events. Research shows that approximately 80% of people with disabilities and 50% of women with hearing loss have been sexually assaulted (Deaf Abuse Women's Network, 2013). These statistics have not changed in years, despite the introduction of numerous programs (Sullivan, Vernon, & Scanlan, 1987; Deaf Abuse Women's Network, 2013).

Similarly, there are no studies exploring the application of TF-CBT with a deaf population. Glickman has explored adapting Cognitive Behavioral Therapy (CBT) with deaf individuals; especially those classified as low functioning or traditionally underserved (2009). The term "traditionally underserved" is often used to describe people who have

inadequate communication skills due to limited language exposure, vocational difficulties, living skills deficiencies, mental and physical limitations as well as behavioral, emotional and social emotional difficulties. One of the most common barriers in therapy with the traditionally underserved is communication. Oftentimes, professionals do not have the language or cultural knowledge necessary to work with the deaf population. Therefore, Glickman suggests adding a pretreatment phase, during which the language and learning challenges will be addressed with the client. During this phase, he advises that the therapist should discuss with the client the purpose of therapy as well as previous negative experiences or attitudes. He also suggests the therapist capitalize on strengths of the client, and avoid an authoritarian stance. During therapy, Glickman recommends focusing on cognitive developmental skill acquisition one at a time, and using the client's cultural beliefs to facilitate therapy.

Although interesting and useful, Glickman's changes are just the beginning. Much more work needs to be done to identify the specific practices that would be helpful with the traditionally underserved deaf adults, clients with hearing aids or cochlear implants, clients who prefer alternative means of communication, and clients with various cultural identities. Such a cultural adaptation to TF-CBT is extremely necessary given the high rates of sexual assault, domestic violence, and abuse present in the deaf and hard of hearing population.

Future Research and Conclusions

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is one of the most well supported Evidence Based Practices (EBP) for children experiencing trauma. It has been shown to reduce PTSD, depression, anxiety, and behavioral symptoms upon conclusion of at least eight sessions. TF-CBT can be used with clients representing many different religions, ethnicities, and cultures. There are currently at least two different adaptations for Latino and Native American cultures.

Nevertheless, TF-CBT has gaps and weaknesses, like most EBPs. TF-CBT does not maintain its efficacy from on a follow-up trial 12 months later for treatment with depression, anxiety, and behavioral problems. Furthermore, TF-CBT does not have much research devoted to clinician characteristics nor patient preferences. Currently, TF-CBT is not conducive to work with a deaf population – many who are at higher risk for experiencing trauma.

Future work with TF-CBT should address a multitude of questions. Questions such as whether all modules are necessary, can TF-CBT be further tailored to the client's cultural context, is a specific therapist temperament more effective, what is the necessary amount of training needed for a therapist, and describing how to maintain the fidelity of TF-CBT during

dissemination is crucial. TF-CBT developed tremendously through the last four years, but it needs to keep developing to be effective with all clients and populations.

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INFLUENCE OF POST-FORMAL THOUGHT ON INTELLECTUAL TESTING

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Postformal thinking (PFT) is a newly defined stage of thinking that is unfamiliar in cognitive testing. In order to have appropriate assessments, clinicians must have a thorough understanding of what PFT is and the stages of how it develops. Hypotheses of how this may influence testing and how a clinician can discern scores that are impacted by PFT are provided with examples.

Keywords: postformal, development, cognitive assessment

The type of thinking measured on intellectual tests, such as the Wechsler Adult Intelligent Scales (WAIS), can be considered formal operational. The formal operations stage is noted by the ability to make and test hypotheses (Miller, 2011). Not only is the person able to solve problems presented, as in the operational stage, the person in formal operations is able to extrapolate future problems and solutions. When offered a novel problem, a person who has reached this stage will go about solving it in a scientific fashion, using logic, prior knowledge, and testing to reach an answer. This is not limited to science and math; these skills allow adolescents to make goals, engage in debate, and reflect on their own thinking. The general principle of this style of thinking is that there is a right, or at least a best, answer.

However, when a question is analyzed in depth, the concept of there being only one answer becomes less obvious. In Piaget's model, cognitive development stops at adolescence at the formal operational stage. At the same time, even ignoring increased crystallized intelligence, the difference between how young adults and older adults approach cognitive tasks is clear. As such, the introduction of post-formal thought occurred.

Defining Post-formal Thought

Post-formal thought (PFT) is the person's ability to understand and coordinate multiple perspectives and apply them appropriately. Kramer (1983) summarizes Post-formal thought into three skills: the realization that knowledge and information is limitless yet relative, the acceptance of paradoxical beliefs, and the integration of conflicting viewpoints into a whole of personal beliefs. This is quite different from formal operational thought. Formal operational thought holds that all knowledge is

attainable given time and resources, while post-formal thinkers understand that some questions do not have answers and what is considered "knowledgeable" varies by context. For example, an undergraduate psychology student's perspective of what "a lot" of research is significantly differs from a graduate student's perspective.

Additionally, the post-formal thinker can accept paradoxical beliefs as having merit, or at least understands the argument of the other side, even if one strongly disagrees with the opposing viewpoint. In formal operational thought, it is generally held that there is one best answer that can be reached. However, reality is often more complicated than having one simple solution and post-formal thought is better able to accommodate this reality. Finally, the post-formal thinker is able to sift through beliefs that seemingly contradict and create a sense of self from that. However, unlike other stages of development, the attainment of PFT means the loss of some other cognitive efficiency. Sometimes, in life, there is a correct answer or a best answer. While the development of PFT is useful in understanding that there are multiple perspectives, it slows the user in finding the correct answer. There is a common pattern in seeing older adults perform lower on intelligence testing, specifically in areas of fluid reasoning (James, Wilson, Barnes, & Bennett, 2011). Part of this may be due to increased PFT and not always due to other factors associated with old age, such as cognitive decline.

Cognitive Testing and PFT

Even though there are more theories and perspectives about intelligence, cognitive testing limits the definition of intelligence to a more concrete and

academic model. This can put people who are vastly intelligent, but do not think in the approach typical for society, at a disadvantage in the testing process. While the ability to think and approach problems in a way that works with general society is important information to gather, the idea that approaching a problem how the majority of people do so quickly and accurately is the only expression of intelligence is clearly false.

In the real world, life cannot be broken down into simple math problems and questions of value are part of determining a feasible solution. What is generally considered to be perseverative or hyper-focusing can be evidence of PFT. For example, some questions on the Comprehension subtest on the Wechsler Intelligence Scale for Children (WISC) and WAIS may evoke in tested person questions about the context. One good illustration is a question, which asks what to do if someone smaller than you is trying to start a fight. It is not considered an acceptable answer to say "allow them to get a hit in and then gently stop the fight" (Wechsler, 1949). However, some cultures do not allow for fights to be shut down as not engaging in a fight initiated makes both parties appear weak (Brehmer, 1990). Additionally, an answer such as this may show consideration of the other person's ego, the context behind why the fight was started, and evidence of the risk of getting hurt as compared to damaging the relationship.

Overall, in cognitive testing, it is crucial to remember that the specific answer serves only one purpose - to produce a score that summarize the intelligence quotient (IQ). However, this number only reflects the number of points earned on the IQ scale without considering the thought process behind it. By assessing why specific answers were provided, additional insight can be gained as to the mindset, cognitive abilities, and emotional functioning. In many cases, the quantitative analysis of intelligence is meaningless without the qualitative data which would go with it.

Testing for PFT

PFT is vastly complex concept and includes a variety of levels. While included in the stepwise stages of Piaget, Commons & Ross (2008) propose that PFT has stages that lead to the development of full PFT. These stages include systematic, meta-systematic, paradigmatic, and cross-paradigmatic. Similarly as in Piaget's stages, each PFT stage builds on the complexity of the thought processes gained before. Of course, different tasks require different skill demands, which means that while basics of each stage must develop in order, expertise in the skills associated with each stage is much more variable than the term sub-stages suggests. In general, however, it is easiest and mostly accurate to assume that stages develop more or less in order.

The first stage of PFT, systemic, include people solving multivariable problems (Commons & Ross, 2008). Tasks at this point include seeing and understanding the multiple and intertwining causes that can lead to a variety of effects. In essence, the person internalizes the concepts of multifinality and equifinality, realizing that different causes lead to the same solution and that the same cause can lead to a variety of outcomes. The person then creates a way to organize this information, using cognitive mapping and/or concrete data tables. Finally, at this level the person can use both types of information to plan action and beliefs based on their preferred outcome and prioritization of factors. The world is seen as a set of interlocking relationships. Though the person is advanced beyond formal operational thought in their ability to take different perspectives, they still process in a way that is remarkably similar to earlier thinking in formal operational thinking. This person, when presented with a problem, will give the 'correct' answer but then provide an explanation why it is not the real answer.

The person at this stage starts to recognize that the complexity of the world's relationships means that they must think about the world differently and that there is really hard to give one simple answer to any given question. At this point, the person enters the multi-systemic stage (Commons & Ross, 2008). In this stage, the person can vary their actions by comparing, analyzing, and synthesizing the relationships and systems they learned to conceptualize in the systemic stage. Each variable the person has learned to see and analyze are now formed into an equation that their perceptions are analyzed with. The comparison and contrast of the systems allows the person to organize the systems into another level of systems, also known as the super-system. It is hypothesized that only about 2% of the United States population function at this level, mostly professors, researchers, and academics. This population will most likely do the reverse of the previous group, first explaining the 'best' answer and then clarifying with the answer they believe the question was seeking.

The last two stages are reached by only a small fraction of the population. These stages, paradigmatic and cross-paradigmatic, include the ability to understand the multifinality and equifinality of the super-system, use this system to explain and predict the world (or explain why it cannot be predicted), and then understand how different models interact and conflict. In essence, the generation of Post-formal thought happens through the person gaining the understanding of increasingly complex relationships and systems. Because such a small proportion of the population functions on this level, and by nature involves the connection of

information from a variety of sources over time, it is difficult to test for these levels of post-formal thought.

In fact, it is difficult to determine the stage of post-formal thought in tested person. In general, psychological testing is better to determine if the person has post-formal thought or not, not for determining on which level of post-formal thought they are at. Testing for post-formal thought can be done through a combination of self-report measures and through qualitative analysis of responses to intellectual tests. For example, one question on the WAIS-IV asks about the equal distribution of toys. A person with post-formal thought may lose the point because they think about the answer too long, but provides an explanation of what 'equal' means (e.g., if the toys are not all the same, should they be weighted based on quality). This can both identify the presence of post-formal thought and categorize the person into either systemic or multi-systemic post-formal thought. Self-report measures are potentially beneficial to see if the person identifies as thinking in similar patterns as other post-formal thinkers, similar to how self-report is used in identifying Attention Deficit Hyperactivity Disorder (ADHD). However, formal measures to assess the thought patterns of PFT and different thought organizations have not yet been developed.

Conclusion

When conducting psychological assessments, it is not only important to consider what is being measured but also the theory on which the selected measurement

is based on. It is important to not over-embrace the typical assumption of testing: lower scores indicate lower abilities. Instead, it is crucial to remember that lower scores on a standardized measure of intelligence which indicate lower performance, can occur for multiple reasons, one of which is cognitive impairment. However, a low score may also be indication of a higher level cognitive functioning, a sign of post-formal thinking. Therefore, in the use of standardized testing, conclusions about the intellectual level of an individual should only be made after careful consideration of their thought processes and approach to testing.

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A Proposed Model for the Construction of Higher Order Cognitive Processing and Application to the Development of Anxiety Disorders

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As anxiety remains a large concern for clinical psychologists, there are only theoretical models to explain the basic etiology of anxiety disorders and no comprehensive theory. While these models focus on treatment and therefore have benefit, they fail to provide an explanation for the mechanisms behind the development of anxiety disorders. Using a multidimensional lens, the proposed model of cognitive development suggests four stages: a) stimulus-response, b) schema formation, c) cognitive network, and d) higher order cognitive processing. The model is further justified by its application in providing a working conceptualization for conceptualizing and treating Generalized Anxiety Disorder as well as other specific anxiety disorders.

Keywords: cognitive model, stimulus response, development, schema network, anxiety

Introduction

Anxiety disorders affect approximately 40 million people worldwide above the age of 18 (18% of the US population), making it one of the most prevalent disorders in the United States (NIMH, 2009). As a result, there are many singular models that attempt to explain the etiology of anxiety disorders. For one, a behavioral theory focuses only on the classically paired stimuli, but these models neglect any cognitive processing that occurs. Another model comes from the psychoanalysis, which describes anxiety disorders as a high level of repressed anxiety eventually overflowing into consciousness, which addresses thought processes but makes anxiety difficult to address. Even with the integrated models, such as cognitive behavioral therapy (CBT), anxiety is reduced to an explanation including behavioral principles that can be used to teach relaxation techniques and how to deflect intrusive thoughts. In essence, these models focus on the treatment of anxiety disorders and fail to provide an etiological mechanism for the development of anxiety disorders, limiting opportunities for prevention and treatment. Using a multidimensional lens combining behavioral principles, ideas based on Piaget's theories of cognitive development, and cognitive models, the current paper suggests a cognitive model for the development of anxiety-based psychological disorders. This model addresses four stages of how anxiety develops: a) stimulus-response, b) schema formation, c) cognitive network, and d) higher order cognitive processing.

These stages both build and interact with each other to result in anxiety, and without intervention, an anxiety disorder.

Stages of Developing Anxiety

Stimulus-Response and Resulting Schemas. The behavioral principle of classical conditioning provides a strong starting point for how the concept of schemas originate. As an individual explores the world, they are exposed to novel stimuli. After exposure to a stimulus, a person produces a response and this response is either reinforced, punished, or extinguished (Cooper et al., 2007). Combined, this response and the corresponding consequence represents a behavior-consequence pair. Based on the conditioning of a specific environmental stimulus to a response, an individual starts to organize stimuli based on consequences. This ultimately leads to the cognitive construction of schemas, from which accommodation and assimilation can occur. Based on Edward Thorndike's law of effect, individuals repeat behaviors that have favorable outcomes and avoid responses with unfavorable outcomes (Thorndike, 1927). Anxiety and its associated behaviors are at the most simplistic level, a learned response.

Development of Schemas and Resulting Cognitive Networks

A schema is defined as a cohesive and repeatable sequence of actions which are tightly bound and controlled by a shared meaning (Piaget, 1952).

Ultimately, schemas represent the specific categories of an individual's global knowledge. At the foundational level, Piaget (1952)'s cognitive developmental model emphasizes the importance of exploration of the environment to the acquisition of knowledge. Thus the need to reorganize schemas based on an individual's exposure to new experiences (Feldman & Acredolo, 1979). Piaget provided two cognitive processes that an individual uses to adjust their cognitive schemas (Wachtel, 1980). The first is assimilation, in which, new information matches preexisting schemas resulting the new information being incorporated into already established schemas. An individual can also modify their schemas through accommodation, in which, new information conflicts with preexisting schemas and results in the construction of a new and more accurate schema. Both processes continue across development and foster cognitive growth. As an individual's understanding of the world around them becomes enriched, new schemas are developed, preexisting schemas are widened, and novel stimuli are categorized into schemas with better efficiency and accuracy. However, while Piaget's definition clearly encompasses the labeling system, this definition fails to explain how schemas are applied and interact with each other.

As more schemas are added to an individual's network, their ability to reorganize their schemas are no longer bound to environmental stimuli (Cheng, & Holyoak, 1985). In turn, repeated exposure to specific behavior-consequence pairs reinforces already constructed schemas concurrently as the individual continues to explore their environment and acquire new knowledge. This continued knowledge acquisition and growth of the cognitive network leads to a more efficient approach to learning and understanding the connection between the stimulus and response. More specifically, individuals utilize previous knowledge in order to manipulate and understand their schemas by using trial and error learning (Case, 1985). During this cognitive process, individuals learn to make assumptions about their environment based on their formed schemas and simultaneously develop effective approaches to test their assumptions. As an individual continues to develop more complex interactions and schemas, they eventually construct a cognitive network.

Cognitive Networks and Resulting Higher Order Processing

A cognitive network can be conceptualized as a web of schemas organized in a way where similar schemas are positioned closer to one another and those that are dissimilar are positioned further from another (Shiffrin & Schneider, 1977). Ultimately, the cognitive network serves as a way to optimize cognitive processing in that it provides a way to activate a large amount of information at one time. Subsequently, the schemas that

activate adjacent to the main schema activate additional schemas in a rippling pattern, such as in how thinking of a dog can lead to thinking of a park. It is difficult to activate schemas further away from the original schema which was triggered, resulting in a gradient of activation. The strongest activation occurs near the triggered schema and then dissipates outward until the stimulus response is so weak that the next level of schemas is not activated (Shiffrin & Schneider, 1977).

Shiffrin & Schneider (1984) continue by explaining two higher order cognitive processes, including automatic and controlled. In short, automatic processing refers to the activation of a cognitive network with minimal cognitive load used. For example, driving a car involves many complex steps; however, through continuous practice an individual arrives at a point where they do not need to think about individual steps. In contrast, controlled processes are those that require more cognitive resources and active attention. For example, a new driver does need to pay attention to the individual steps, because they do not yet have the sufficient practice to have automatic activation. The lines between these two higher order processes can become blurred or more than one type of process can occur simultaneously. When conceptualizing anxiety, it is most critical to understand the difference between these two processes.

Anxiety is defined as excessive fear and/or worry that is not warranted given the current environment (American Psychiatric Association, 2013). Anxiety can be as focused as phobias or as global as Generalized Anxiety Disorder (GAD). Currently, behavioral theories are used most often in the conceptualization and treatment of anxiety disorders. However, behavioral theories fail to explain how the stimulus-response model develops into a cognitive process. Alternatively, cognitive models focus only on overgeneralizing and the catastrophizing of thoughts, neglecting to explain where the original cognitive construct derives. Furthermore, both models do not explain how the range of anxiety disorders develops. Application of the proposed cognitive model bridges the gap between environmentally bound stimuli and freely associated thoughts. GAD is one anxiety disorder that is often not well addressed by either behavior or cognitive models. Due to this deficit, the proposed model is explained here in order to exemplify how these concepts are integrated.

Mechanism for the Development of Generalized Anxiety Disorder

Overall, the development of GAD is conceptualized with this model as the result of either a weak schema or the overlap of two or more preexisting schemas. Based on the proposed model, the atypical development of a schema can occur at any of the stages of cognitive development (i.e., stimulus-response, construction of a

schema, development of a cognitive network, and high order processing). It is important to note that this model does not specify one specific stage that anxiety develops. Instead, the proposed model supports that anxiety can develop across any stage or across stages.

At the first stage, GAD can develop through repeated exposure to negative stimuli that trigger anxiety. At this level, an individual may be exposed to threatening stimuli and through classical conditioning pair the physiological changes (e.g., increased heart rate, increased respiration, perspiration, and heightened level of cortisol in the blood stream) to neutral environmental stimuli. Depending on the intensity of the consequence and the individual's ability to discriminate stimulus gradients, the result could be the development of anxiety ranging from a specific phobia to GAD. If the pairing of the anxiety producing stimuli to the physiological changes is so strong, the result could be the development of a phobia. Alternatively, if the individual struggles to identify differences in similar stimuli, the result could be stimulus generalization and the development of GAD. Wastson and Rayner (1920) demonstrated this phenomenon with their famous Little Albert experiment.

The proposed model of cognitive development indicates that an individual constructs schemas through learning the associations between environmental stimuli, their behavior, and the consequences. This allows an individual to develop a strong schema after several experiences that support similar outcomes. However, during the early development of a schema, there may be only weak associations as the individual searches for further support (Derry, 1996). For example, as a person experiences anxiety more often, they will begin to assimilate more environments with their schema for being anxious. Between the schema for their environment becoming enmeshed with their schema for anxiety and potential reinforcement for anxiety, the individual's anxiety becomes strengthened and can widen into more aspects of their life. At this point, this weaker schema may lead to GAD as opposed to the development of other anxiety disorders, though either are possible.

The next stage of the proposed developmental model of cognition is the schema networks; at this level, GAD may develop from the overlapping of preexisting schemas. This applies to one of the most common symptoms of GAD, catastrophizing (Keogh, & Asmundson, 2004). At this stage, an individual experiences a triggering event which activates a specific schema; subsequently, related schemas are simultaneously activated. GAD can develop from the continued association of minor problems, such as failing a test, with schemas that encompass larger and more traumatic events. This makes all problems traumatic and anxiety provoking, thus inevitably leading to an anxiety disorder.

The final stage of the proposed developmental model of cognition is the higher order processing. As Shiffrin & Schneider (1984) indicated, cognitive processing at this level occurs as either automatic or controlled. For example, someone who has experienced a traumatic event may begin to fear that further negative events are possible at any time. This becomes an automatic process to unfamiliar stimuli with novel stimuli being seen as anxiety provoking. Anxiety can also be a controlled process as some people undergoing treatment for GAD may experience a period of time when their symptoms begin to decrease, they become anxious about their lack of anxiety.

Executive Functioning: Influences on Anxiety and Intervention

Interventions, such as behavior therapy and CBT utilize the notion that controlled processes involve the active regulation of schemas. Therefore these interventions attempt to teach the clients how to make their automatic processes related to anxiety something that they can understand and relabel (Cottraux, & Mollard, 1988). For example, a person with GAD can be taught to consciously label new environments that are automatically assumed to be dangerous as simply being new and potentially positive. Such interventions seek to differentiate various stimuli with specific responses, strengthen schemas, or use controlled processing as a way to relabel their situations. The process of changing automatic thought processes to controlled thought processes is only possible with the use of executive functioning skills. As a result, executive functioning skills become a moderating factor across the proposed stages of cognitive development.

Executive functioning which is specific to an individual's ability to attend to, organize, plan, and process information, becomes a critical component to the proposed theory. Within this theory, executive functioning skills can either directly ameliorate symptoms of anxiety through more focused attention, precise regulation, and organization of schemas and stimulus-response sets, or exacerbate symptoms of anxiety. At the same time, the ability to perform higher order processing, more specifically controlled processing depends on the individual's ability to regulate, plan, organize, and attend to external stimuli (Zelazo, & Muller, 2002). On the other hand, poor executive functioning may exacerbate anxiety disorders across the stages of the proposed development of cognition.

Stimulus-response and early schema level

While stimulus-response and the construction of schemas can occur without sustained attention or organization, stronger executive functioning skills could prevent the development of anxiety during both the

stimulus-response stage of cognitive development and during the early schema development stage. For example, a person with strong executive functioning skills may be able to interrupt the process of pairing environments with anxiety by restructuring their schemas. By separating the anxiety provoking stimulus from the environment at a schematic level, the chance of developing GAD or other anxiety disorders is significantly reduced. However, poor executive functioning skills prevent this separation, thus increasing the likelihood of developing anxiety.

Cognitive network

Just as executive functioning impacts the early stages of the proposed model of cognitive development, it also has the potential to help at the schema level. For example, activation of corresponding schemas associated with the anxiety-provoking schema could be regulated by executive functioning and attention. If an individual is able to attend or actively repress/recall schemas, they can then use this skill during the activation of an anxiety provoking schema. Given a person with a focused anxiety disorder related to school, the client may have originally only have anxiety towards homework. However, as this schema was activated, the associated schemas of school, classroom, teachers, and classmates were also activated. Now, the individual struggles with a school-related anxiety as opposed to anxiety related to just homework. Having strong executive functioning skills allows the individual to attend only to the anxiety provoking stimulus, in this example, homework, and actively repress the onset of the associated schemas. As a result, the individual is no longer struggling with general anxiety, but a more focused and manageable anxiety specific to their environment.

In contrast, poor executive functioning can both worsen anxiety and impede treatment. When a person's schemas are organized haphazardly, they cannot control or label the true source of their anxiety. For example, a person's source of anxiety may actually be homework, but eating, a seemingly unrelated activity and schema that would not overlap, also causes anxiety. This can be due to weak or superficial organization of schemas. Additionally, if the person has a poorly structured cognitive network, they may experience a general feeling of anxiety because so many schemas are consistently being activated. Therefore, the sheer cognitive load required to manage their schemas leaves the person overwhelmed and potentially anxious.

Higher-order processing.

Controlled processing, by definition, includes the ability to regulate organize and relabel information and schemas. It is for this reason that most of the therapies associated with anxiety disorders, such as CBT, focuses

on relabeling a person's schema of what is considered anxiety provoking (Department of Psychiatry, 2014). By nature, this active selection of schemas and the guided transition of automatic processes to controlled processes require executive functioning skills. In order to take an automatic process and convert it into a controlled process this requires a large amount of cognitive effort specifically related to sustained attention. As a result, it would be predicted that individuals that have stronger executive functioning skills would be more receptive to therapy, resulting in a higher probably for better outcomes. Contra, those that struggle with executive functioning skills, may find therapy additionally challenging when the therapist requests them to challenge there schema network.

Conclusion

Anxiety remains a large concern in the field of clinical psychology and for the millions of people that struggle with the disorder. While current theories and models of cognition attempt to provide a model adequate to explain the intricacies related to the development of anxiety, most fail to explain a mechanism underlying the theory. For this reason, the proposed model combines several well-known theories as a way to bridge the gap between behavior and thoughts. As a result, the proposed model of cognitive development suggests four stages: a) stimulus-response, b) schema formation, c) cognitive network, and d) higher order cognitive processing. When conceptualizing anxiety disorders, the model is evidenced by its explanation of both the development and treatment of the disorder. Additionally, the proposed model accounts for additional cognitive factors (i.e. executive functioning) that aid in the prevention, treatment, and conceptualization of anxiety disorders. While GAD shows the application of the model without the use of a case example, it is hypothesized that other anxiety disorders can be conceptualized with this model. With this understanding, further research into how anxiety develops is crucial in order to support the model and develop methods to potentially prevent anxiety disorders.

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Nicholas M. Gala, M.S., has a Bachelor of Science in Neuroscience and Bachelor of Arts in Psychology and American Sign Language from the University of Rochester, as well as a Master of Science in Applied Behavioral Analysis from Florida Institute of Technology. Currently, he is in his third year of the Clinical Psychology PhD program at Gallaudet University. He hopes to specialize in Forensic Neuropsychology and holds research interests in affective neuroscience and emotional display rules. His clinical experience includes working two years as a behavioral analyst providing school and home based intervention. He has helped to establish school-wide programs and parent/teacher trainings addressing behavioral intervention and treatment plans. Gala has completed a summer externship with the Multicultural Clinical Center and D.C. Superior Courts and currently he continues therapeutic training with D.C. Superior Courts and neuro-forensic assessment training at Saint Elizabeth's Hospital.

Editors-in-Chief



Joanna Dziura, M.A., is a third year Clinical Psychology PhD student at Gallaudet University. Previously, Joanna attended Wroclaw University in Poland, where she obtained a Master of Arts degree in Psychology. Right after graduation, Joanna joined the Polish Army and served for 8 years as a uniformed military psychologist in engineering and armor units. During that time, she was deployed multiple times to Iraq and Afghanistan, where she provided psychological help to soldiers from 18 different nations and multinational civilian contractors. Joanna also served as the Chief of Humanitarian Assistance Coordination Center, where she was assessing the critical needs of local Iraqi institutions and organized financial and material humanitarian help for hospitals, schools, and Non-governmental organizations (NGO). During the time she spent in Iraq and

Afghanistan and through work with the civilian population in these countries, Joanna had a chance to observe first-hand the impact that disability had on people's lives. This experience resulted in a strong desire to understand this topic better and specialize in the psychology of health and illness. Currently, her main area of research interest is the late acquisition of visible and hidden physical disabilities in civilian and military populations.

Joanna wrote chapters to three books dedicated to military psychology and presented multiple times at professional conferences delivering lectures on pre-deployment psychological preparation of military personnel, PTSD, deployment stress, and issues related to the late acquisition of disability. Joanna also deeply believes that the road to being a great professional starts early in a student's education and requires being actively involved in students' affairs.



Gregory Farber, B.A., is a second year deaf Clinical Psychology PhD student at Gallaudet University. Previously, Greg attended Rochester Institute of Technology where he obtained a Bachelor of Science degree in Psychology. His own experiences of deafness and his observation of frustrations and struggles of his deaf peers led him to become fascinated with impact of life experiences on one's development and with psychology in general. Greg knew there is no better place to pursue his dream than Gallaudet University, the cultural mecca for the Deaf community. He remains true to his first psychological interest and his research interests are still closely related with areas of D/deafness, development of D/deaf individuals, and the Deaf community. In the

future, Greg hopes to become a Clinical Psychologist serving Deaf community and a professor of psychology. He also hopes to specialize in Developmental Neuropsychology. While in Gallaudet, Greg noticed that the majority of studies and research that his fellow students conduct remain unknown. This observation brought him to the idea of reactivation of the Gallaudet Chronicles of Psychology, a journal where Gallaudet students could publish their findings. As a co-Editor, Greg has two goals - promoting psychological research related to disability and deafness and helping his fellow graduate students to share their works with the rest of the D/deaf community.

Faculty Editorial Supervisor



Dr. Day, Ph.D., received her Ph.D. in Clinical Psychology from Gallaudet University. She completed her internship at Baylor College of Medicine in Houston, Texas; and she completed her post-doctoral training in Pediatric Neuropsychology at The Kennedy Krieger Institute/Johns Hopkins Medical School. She has been an Assistant Professor in the Clinical Psychology Doctoral Program since 2012 where her responsibilities include teaching, research, supervision, and mentoring of graduate students. Her current research interests include: adapting Parent-Child Interaction Therapy (PCIT) to be accessible for deaf individuals, adapting psychological measures for deaf individuals, and developing a technology based literacy program for deaf students. Dr.

Day is a peer reviewer for The Journal of Deaf Studies and Deaf Education. Her most recent publications have included articles in the Journal of Deaf Studies and Deaf Education and Rehabilitation Psychology. She has also presented her research at local, national, and international conferences. She is committed to involving graduate students in all aspects of the research process, including publication and dissemination of findings.

Publication of *Chronicles of Psychology* would not be possible without the students who answered the call to review manuscripts submitted for publication. We, Editors-in-Chief and the Faculty Editorial Supervisor, are very grateful for their thorough and timely efforts to ensure that manuscripts appearing in *Chronicles of Psychology* adhere to high scientific standards. The following students served as manuscript reviewers for *Chronicles of Psychology* in 2014.

Yasmeen Alhasawi, B.A., received her Bachelor's degree in Psychology at Purdue University. She completed a research fellowship in molecular genetics and otolaryngology at the Harvard Medical School. Her research interests are in audio-visual integration and long-term auditory memory in late-deafened adults. Ms. Alhasawi has presented her research at conventions for the American Psychological Sciences and the Association of Late Deafened Americans. She currently serves as an international ambassador to Psi Chi National Honor Society of Psychology.

Timothy J. Ainger, M.S., M.A., is currently on his clinical internship at the Hunter Holmes McGuire VAMC in Richmond, VA. His research interests focus largely on neuropsychology, serious mental illness, forensics, human sexuality, and multiculturalism. He has most recently published an article entitled "Contemporary Society and the Issues Facing Deaf Baby Boomers When Compared to their Hearing Counterparts: A Review," and co-lead the presentation "Antisocial Personality Disorder (APD) in Soldiers and Veterans," at the Virginia Psychological Association conference.

Nicholas M. Gala, M.S., has a Bachelor of Science in Neuroscience and Bachelor of Arts in Psychology and American Sign Language from the University of Rochester, as well as a Master's of Science in Applied Behavioral Analysis from Florida Institute of Technology. Currently, he is in his third year of the Clinical Psychology PhD program at Gallaudet University. He hopes to specialize in Forensic Neuropsychology, and holds research interests in affective neuroscience and emotional display rules.

Evan Goodman, M.A., is a PhD candidate in the clinical psychology program at Gallaudet University. His research interests are in the areas of ASL and cognition, psychometrics, neuropsychology, psychopharmacology, and human factors in transportation. Mr. Goodman has performed research with data collected from Visual Language, Visual Learning (VL2) projects at Gallaudet and has conducted important studies related to factors affecting public transportation perception and usage by deaf students.

Wyatte Hall, Ph.D., is a recent Deaf graduate of Gallaudet University's Clinical Psychology program. He is currently a Psychology Postdoctoral Fellow in the Department of Psychiatry at UMass Medical School. He is working alongside Melissa Anderson, Ph.D. and Marlene Elliott, CI/CT to establish the DeafYES! Program, a Deaf behavioral health center that provides clinical services, provides clinician and interpreter training, and conducts research on improving behavioral health services for Deaf people.

Hannah Joharchi, M.A., previously earned a Masters of Arts in General Psychology as well as a Masters of Arts in Negotiation, Conflict Resolution, and Peacebuilding. Currently in her fourth year in the Clinical Psychology program at Gallaudet University, Ms. Joharchi is working on research with Deaf immigrants as well as research regarding positive sexuality in the Deaf community. She recently published an article titled *A Glimpse at American Deaf Women's Sexuality*.

Danielle Previ, B.A., earned her Bachelor of Science degree in Psychology from Rochester Institute of Technology and is currently in her fourth year of the Clinical Psychology Ph.D. Program at Gallaudet University expecting to graduate in 2017. Her current research focuses on family therapy with deaf children. Once she completes the Clinical Psychology program, she hopes to do clinical work with deaf children by providing psychological evaluations and therapy.

Angela Turner, B.A., is currently in her third year as a predoctoral student in Gallaudet's Clinical Psychology Program. She earned her Bachelor of Arts degree in Psychology from the University of Denver. Her recently published manuscript in *Language and Speech* was the result of her undergraduate honors research thesis. Her current research endeavors focus on resilience related to interpersonal skills in children with multiple, complex conditions, including deafness in the presence of an additional diagnosis.

Submission. Manuscripts should be submitted electronically (.rtf or .doc file ONLY) to psychology.chronicles@gallaudet.edu. Prior to submission, please carefully read and follow the submission guidelines detailed below. Manuscripts that do not conform to the submission guidelines will be returned without review. The *Chronicles of Psychology* encourages all graduate students to submit manuscripts for publication. Although submissions with relevance to the issues of deafness and disability are especially welcomed, the *Chronicle* does accept materials related to a wide variety of topics in psychology. The process of publication of the *Chronicle* closely mimics that of other peer-reviewed professional journals which provides students with a great opportunity to gain exposure to the publishing process. We welcome article submissions in the following areas:

- Quantitative and qualitative empirical research
- Theoretical/conceptual papers
- Comprehensive literature reviews
- Case studies that highlight critical or overlooked issues of assessment and therapy with persons from minority and/or disability groups
- Manuscripts addressing the unique challenges of psychologists working with exceptional clients

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- Acceptance,
- Acceptance with minor revisions,
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