Chapter Twelve

**Risk, Trauma &
Resilience**

Risk and Resilience: Adjustment of Siblings of Children with Serious Emotional Disturbances

Ryan P. Kilmer
James R. Cook

Introduction

This project assesses the adjustment of the siblings of children with severe emotional disturbances (SED). This report presents early findings from the first step of a planned longitudinal effort to compare stress-resilient and maladjusted children and examine the child attributes, caregiving variables, qualities of the family environment, and other contextual circumstances that differentiate siblings adapting successfully from those experiencing problems. It focuses upon study rationale and implications, as well as preliminary descriptions of an early sample of siblings, the life stress they have experienced, and caregiver ratings of their adjustment.

Resilience, i.e., effective coping and adaptation in the face of major life stress, has been the focus of much recent research (Cicchetti & Garmezy, 1993a; Cowen, Work, & Wyman, 1997; Masten & Coatsworth, 1998). This research has identified child, family, and environmental variables that relate to resilient outcomes and appear to serve a "protective" function under conditions of stress, reducing children's risk for maladjustment and increasing the likelihood of healthy outcomes (Werner & Smith, 1992; Wyman et al., 1999). In fact, researchers have identified factors promoting competent adaptation among children experiencing varying risk conditions (e.g., maltreatment; poverty; parental psychiatric disorder; multiple-risk backgrounds). However, the area is less well charted for the siblings of children with SED. These understudied children are at elevated risk because they share risk factors with the child experiencing problems, and are also influenced by that child's impact on the family system. For example, in the context of coping with the identified child's difficulties, siblings may experience decreased parental attention and be subjected to increased family turmoil.

This project assesses the adjustment of siblings of children identified through the Center for Mental Health Services (CMHS)-funded Systems of Care (SOCs) at multiple sites across North Carolina, to ascertain the range of adjustment outcomes and determine the degree to which these children are functioning adaptively. A multi-step procedure will identify children at-risk of developing more serious mental health difficulties and those who appear to be adjusting well at home and school.

Once such children have been identified via this study, subsequent research can focus on siblings who have "overcome the odds" and adjusted successfully despite significant family turmoil (e.g., psychological disorder, parental substance use, legal involvement) and/or exposure to other stressors (e.g., poverty, neighborhood violence). System-identified children will be involved in this mental health program for several years, with multiple follow-up assessments.

Thus, this project can be viewed as providing the initial framework for a longitudinal effort examining adaptation in the siblings. Such work can help clarify the paths children follow to healthy development in the face of adversity (Cowen, 1994; Masten, Best, & Garmezy, 1990), and identify conditions that contribute to the enhancement or erosion of adaptation over time, with implications for education, prevention, training, policy, and service provision.

Methods

Participants: Sibling participants are being recruited from families involved at four sites of the NC FACES (Families and Communities Equal Success) statewide initiative to create community-based SOCs for children with SED and their families. Approximately 200 children are currently served in North Carolina by this integrated system of mental health care. These multiethnic children reside in

urban, suburban, and rural areas, and, although predominantly poor, come from households with varying levels of socioeconomic status. All siblings aged 5-18 will be assessed via this initial screening, and parents will be reimbursed for each set of completed measures. At this time, caregivers have provided information on seven siblings in Cleveland County, N.C.

Procedures and Measures. This project is obtaining global assessment data and identifying stress-resilient and maladjusted children among the siblings using selection procedures comparable to those used in prior research (e.g., Cowen et al., 1992). Participants will be classified using the following screens:

1. **Life Events Checklist (LEC; Kilmer, Cowen, Wyman, Work, & Magnus, 1998).** This is a parent-completed measure of stress exposure, with items reflecting: Family Turmoil, Poverty, Family Separation, Illness/Death, and Violence. Although some items reflect discrete events, most describe chronic stressors.

2. **Parent-Child Rating Scale – Revised (Cowen et al., 1996).** This instrument assesses parent perceptions of children's problem behaviors and competencies across four subscales: Acting Out, Frustration Tolerance, Shy-Anxious, and Peer Sociability.

3. **Teacher Global Ratings (Hoyt-Meyers et al., 1995).** This instrument is used twice, i.e., for *current* and *prior year* teachers' ratings of children's adjustment relative to same-sex classmates.

Only children who have experienced ≥ 4 stressors, a criterion for "highly stressed" used in several resilience studies (e.g., Cowen et al., 1992; Werner & Smith, 1982), will be included in subsequent analyses (all assessed siblings will be included in the current study). Then, 6 to 10-year-old children evidencing demonstrably good adjustment (relative to same-sex peers) on the remaining screens will be classified as *resilient*, and those evidencing poor adjustment will be classified as *maladjusted*; children not meeting criteria for either will be designated *intermediate*. Following group identification, sibling adjustment will be compared using the following two scales:

1. **Behavioral and Emotional Rating Scale (BERS; Epstein & Sharma, 1997).** This is a strengths-based, parent-assessment of children's adjustment on: Interpersonal Strength, Family Involvement, Intrapersonal Strength, School Functioning, and Affective Strength

2. **Teacher-Child Rating Scale (T-CRS; Hightower et al., 1986).** This teacher-completed measure assesses children's problem behaviors (i.e., Acting Out, Shy-Anxious, Learning Problems) and competencies (i.e., Frustration Tolerance, Assertive Social Skills, Task Orientation, Peer Sociability).

We will also utilize sites' existing databases to explore background variables that correlate with sibling adjustment. This report includes data regarding seven child (e.g., physically or sexually abused) and five family risk factors (e.g., family history of mental illness, violence, or substance abuse, caregiver felony conviction) from one site, i.e., Cleveland County.

Results

Data collection is just underway. As such, this report presents very early findings from a small sample of siblings, regarding: (a) their stress exposure; (b) risk factors for the family and SOC for the child; and (c) relationships between sibling characteristics and those of the SOC-identified child on the BERS subscales.

Among SOC target children (n = 40), the mean number of endorsed child risk factors was 5.50 (SD = 1.40) of seven possible factors. Similarly, caregivers (n = 67) reported an average of 2.66 (SD = 1.43) of the five family risks. On the LEC, caregivers reported that siblings (n = 7) and their families had experienced 11.71 (SD = 3.25) of the 32 stressors. The current sample size precludes significance testing; however, mean scores of siblings (n = 6-7) tend to exceed those of SOC targets (n = 122-123) on the BERS Interpersonal Strength subscale and total score. Figure 1 illustrates these early differences.

Figure 1
Mean Scores for Target Chidren and Siblings
on BERS Subscales
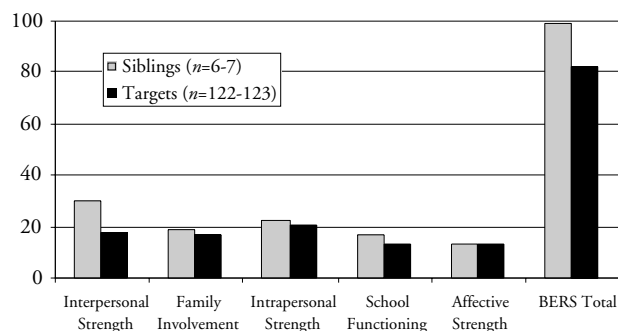
Discussion

These preliminary analyses do not allow for conclusions to be drawn. Nonetheless, taken in sum, the data suggest that the children and families served by the SOC, including the siblings, have experienced significant adversity; caregivers report *very* high levels of risk for their identified children, the siblings, and their families. Although chronic stressors (e.g., family tension and violence, ongoing child abuse, growing up in poverty) are thought to have greater risk potential (Cowen, Wyman, Work, & Parker, 1990), studies of the effects of stress on children have documented negative sequelae for both circumscribed events and chronically stressful conditions (Johnson, 1986). Furthermore, exposure to multiple, major stressors can increase stress' negative effects multiplicatively (Rutter, 1979; Sterling, Cowen, Weissberg, Lotyczewski, & Boike, 1985), i.e., children experiencing two co-occurring risk factors evidence a four-fold increase in adjustment difficulties, escalating ten-fold when four or more factors exist (Rutter, 1979). However, children vary in their responses to stress (Cowen, 1994; Wyman, Sandler, Wolchik, & Nelson, 2000), and some adapt and function well despite adversity, i.e., are resilient. Viewed within this context, it is crucial to document the effects of stress, as well as potential protective factors, and identify the processes that appear to shape stress-resilient outcomes among these siblings (Cicchetti & Garmezy, 1993b; Cowen et al., 1990).

Indeed, in addition to the heuristic appeal of this study (i.e., the literature regarding the siblings of children served by the SOC is far less well-developed than the research base on identified children), this project lays important groundwork for a statewide study of child resilience. Enhancing understanding of resilience can increase focus on what "goes right" in development. Furthermore, an examination of the characteristics of the child, parent-child relationship, and/or other environmental variables (e.g., supportive relationship with non-parental adult) that contribute to healthy adaptation may provide knowledge that can be applied to improve preventive interventions for at-risk children and their families (Cowen, 1994; 2000). The current study will not only be used to identify resilient children; it will also identify children who are beginning to exhibit emotional and behavioral problems. This step is crucially important in its own right—it is imperative that such children receive services before their difficulties become entrenched—and is consistent with the family-focused nature of the SOC.

Furthermore, by exploring what is going well, along with areas where children may be having difficulties, the project can provide useful knowledge to service providers and parents about how to best meet the needs of these children and families, help professionals better understand the families with whom they work, and have immediate applications in service delivery. Moreover, information garnered through this assessment can be used by those advocating on behalf of the children and families served by the SOC.

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CONTRIBUTING AUTHORS

Ryan P. Kilmer, Ph.D.
Dept. of Psychology, The University of North Carolina at Charlotte, 9201 University City Blvd., Charlotte, NC 28223-0001; 704-687-3689, Fax: 704-687-3096; E-mail: rpkilmer@email.uncc.edu

James R. Cook, Ph.D.
Dept. of Psychology, The University of North Carolina at Charlotte, 9201 University City Blvd., Charlotte, NC 28223-0001; 704-687-4758, Fax: 704-687-3096; E-mail: jcook@email.uncc.edu

Post Restraint Sequelae Five Years Out: Concerns and Policy Implications

Wanda K. Mohr
Andrés J. Pumariega

Introduction

The topic of physical restraint has assumed national prominence in the wake of both media and Joint Commission on Accreditation of Healthcare Organization (JCAHO) reports of patient deaths proximal to their use. These deaths have galvanized advocacy and professional communities to seek solutions that range from promoting "best practice" models to seeking regulatory solutions. In the past two years the use of physical restraint has been scrutinized, and most settings are moving away from a restraint model and in the direction of prevention and early intervention of violent behavior. Two studies (Phase I and Phase II) were undertaken to explore the sustained effects of exposure to physical and mechanical restraints on the same population of individuals. Findings are described below and future research and public policy initiatives are recommended.

Methodology

Phase I

Phase I of the restraint study involved in-depth and open ended interviews with 19 former pre-teen and adolescent psychiatric patients residing in Texas to ascertain their memories pursuant to having been physically restrained during their hospitalizations. Mean ages of the participant sample at time of their hospitalizations was 11.5 and at the time of interviews was 17.2. The sample consisted of 10 males and 9 females. Their diagnoses included Obsessive Compulsive Disorder (OCD), Attention Deficit Hyperactivity Disorder (ADHD), Conduct Disorder, and Major Depression. Medical records were used to corroborate the actual restraint episodes. Qualitative content analysis was used to analyze the interviews.

Phase II

The second phase explored in more depth the direct trauma aspects of these individuals' experiences and the stability of the memories over five years. The same 19 individuals and some of their parents have maintained contact with the researcher for the past 5 years. Contact was enhanced by sending birthday and Christmas cards, bi-yearly newsletters, and other prompts. Once yearly the former patients and their parent(s) were contacted by telephone and interviewed about their physical and emotional well-being. Questions consisted of items from a semi-structured questionnaire were posed by the principal investigator in each instance. Parents were interviewed in an attempt to triangulate the data, but as two of the parents had died and one was suffering from early dementia, complete triangulation could not be achieved. Analysis of the data is ongoing as data collection was completed on 10/9/00.

Results

Phase I

Experiences as recalled by the youngsters clustered into 3 major themes: *Vicarious trauma*, *Alienation* (from staff); and *Direct trauma*. Vicarious trauma included painful memories and fearfulness at seeing or hearing others being restrained. Alienation from staff included withdrawing from staff members and actually fabricating symptoms, histories, and feelings in attempts at palliation and "to keep staff off my back." Direct trauma included symptoms that patients directly attributed to having been placed in restraints themselves. Phase I results were published in 1998. (Mohr, Mahon, & Noone, 1998; Mohr, 1999).

Phase II: Preliminary findings

Ten of the individuals have received out-patient psychiatric treatment during the five years following initial hospitalization; four were hospitalized briefly and are continuing treatment as out patients; two have had substance abuse problems and went through appropriate programs to treat their addictions. The remaining three have not and are not receiving treatment—although they attribute this to their aversion of mental health professionals rather than an absence of troubling symptoms.

Very preliminary analysis comparing the direct trauma theme from Phase I coupled with analysis of relevant data about wellbeing on all interviews revealed that former patients continued to experience traumatic sequelae including intrusive thoughts, recurrent nightmares, avoidance behaviors, pronounced startle responses, mistrust, and hyper-vigilance. While it can not be said with certainty that these sequelae were caused by the restraint experiences, the study participants and their parents did attribute them to the restraint events.

Discussion

Continued reports of deaths proximal to restraint use are indeed disturbing, but ongoing traumata is something that has only been alluded to and speculated upon in the literature. Although this sample is very small, two findings are of particular interest and warrant further study. First, the enduring nature of the symptoms is consistent with Post Traumatic Stress Disorder (PTDS). Second, all 19 individuals contributed to the data collection over the five year study, even though they had moved to different states.

Policy Recommendations

The advocacy community has long been concerned about death and injury proximal to restraint of persons with mental illnesses in institutional settings. Patients have spoken to the issue of emotional trauma in postings on the website of the National Alliance of the Mentally Ill (NAMI; A Summary of Reports of Restraints, 2000). This national organization has expressed its concern via policy proposals aimed at efforts to regulate restraint use. Their efforts have been partially successful with the successful implementation of the Health Care Financing Administration (HCFA) regulations.

Other recommendations for policy initiatives, proposed by NAMI, and endorsed by the authors, include:

- Mandatory reporting of deaths and serious injury to state-legal entities with investigative authority;
- Enforceable national standards on appropriate use of restraints representing best practices;
- Use of independent 3rd party monitoring groups to conduct unannounced inspections of facilities providing psychiatric treatment, including family and consumer-staffed monitoring groups;
- Allocation of funds for the express purpose of training treatment staff in alternatives to restraint and seclusion and their appropriate use, and;
- Active consumer (and where appropriate, family) involvement in treatment planning, to include: the use of admission assessments, debriefings for each episode of restraint or seclusion, and use of psychiatric advance directives.

Research Recommendations

By patient account, being restrained is aversive and traumatic. Moreover, as evidenced by reports of death and injury, restraints are potentially dangerous. Despite a great deal of discussion concerning restraint use and safety, the medical community still lacks a solid empirical understanding of what leads to restraint episodes and how best to intervene in potentially violent situations in psychiatric settings. We propose a program of research that would begin to build a basis for future prevention and intervention efforts. This program would involve determining what factors lead to injury or death and would consider:

1. The independent effects of hypothesized structural and process risk factors on restraint outcome,
2. The interactive effects of these risk factors on restraint outcome, and
3. The cumulative effects of these risk factors on restraint outcome.

Determining what factors contribute or buffer restraint episodes can inform future research that might include developing risk assessment instruments, and the development of primary, secondary, and tertiary prevention interventions. Most importantly, this research would have the potential to reduce staff and patient injury while brining needed rigor to the field of violence prevention in psychiatric settings.

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CONTRIBUTING AUTHORS

Wanda K. Mohr Ph.D., R.N., F.A.A.N.
Associate Professor, Psychiatric Mental Health Nursing, Rutgers University, 180 University Ave. Newark, NJ 07102-1897. J; E-mail: mohr@nightingale.rutgers.edu

Andrés J. Pumariega M.D.
Professor, Dept. of Psychiatry and Behavioral Sciences, James H. Quillen College of Medicine, East Tennessee State University, P.O. Box 70567, Johnson City, TN; 423/439-7786, Fax: 423/439-7033; E-mail: pumarieg@access.etsu.edu

Reduction of Seclusion and Restraint: Implications from the Indianapolis Experience

Theodore A. Petti
Linda Sims
John Somers
Wanda K. Mohr
Diana Haugh

Introduction

In this summary, we describe the dramatic, sustained reduction of seclusion and mechanical restraint (S&R) in children and adolescents residing in an intermediate-term state psychiatric hospital, and we consider the resulting research implications for the use of S&R. Increases in S&R rates since the early 1970s are partially attributed to both the increasing severity of presenting pathology and concomitant decreases in acceptable staffing ratios.

The evaluation studied the 42-bed Youth Service (YS) of Larue Carter Hospital, an intermediate-term state psychiatric facility with three clinical units that treat different age groups of children and adolescents. High S&R rates resulted in concerns voiced by evaluators during accrediting and certifying body visits. Multiple strategies were employed to reduce and eliminate S&R restrictive practices in the YS as part of a total hospital effort since 1995 (Petti, Sims, Somers, & Haugh, 2000), but these efforts were unsuccessful. Although significant gains were made initially through programmatic change, the S&R rate doubled in 1998-1999. Many patients had learned to depend upon restrictive, coercive measures as their means to gain self-control. However patient and staff injuries and external pressures catalyzed efforts to solve these problems. In April 1999 a debriefing effort was initiated. This systematic debriefing lowered S&R episodes and total time in S&R dramatically. This report details the insights gained from that debriefing process.

Method

A structured questionnaire was developed to cover specific questions including the need for using S&R, alternatives that could have been employed, interventions employed prior to the restrictive intervention, perceived safety, and respect for patient rights. Nursing staff other than those directly involved with the incident, were asked to meet with each patient who had been secluded or restrained as soon thereafter and when the child could respond coherently to questions about the incident. Beginning in October 1999, nursing staff involved with the S&R were asked similar questions, and the responses of both child and staff were recorded verbatim on a form that indicated the date reviewed by the team and the actions taken in response to the patients and staff members involved

Data from patients and staff were collected on the YS from October 1999 through September 2000 and represent separate debriefings on a sample of 81 incidents. A summary form was created for each question; each entry was coded an average of four times as categories of responses were compared and collapsed. Each coding was subjected to an inter-rater reliability procedure whereby the data analyst and her assistant compared final coding ratings. Reliability indices between coding categories ranged from .92 to .99. In the case of significant disagreement, two clinical nurse specialist faculty members were consulted to make a final determination. The responses provided a rich source of data that might not have surfaced with a more controlled collection format.

During this period, 157 separate instances of seclusion or restraint occurred involving 43 different patients. Debriefings were conducted formally in 81 instances with 31 different patients.

Results

The range of patient and staff perceptions is notable. Safety was most frequently mentioned by patients as the reason for S&R (33/81). An additional 11 patients gave safety-related responses suggestive of assaultive behavior and verbal aggression or assaults. Staff perceived safety as the factor in

more than half the cases (53/81) with related ambiguous responses by 22 more. The patients considered non-compliance as the cause in 15 cases, anger in 5, and no reason was reported in 16 cases.

Considering alternative actions that could have prevented the seclusion or restraint, 23 patients reported specific or non-specific responses that called for compliance with staff requests. Alternative choices to avoid the restrictive intervention were given by 30 patients, 21 of which were considered general (e.g., "I could have talked to someone and stayed in the quiet room." More specific responses, (e.g., "I should have gone to the quiet room when I was asked by staff," or "I should have found something else to do besides trying to hit staff and go into seclusion.") were given by 9 patients. Only 17 patients gave no reportable response, while 4 provided directives to staff as to what could have been done differently. By contrast, in only 12 instances did staff take responsibility for changing their approach through identifying earlier interventions they could have employed; in 45 instances staff blamed the patient ($N = 29$), the system ($N = 9$), or inadequate dosages of medication. Thirty percent were either at a loss as to what they could have done differently, or gave no response or an inadequate answer to code.

When asked what had actually been provided prior to the use of seclusion or restraint, 45% reported being in Time Out, away from others. Yet almost 40% said that PRN medicine was given. Five patients said they tried tension-reducing exercises and 18 reported that therapeutic-intended talks with had staff occurred prior to the S&R. Only 9 patients reported that staff told them to change their behavior and warned them of consequences if they failed to do so. Almost 40% ($N = 35$) gave no response, misunderstood the question, said "None," or could not remember. In contrast, staff responses listed Time Out-related interventions in 58 instances, medication in 54, and therapeutic talking in 50. Therapeutic-intended suggestions were reported in 21 cases, therapeutic holds in 18, and directions to change behavior in 21, while in 6 cases a defensive or no response was elicited.

The use of PRN medication reported by the patients in the debriefing episode indicated that 63% ($N = 51$) received one dosage before the seclusion or restraint, 22% ($N = 18$) during, and 6% ($N = 5$) after. Only 7 patients gave no answer.

Almost 80% ($N = 64$) stated that they had been given an explanation for the use of seclusion or restraint, 10% ($N = 8$) said they had not been given an explanation, and 10% gave no answer. Similar percentages held for those responding to whether the release criteria had been explained to them ($N = 63$, 6% and 12% respectively).

Safety has been a focus of attention concerning deployment of S&R interventions. Almost 65% ($N = 52$) of the patients stated that they had felt safe during the episode. But over 25% ($N = 22$) stated that they had not. About 10% did not answer. Injuries to patients or staff occurring during the restrictive episode were reported by 12% ($N = 10$), while almost 75% said no injury had occurred and 14% provided no response. Over 70% ($N = 58$) of patients felt that their dignity and privacy were respected during the S&R episode, while 15% felt it had not, and 14% did not respond.

However, staff reported that only 53% felt safe during the procedure, 36% reported not feeling safe and 11% had no comment. Injuries sustained were reported by 14% of staff, and a like number declined to comment. No injuries were reported by over 73% of staff. Respect for dignity and privacy during the seclusion or restraint were reported in 90% of staff responses; 4% of respondents felt that dignity and privacy were not respected, and 6% had no comment.

Discussion

Maintaining decreased S&R levels over almost 24 months is noteworthy given the types of patients admitted. Changing an organization's culture is a slow, arduous process that constantly requires attention to prevent regression to old behaviors and thinking. For example, staff will still on occasion be heard complaining that youngsters who have lost control should have been secluded or restrained,

particularly for injuring a staff member or for causing extensive property damage. We have experienced sporadic slippage and have attempted to move quickly to address underlying issues. This is particularly difficult when the patients do not seem to care if they are secluded or restrained. A structured debriefing process allows for ongoing monitoring of perceptions, distorted cognitions, and poor care. As S&R continue to demand the attention of multiple stakeholders, data and insights from a debriefing process are valuable in developing understanding of underlying cognitive, behavioral and psychodynamic factors.

Institutional change is difficult. The debriefing process allows clinical leaders to determine where problems might exist and provides material for considering measures to address such problems (Petti, Mohr, Somers, & Sims, 2001). Decreases in injuries associated with the decreases in S&R rates seem to have little impact on staff perceptions. However, situations definitely exist in which S&R is required (Troutman, Myers, Borchardt, Kowalski, & Bubrick, 1998). Determining when this may be true and the best means by which to employ such restrictive interventions requires further study. S&R phenomena represent a legitimate and fruitful area for scientific study.

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CONTRIBUTING AUTHORS

Theodore A. Petti, M.D., M.P.H.
Arthur B. Richter Professor of Child Psychiatry, Indiana U. School of Medicine, 3701 Riley Hospital, 702 Barnhill Drive, Indianapolis, IN 46202; 317-941-4085, Fax 317-941-4085; E-mail: tpetti@iupui.edu

Linda Sims, M.S.N., R.N.
Associate Director of Nursing, Larue Carter Hospital, Larue Carter Hospital, 2601 Cold Spring Rd., Indianapolis, IN 46222; 317-941-4166, Fax 317-941-4085; E-mail: lsims@fssa.state.in.us

John Somers, Ed.D.
Youth Service Line Manager and School Principal, Larue Carter Hospital, 2601 Cold Spring Rd., Indianapolis, IN 46222; 317-941-4022, Fax 317-941-4085; E-mail: jsomers@iupui.edu

Wanda K. Mohr, Ph.D., F.A.A.N.
Associate Professor Psychiatric Mental Health Nursing, Indiana University School of Nursing, Indianapolis, IN 46202; 317-278-4896, Fax 317-278-4896; E-mail: wkmohr@iupui.edu

Diana Haugh, M.S., R.N.
Superintendent, Larue Carter Hospital, 2601 Cold Spring Rd., Indianapolis, IN 46222; 317- 941-4234, Fax 317-941-4085; E-mail: dhaugh@fssa.state.in.us

Psycho Social Participation In Armed Conflicts and Natural Disasters

Jorge Ivan Lopez Jaramillo

Introduction

A crisis generated by a huge disaster, either natural or due to armed conflict, creates unbalance in the community and in an individual's bio-psycho-social integrity. When such crises occur, a set of psychological reactions may result from the loss of physical, affective, work related, housing, and recreation factors; in general these changes make it difficult for individuals to adapt to daily social life after the immediate events of the disaster have subsided.

Both natural disasters and those generated by armed conflict can be conceptualized in two ways: as creating situations that are dangerous, or that offer potential opportunities for community and personal growth. A dangerous situation will involve few opportunities to learn from the disaster or to grow from it, and the maturity to solve problems of daily living caused by the disaster will be lacking. This inability to solve problems that have been created or exacerbated by the disaster can result in diverse problems and difficulties, such as loss of meaning in life, increased rates of suicide, psychosomatic illnesses, and violence within the family and in society, among others.

However, such crises can also be responded to through healthier and more flexible ways that create opportunities for people to grow. This makes the ability to solve conflicts possible, and strengthens those community bonds and values that encourage respect for others and which contribute to the establishment of a common cause by which people may improve the quality of their lives.

Background

This paper reports on a participation model for times of crisis that has been developed as a result of the experiences of our work team in Colombia and through support given to neighboring countries during times of crisis attributed to the damaging effects of natural disasters or armed conflicts. From these experiences, we have developed a participation model that can provide opportunities for development in the aftermath of natural or armed crises.

The model has emerged through the support of diverse communities and professionals in different fields who employed psychosocial programs in response to the following crises:

- **The Uraba region in the northwestern part of Colombia due to the armed conflict. (1995-1997).** The initial phase of the model of participation was developed in this region through the Programa Uraba de la Cruz Roja Colombiana; the program was oriented primarily toward children living in the rural areas who were affected by the armed conflict. Over a two-year period, nearly 40 rural communities took part in our study to determine the effects that the Colombian armed conflict had on boys and girls between the ages of 5 and 12. Educational activities using a participation and diagnosis method were utilized.

- **Nicaragua in Central America—Hurricane Mitch 1998.** A psychosocial rehabilitation program for children affected by Hurricane Mitch took place together with UNICEF and the Ministries of Health and Education in Nicaragua. This program served 14 States and 84 Municipalities and included nearly 60,000 boys and girls. Indicators of Post-Traumatic Stress Disorder (PTSD) varied from 10% in the area near the Volcan Casitas, an area of greater mortality rates, to 2% in the Municipalities having lower mortality rates. Recovery rates from PTSD were over 90% after participation in the program.

About the author: *Jorge Ivan Lopez Jaramillo is a Medical Doctor and Surgeon from Universidad de Antioquia, A University in the City of Medellin (Province of Antioquia), Colombia. He has a Specialization in the Management of Public Health degree, conferred by Instituto de Ciencias de la Salud - CES in the City of Medellin. Currently he is Director of the Centro de Entrenamiento Médico y Paramédico con Simuladores (Medical and Paramedical Training Center Through Simulators - CEMPAS of the CES (The Health Sciences Institute of Medellin-Antioquia). Dr. Lopez has developed activities related to the prevention, and assistance in disaster events for two decades, by giving support and advice to both domestic and international organizations.*

- ***Region Eje Cafetero in Colombia due to the Earthquake in 1999.*** This earthquake measured 6.2 on the Ritcher scale and affected nearly 20 towns in 4 states in the country. The program's methodology was developed by the Cruz Roja (Red Cross) together with the Instituto de Ciencias de la Salud (CES) and other universities. The program focused mainly on the Municipality de Cordoba (Quindio), epicenter of the earthquake, and served 110 families from the urban area. As with the Hurricane Mitch event, PTSD was also observed in as few as 10% of those who participated in the program. Many symptoms of PTSD disappeared after the initial program started. In cases where the program was less than effective, individuals received clinical attention and follow up by the local mental health work team.

- ***Armed-group confrontations in Colombian towns, 2000.*** The participation model has been especially useful in towns that have recently been affected by armed-group confrontations. In the Municipality of San Luis (Antioquia), the model was employed in the urban area by an interdisciplinary group from CES and the Cruz Roja. The program had coverage of nearly 800 boys and girls from the urban areas and displaced people from the rural area. Out of 55 cases of PTSD, nearly 20% were found in children who were five years old. Among children ages 7 through 12, 50% were found to have posttraumatic stress, and 20% of adolescents between the ages of 12 and 15 were found to have posttraumatic stress. The remaining 10% of cases were reported in adults (Institutio de Ciencias de la Salud, 2000).

Participation Model

General objective

The general objective of the model is to contribute to the holistic recovery of the community by using participation as a strategy in the areas of: (1) health, (2) education, (3) social organization, and (4) social and physical reconstruction; these areas address the affected population and both consolidate and strengthen community reorganization and self management. Lines of action that focus on these four areas complement each other and can be addressed simultaneously. They also work with different communities, and with official and private institutions operating in the affected area. The program takes into account activities which carry out diagnosis.

Philosophical Principles

This model is conceived and oriented in a way that follows certain principles in order to guarantee that the project becomes a tool to generate social, sustainable development. The principles are as follows:

- Participation as a whole,
- Respect for anyone's right to participate,
- Focus on the population,
- Focus on gender,
- Coordinated actions are promoted,
- Program sustainability,
- Evaluation must be possible, and
- The experience of participation must be replicable.

Participation Areas

Health

Participation in health takes into account the following activities:

Carrousel. This is the initial activity of the program. It is the process of working with a specific community (affected place or shelter), of developing activities of diagnosis, recreation and rehabilitation in a period of four to six hours after the disaster and aimed at generating processes of self and mutual assistance. The products that come out of this activity will be used for health participation activities as well as diverse actions of social organization.

Each carrousel is directed by professionals in the areas of psychology, education and social work supported by health staff, one psychiatrist and community volunteers. These volunteers are community leaders represented by teachers, area leaders, and mothers who care for children in the community, among others. The covered population varies from 200 to 400 people, and each carrousel should gather in parks or in other open, outdoor places for meetings.

Education and Training of Leaders in the Area. The work to be done in health prevention and promotion must be developed through *education and training of leaders in the area.* Each leader represents a particular geographical area and assumes duties in local health provision and generally serves as a fundamental organizing base for the community.

The leaders in the area are selected through a screening process from the local leaders. They first receive training related to *carrousel,* and then receive specific training. One of the themes highlighted in the training is the making of *mapas mentales* (mind maps)—a very important tool for the process of physical reconstruction.

Education

Participation in education includes the following activities:

Education camps (recreation programs). A series of academic non-formal activities generated through school, which become recreational programs.

Emergency Squads. Groups of boys and girls, adolescents, young people and adults are trained to participate in emergency squads. They can also recruit others interested in becoming part of an emergency squad. This is done through the local leaders and the education camps. The main objective is to prepare the community with basic tools to prevent and\or adequately confront similar, large-scale crisis situations.

Teacher awareness and training workshops in psycho-social issues. This activity involves the creation of a series of workshops that promote participation and self-reflection. The aim is to offer tools to teachers and other community leaders that can help them solve problems in a positive way. These problems may include inter-family violence, mistreatment, drug abuse, and so on, which may increase during times of natural or national disaster.

Organization of the Community

Community organizations are formed based upon the actions that resulted from work in the areas of health and education. Organizational strategies help the community organizations avoid conflicts that might otherwise escalate as a result of the natural- or human-caused disaster currently suffered by the community. The activities that contribute to community organization are:

Leadership. Since its inception, the project searches for community leaders (people and/or institutions) who have distinguished themselves in the areas of health and education; gradually, these potential leaders are brought into the program. The work done by local leaders and teachers in educational activities are both formal and non-formal. The organization of local groups generates a friendly environment for the growth of the whole community.

Leadership training. Training leaders through a series of workshops provides them with the tools to become better leaders in areas such as: communication techniques, group management, and the creation and implementation of projects specific to the goal of rebuilding communities and individual lives after natural or national crises.

Training local multipliers. Local multipliers of the project come from the targeted areas the and the institutions in the municipality that have been working with the affected communities; their role is needed in order for the activities related to the project to take place.

Social and Physical Reconstruction

A reconstruction strategy must arise out of the process of recovery and strengthening of the whole community. Activities that can lead to a shared and arranged reconstruction process are:

Generation of community organization. This is the main contribution to the process of participation and agreement, and different contributors to the strategies involved will generate organizational structures specific to the rehabilitative needs of their particular community.

The making of mind maps. In anticipation of future disasters, each community leader creates, literally, a mental a map of each operating area (i.e., a block, street, neighborhood, etc.) for which he or she has responsibility. These mental maps reduce reaction time before, during, and after the crisis event.

Community projects implementation. *Micro community projects* (environmental, health, productive) arise from the different activities within the project itself, and can contribute to the benefits, necessities and expectations of the community.

The creation of small businesses. A great majority of the resources required for reconstruction can be generated through local, pre-established businesses, organizations, cooperative societies, and associations. After a disaster, these groups provide materials needed for reconstruction (e.g., roof recycled tiles, and construction material in general), and manual labor.

Control and Evaluation

A *linea de base*, starting point, works as a follow up and evaluation criteria. It is done to establish the affectation level of a community and to evaluate the psychosocial conditions of the community in terms of sleeping disturbance, digestion, physical health, socialization, behavior, family support, and management of free time. A *diagnóstico rápido* (quick diagnosis) on the psychosocial situation of the affected population is performed. The helping local community groups define an easy to handle index ensemble, which will be held during the activities, and looked after by the university work teams and the established local structure. These will allow work teams to measure the performance and fulfillment of the activities and the repercussion of the project, using the methods of participant evaluation. Evaluation includes the analysis of the qualitative evaluation, which is obtained through surveys completed by a representative group of people, community leaders, participants, and non participants of the process. Diverse entities and agencies may also support financing of the project, and national organizations may provide other, qualified participants to conduct evaluations.

Summary

Psycho-social participation programs can be developed through the cumulative knowledge and experience of the proposed model. Specifically, the areas of health, education, social organization, and social and physical reconstruction have benefited from, and have continued to develop this model of participation. Concrete results of the program have been found within a two-year period.

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CONTRIBUTING AUTHORS

Jorge Ivan Lopez Jaramillo, M.D.
Transv. Superior con Calle 10 A #22-04, Medellin, Colombia;
574-268-3711, ext. 518 Fax: 574-268-2876; E-mail: lopezja@ces.edu.co

Volunteer Provider Participation in the Mental Health Response to the Columbine Shootings

David A. Bartsch
Alison Parsons

Introduction

On April 20, 1999, the murder-suicide of students and a teacher at Columbine High School in Littleton, Colorado shocked the community, the nation and the world. The tragedy at Columbine High School created one of the greatest challenges ever faced by local disaster response personnel. A great deal of assistance was needed from the community, in addition to the involvement of many agencies (Bartsch & Parsons, 2000), to respond effectively to the needs of those affected.

The Jefferson Center for Mental Health (Jefferson Center) had local responsibility for the mental health component of the disaster response. In addition to the Jefferson Center and other agencies responsible for the disaster effort, many individuals and agencies from the community volunteered to help assist in the response efforts. These volunteers were coordinated by the State of Colorado, Center for Mental Health Services (CMHS). In that process CMHS developed and maintained a database of volunteer providers. This database of community providers was developed in direct response to the shootings. In addition, data had not been collected previously in Colorado from providers volunteering to assist with disaster response in the community.

To assess the volunteer effort and to provide feedback for future response efforts, the volunteer providers were surveyed. The survey sought to collect data on the degree to which each volunteer provider was prepared to respond, their degree of involvement in the response efforts over the first eleven months of the response, the impact they experienced personally, the degree to which they were supported in their efforts, and the effectiveness of the services they provided.

Methods

The survey of Columbine community volunteer service providers was conducted in March 2000, approximately eleven months after the shootings. Surveys were mailed to 655 volunteer service providers listed in the CMHS volunteer database. Two hundred and two surveys (30.1%) were returned. Of those, 124 respondents (61.4%) indicated that they provided services to people affected by the Columbine shootings. Seventy-nine people (63.7%) were solely volunteers and 45 (36.3%) were employees of a corporation or agency that had committed staff to assist in the response.

Over half of the survey respondents were female (69.6%), and almost all were Caucasian (92%). The average age of the volunteers was 47 years, and they averaged 17 years of professional experience. Private practitioners represented 34% of the survey respondents, and 28% worked for a community mental health center, clinic or hospital. Staff from other public agencies accounted for 17.6% and staff from corporations another 8.8%.

Results

Preparation

Volunteer providers were asked to rate their preparation to deal with "general trauma" responses and to deal with "this particular type of disaster." The majority of respondents (87%) indicated that, prior to the Columbine shootings, they were moderately to highly prepared (a 3 or a 4 on a scale from 1, not prepared, to 4, highly prepared) to deal with general trauma. In comparison, significantly fewer volunteer providers (57%) were either moderately or highly prepared to intervene in this particular type of disaster response ($t(123) = 10.1$, $p < .01$).

Trauma Exposure and Personal Impact

Questions were asked on the survey related to provider exposure to trauma. Based on their survey responses, providers were grouped on each of three components into three exposure categories: low, moderate or high. These categories are defined below. Figure 1 shows the percent of providers in each exposure category.

1. **Time on scene in first 10 days:** None (low), some (moderate), or most of the time (high).
2. **Length of time involved in response efforts:** 1 to 10 days (low), 11 days to 2 months (moderate), more than 2 months (high).
3. **Degree of service involvement in two service categories:** Providers were asked to rate their degree of involvement in two service categories. The first was involvement in providing direct services such as crisis counseling, group therapy or individual therapy. The second was providing services to the population of Columbine students or their family members or faculty at the Columbine High School. Exposure was considered high if respondents scored high on their involvement for either direct services or services specific to Columbine students, families or faculty/staff. Exposure was considered moderate if they were not in the high group and they scored moderate on either of the two services categories, e.g., a "low" and a "moderate" report would yield a "moderate" overall categorization. The "low" category captured respondents indicating low or no involvement for the two service categories.

Providers were given a score on each component of 1 for low, 2 for moderate or 3 for high. Their scores for each exposure component were summed to obtain a combined exposure measure that was used to group each person into one of three exposure groups.

- The **low exposure group** included 43.5% of providers, those who had either a 3 or a 4 on the combined exposure measure (moderate on no more than one component).
- The **moderate exposure group** included 34.4% of providers, those with a score of 5 or 6 (moderate scores on at least two components).
- The **high exposure** group included 22.1% of providers, those with scores from 7 to 9 (at a high score on at least one component).

Figure 1
Provider Exposure Components
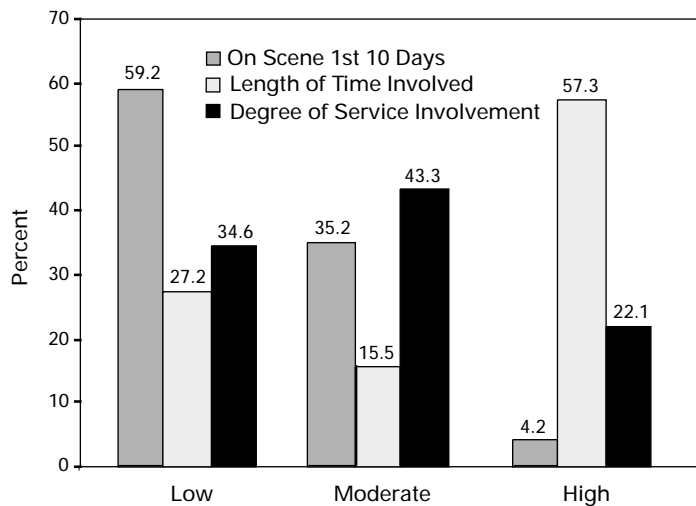
Trauma exposure was significantly related to the number of people served, the number of service contacts with those people, and the time involved. The high exposure group served significantly more ($F_{(2,110)}$ = 3.21, $p < .05$) people (average = 55) and had significantly more ($F_{(2,111)}$ = 6.53, $p < .01$) service contacts (average = 95) than both the moderate (27 people, 40 service contacts) and low exposure group (31 people, 28 service contacts). All exposure groups differed significantly in the duration of their involvement ($F_{(2,100)}$ = 16.4, $p < .01$). The high exposure group's average time involved was nine months, the moderate exposure group five months and the low exposure group three months.

The exposure groups did not differ in age (Nixon, Schorr, Boudreaux, & Vincent, 1999; average 46 years), years of experience (average 17) or the number of hours of TV they watched (average 18 hours) in the two weeks following the shootings. Also, all three groups indicated that "some" of the TV they watched was related to the shootings on a scale from "none" to "all". There were no differences between exposure groups in their preparation or degree of support received. Finally, exposure was not related to self-reported effectiveness in working with people in treatment.

The personal impact the providers experienced from the combined emotional impact of the of the shooting incident and the provision of services was significantly higher for the high and moderate exposure groups than it was for the low exposure group ($F_{(2,118)}$ = 4.4, $p < .05$). The overall emotional impact of the shootings was rated as moderate (2.9 on a 4 point scale ranging from 1 "no effect" to 4 "severe"). The overall emotional impact of providing services was significantly lower at 2.7 ($t_{(121)}$ = 2.7, $p < .01$), but also moderate. The specific areas of sleep, alcohol use, personal relationships, workplace morale, absenteeism, and illness were only mildly impacted.

Training and Support

Provider support and training questions assessed professional and personal resources available to providers. Overall, 55% of providers indicated the level of professional training and support they received was low or very low. Approximately half of all providers (53%) attended a median of two formal debriefings. Of those who attended debriefings, 54.8% found them somewhat helpful while 37.1% found them very helpful.

Respondents were also asked to rate the extent to which they received support from personal resources. Support from spouses or significant others was prevalent with 57% receiving a high degree of support and 35% receiving a moderate degree of support. Providers also received support from co-workers (39% high, 36% moderate) and from faith organizations (28% high, 23% moderate).

Training or preparation to treat people exposed to trauma overall was significantly related ($r_{(122)}$ = .385, $p < .01$) to provider reported effectiveness in helping people they served, with higher levels of preparation associated with higher levels of effectiveness. Provider support, on the other hand was significantly related ($r_{(122)}$ = .255, $p < .01$) to the impact the providers experienced overall from the shootings and providing services. The greater the impact, the higher the level of support they perceived from informal and agency sources.

Effectiveness

Overall, about 82% of providers indicated they were moderately or highly effective in helping the people they served. Providers also rated their perceived effectiveness in four specific areas: safety, grief and loss, Post Traumatic Stress Disorder (PTSD) reactions, and helping victims regain control of their lives. Providers' average ratings of effectiveness on a scale of 1 "not at all effective" to 4 "highly effective" in helping people deal with grief and loss issues was 3.1. This, and effectiveness with post traumatic stress reactions (average = 3.1) were significantly higher ($t_{(> 103)}$ > 4.6, $p < .01$) than helping people reestablish perceived levels of safety (average = 2.8) or regain control over their lives (average = 2.8).

Conclusions

Even though providers perceived themselves as being moderately to highly effective, these finding suggest some recommendations for future responses to human-caused disaster of this type. For example, the emotional impact experienced and its relationship to provider exposure indicates that agencies should consider specific measures to decrease disaster-related impact on responders. Such measures may include: shorter working days for staff; working only half time or less with the response effort, and/or; limiting the total duration of providers disaster-related involvement. Finally, perceived provider effectiveness and its relation to training and preparation suggest that providers should receive additional training to increase their preparation for this type of human-caused trauma. This is especially the case for those who become involved after the initial response, where there may be time to provide ongoing training.

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CONTRIBUTING AUTHORS

David A. Bartsch, Ph.D.
TriWest Group, 5345 Arapahoe, Suite Five, Boulder, CO 80303;
E-mail: dbartsch@triwestgroup.org

Alison Parsons, Psy.D.
Jefferson Hills Unit Manager, Jefferson Center for Mental Health, 1290 South Potomac Street, Aurora, CO 80012; 303-903-1777; E-mail: parsonsap@hotmail.com

Attributional Patterns in Men Who are Domestically Violent and Men Who are Not

Amina Porter
James Epps

Introduction

According to Cascardi, Langhinrichsen, & Vivian (1992), 71% of maritally-discordant couples seeking psychological treatment report involvement with at least one episode of domestic violence. Over 50% of all women will experience physical violence in an intimate relationship, and for 24-30% of those women the battering will be regular and ongoing. Estimates suggest that woman is beaten by her intimate partner every fifteen seconds (National Coalition Against Domestic Violence, 1996).

Only recently have researchers begun to study the potential role of cognitive processes in marital violence. Specifically, they examine the attributions, or accounts, offered by violent couples for events that happen in their relationships (Holtzworh-Monroe & Hutchinson, 1993).

The current study investigated attributions made by three groups of men: 1) men who were domestically violent and in distressed relationships, 2) men who were not domestically violent and in distressed relationships, and 3) men who were not domestically violent and in nondistressed relationships. Attributions and level of emotional arousal were investigated for negative domestic partner behavior, and the behavior of other women. The purpose of the study was to see if there was any difference in the level of emotional arousal and attributions made between these three groups of men, and to see if there was any difference in the attributions made within and outside of the dyadic relationship.

Method

Participants were 54 adult males residing in urban areas in Florida. All of the participants were currently living with an intimate female domestic partner (i.e. wife, fiancee, or girlfriend). The participants were compensated by having their name being entered into a drawing to receive a $100 money order.

Participants included in the analysis ranged in age from 19 to 61. The average age was 29 (SD = 9.4). Of the men who participated, 50% were Caucasian, 35% were African-American, 10% were Latino, and the remaining 5% were Native American, Asian or indicated that their racial background did not match any of the category options. The majority of the men (71%) were legally married, while the remaining 29% were living with a partner as if married. The average length of time the participants had been married or had lived together was 4.8 years (SD = 7.2). Sixty-two percent of the men reported having a religious affiliation. Ninety-six percent indicated that they had an occupation or profession, or were currently enrolled in school. Ninety-three percent had a high school diploma.

Participating men were asked to fill out a demographic questionnaire, as well as the following five measures: 1) the Marlowe-Crowne Social Desirability Scale (M-C SDS; Crowne and Marlowe, 1960), which is used to account for response distortion with face valid instruments, 2) the Beck Depression Inventory (BDI; Beck, 1978), which assesses the severity of state and trait depression in adults and adolescents, 3) the Conflict Tactics Scales (Straus, 1979), which consists of a list of actions that a family member might take in a conflict against another family member, 4) the Dyadic Adjustment Scale (DAS; Spanier, 1976), which measures the quality of a dyadic relationship, and 5) the State-Trait Personality Inventory (STPI; Speilberger, 1979), which measures the presence of state and trait anxiety, curiosity, and anger.

After completing the questionnaires, each participant was presented with a series of hypothetical scenarios that described a negative social interaction between himself and either his domestic partner, or a woman with whom he is not intimately acquainted. The scenarios were sculpted to reflect either benign, ambiguous, or hostile intent on the part of the other person. Following each scenario,

participants were asked to rate their level of anger, and the other person's perceived intent and hostility, using a Likert-type scale of 1 through 9.

For the analyses, the participants were divided into three categories:

1. *Nondistressed Nonviolent*: non-domestically violent men in nondistressed cohabitating relationships (*N* = 20)
2. *Distressed Nonviolent*: non-domestically violent men in distressed cohabitating relationships (*N* = 14)
3. *Domestically Violent*: domestically violent men in cohabitating relationships (*N* = 20).

Men who were classified as "Nondistressed Nonviolent" reported no instances of domestic violence against their wives or cohabitating partners on the Conflict Tactics Scales, and scored in the upper half of the average range or above on the Dyadic Adjustment Scale. Men who were classified as "Distressed Nonviolent" reported no instances of domestic violence against their partners on the Conflict Tactics Scales and scored in the lower half of the average range or below. Men classified as "Domestically Violent" were enrolled in either a 10 or 26 week treatment program for perpetrators of domestic violence, and/or had at least one episode in which they were the perpetrator of physical violence against their domestic partner during the last twelve months.

Results and Discussion

The findings of this study suggest an association between the type and quality of a dyadic relationship and the emotional and cognitive result of negative interactions. Specifically, men who were in Nondistressed relationships experienced higher levels of anger towards women outside of their relationships than they did towards their domestic partners.

Table 1
Ratings of Men in Nondistressed, Distressed, and Violent
Relationships on Dependent Variables

	Nondistressed		*Distressed*		*Violent*	
	Wife	*Other*	*Wife*	*Other*	*Wife*	*Other*
Anger	3.94	4.89*	4.06	4.21	4.62	4.51
Intentionality	4.05	5.57*	4.59	5.73*	4.67	5.48*
Hostility	3.78	5.53*	4.32	5.36*	4.67	5.37*
Benign Scenario Anger	3.30	3.70	3.65	3.54	4.04	3.93
Benign Scenario Intentionality	2.86	3.75*	3.54	4.04	3.61	4.46
Benign Scenario Hostility	2.60	3.63*	3.38	3.77	3.93	4.75
Ambiguous Scenario Anger	2.53	4.93*	3.15	3.81	3.64	4.25
Ambiguous Scenario Intentionality	4.13	6.35*	4.62	6.73*	4.96	5.71
Ambiguous Scenario Hostility	3.85	6.45*	4.54	5.96*	4.57	5.64*
Hostile Scenario Anger	6.00	6.05	5.38	5.31	6.18	5.36
Hostile Scenario Intentionality	5.15	6.63*	5.62	6.42	5.43	6.25
Hostile Scenario Hostility	4.90	6.53*	5.04	6.35	5.50	5.71

* denotes significance at the .05 level

Another interesting finding is that in all types of scenarios, men who were in nonviolent and Nondistressed relationships perceived that other women had acted more intentionally than did their wives. They also attributed more hostility to other women than they did to their wives. Generally, men in distressed marriages and men who were violent did not exhibit this pattern.

These findings suggest that men in nondistressed and nonviolent relationships may overlook hostile situational cues in situations involving their domestic partners. This finding of a tendency for happily married men to give their wives the "benefit of the doubt" even in hostile situations is consistent with previous research on quality of relationships and attributions (Heider, 1958, in Bradbury & Fincham, 1990). It seems that, even in hostile situations, there may occur a "halo effect;" i.e., men in nondistressed, nonviolent relationships may judge their wives' actions more kindly, albeit less accurately, then men in distressed and violent relationships.

It will be worthwhile for future studies in the area of attributions and domestic violence to focus on the role of depression as a potential moderating or mediating factor. The presence of depression was controlled for in this research study, but may be a contributing factor to the real-life negative attributions and cognitive distortions of violent and distressed men.

A potential limitation of this study is that generalizability may be restricted. Because the nonviolent populations of men were composed of university affiliates, and the domestically violent population came from a court-ordered treatment facility, these two subsets may not be representative of the entire population. Care must be taken when extending the interpretations of these results to other domestically violent and nonviolent populations of differing demographics.

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CONTRIBUTING AUTHORS

Amina Porter, M.A.
E-mail: aporter@luna.cas.usf.edu

James Epps, Ph.D.
E-mail: jepps@luna.cas.usf.edu

All authors: *Department of Psychology, University of South Florida, 4202 E. Fowler Avenue, Tampa, FL. 33620; 813-974-2492, Fax: 813-974-4617*

Institutionalized Youth and the Social Construction of Resilience: A Study of Health-Enhancing Deviance

Michael Ungar

Introduction

This paper reports on case studies of 43 youth in mental health and closed custody settings and examined how these youth and their institutional caregivers participate in the social construction of resilience. Practical application of the findings to ameliorating the negative impact of collaborative teamwork are also discussed. Two questions guided this study: (1) How do some children who suffer severe abuse and deprivation, grow up and not only survive, but thrive? and (2) how is the process that protects vulnerable teenagers similar to the process of empowerment? Through contact with teenagers and their families who have experience in institutional mental health and custodial settings, experiences of power were examined which might protect high-risk youth against the impact of biopsychosocial risk factors. These risk factors include poverty, the mental illness of one or more parents or caregivers, physical and sexual abuse, family violence, neglect, intellectual and physical challenges, as well as mentally disordered behaviors such as depression and addictions. Some combination of three or more of these risk factors were present in the lives of all study participants.

This study is significant for two reasons. First, it is one of the few studies that has examined how children construct a discourse of resilience despite institutional and community interventions which label them as mentally ill. Second, it privileges the participants' discourse over that of mental health professionals, challenging us to look again at what is and is not a measure of healthy functioning. Enhancing the discursive power of research participants leads to greater clarity in conceptualizations of mental health related phenomenon. Participants in this study showed that standardized measures of resilience and vulnerability ignore aspects of health indigenous to marginalized social groups. What are taken as indications of vulnerability can also be the basis for child and family resilience when these experiences are understood from the perspective of those affected. This connection between power and the social construction of health has been examined before in both clinical and nonclinical settings, but almost exclusively with adults.

Methodology

Sample selection

The study aspired to look beyond the diagnostic labels assigned to the participants and focus on the process behind their mental health constructions (Ungar & Teram, 2000). It sought to understand the effect institutional and multi-systemic interventions have on the way youth construct either health-enhancing or problem-saturated identities. Therefore, participants were selected based on the variability in the ways they cope with the biopsychosocial risk factors present in their lives. This approach allowed high-risk youth with both socially acceptable and unacceptable behaviors to explain how they nurture and maintain mental health. The study produced some novel results. As one parent commented with regard to her delinquent teen, "You want to interview Christopher about his mental health? That will be different."

All participants were between 13 and 18 years of age. The first group (*n* = 21) was comprised of Caucasian, 12 girls and 9 boys being seen at an urban outpatient mental health clinic in Southwestern Ontario. A second group (*n* = 22) consisted of 4 females and 18 males, (19 Caucasian and 3 Native) who came from a closed custody facility in Atlantic Canada. Each teen participated in two interviews lasting from 1 to $1^1/_2$ hours. The first interviews used open-ended questions covering issues related to adolescence, mental health, relationships, experiences of power and control, competencies, and coping strategies.

Analysis

Both data collection and analysis were guided by Glaser and Strauss' (1967) constant comparative method. Indigenous and sensitizing concepts reflecting the themes emerging from the data were used to structure a coding and recoding process that was both additive and divisive of categories. Individual interviews were first analyzed one at a time and later subjected to cross-case analyses.

The trustworthiness of data (Lincoln & Guba, 1985), which is a measure of the isomorphism between the emergent data, the participants' experiences, and the observed phenomenon, was established in a number of ways: (a) participants were asked to review the transcripts of their interviews to ensure their accuracy; (b) the second interviews were used to discuss the emergent theory as part of a process of dialogic retrospection in which the participants and the researcher collaborated on theory development; (c) case material from each participant's clinical file was reviewed between interviews; and (d) focus groups with parents, professionals, and other teens provided feedback that established the transferability and relevance of the emergent theory. Other means of making the study trustworthy included the lengthy period of engagement with the participants and the subject matter, the thickness of presented data, and an audit of the first set of interviews by a third party. Nevertheless, the conventions of qualitative research require that readers form their own opinion about the transferability and relevance of the theory to their own contexts.

Results and Discussion

Overview

Findings indicated that collaboration between service partners can have a negative impact on the development of healthy identities in high-risk youth. Professionals, paraprofessionals, lay service providers, families and communities can impede healthy development when these partners participate in the construction of problem-saturated identities. High-risk youth challenge these identities by arguing for recognition of the health-enhancing aspects of deviant behaviors such as drug and alcohol use, early sexual activity, time spent living on the street, negative peer associations, and custodial dispositions. Mental health outcomes were closely linked by participants to their control of the labels that define their health status, a control largely denied them in the mental health discourse found in institutional and out-patient settings. High-risk youth explained that they are disadvantaged by age, race, gender, social class and physical challenges in the social discourse which defines them and their mental health status.

Mental Health and Social Discourse

Though naive in their understanding of postmodern interpretations of language and power, adolescent participants argued that control over their identity stories was the fulcrum upon which their mental health balanced. "Sticks and stones may break our bones, but names *will really hurt us*," they argued. These 43 case studies demonstrate that at-risk youth define themselves as healthy and their behaviors as health-seeking even when their caregivers believe otherwise. These marginalized youth experience coordinated interagency interventions as further stigmatizing them and their lifestyles. Goffman (1961), Laing (1967) and Foucault (1965/1961) have already partially charted this conceptual territory. We know that time in institutions affects identity constructions. And we know from more recent studies that interagency wranglings for control of "clients" determines which system, and consequently, which identity, individuals are assigned (Rains & Teram, 1992). However, there has been little attention paid to how youth construct healthy self-definitions despite the negative labels that attach to them during periods of incarceration or in-patient and out-patient care.

The findings from this study have been used as the basis for successful clinical work with young people both inside and outside mental health and correctional settings (Ungar, 2001). A further study to determine the effectiveness of this constructionist approach to treatment is currently being designed.

Healthy Deviance

An extensive review of the literature pertaining to high-risk youth suggests that support for this constructionist position can be found embedded within the findings of a number of international qualitative and quantitative studies. Without the resources to nurture and maintain their mental health, disempowered youth have little hope of identifying in themselves aspects of healthy functioning. They explain that they resort to behaviors such as joining street groups of delinquent youth (Pombeni, Kirchler, & Palmonari, 1990; Ungar, 2000), smoking (Michell & West, 1996), heavy drinking (Ziervogel, Ahmed, Fisher, & Robertson, 1997), carrying guns to school (Simon, Dent, & Sussman, 1997), and other forms of behavior that are empowering for them but are considered deviant by the standards of their families and communities. Borrowing Ogbu's (1981) concept of culturally defined competence, we see teens engaged in discursive resistance to the definition of their survival strategies as problematic. Participants in this study demonstrated that some high-risk youth nurture and maintain their mental health through behaviors most often considered deviant. This study joins a growing body of literature that asserts the presence of mental health in individuals who are diagnosed with a mental disorder (Gergen, 1990; Health and Welfare Canada, 1988; Nylund & Ceske, 1997; Reich & Zautra, 1988; Stoppard, 2000; Veit & Ware, 1983).

Application of Findings

The findings suggest that institutional settings may potentially be a forum in which to construct healthy and empowering identities for high-risk youth and their families if patterns of resilience that are labeled as deviant are instead given discursive value. This can be accomplished when professional and lay staff acknowledge the resilience of troubled youth who survive by relying on deviant behaviors to enhance their feelings of well-being. The study's findings offer a possible explanation for these observed patterns of adolescent "problem" behavior. Analysis of the data suggests that devaluing "deviant" behaviors is bound to be counterproductive. A more effective intervention strategy would be to acknowledge the mental health benefits of such behaviors through an empowering dialogue. The onus is then on caregivers to find ways that institutionalized youth can achieve power through mental health discourse in a more socially acceptable manner. Strategies to accomplish this are currently under study.

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CONTRIBUTING AUTHORS

Michael Ungar, Ph.D.
Associate Professor, Maritime School of Social Work, Dalhousie University, 6414 Coburg Road, Halifax, Nova Scotia, Canada B3H 2A7; 902-494-3445, Fax: 902-494-6709; E-mail: michael.ungar@dal.ca