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Differential Stress Reactions of Graduate and Undergraduate Students

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This study examined the differential stress reactions of both undergraduate and graduate students enrolled in the Communications program at Monmouth University. Thirty-one undergraduate students and 25 graduate students were given the Student- Life Stress Inventory. This inventory measured various stressors a student may face, including frustrations, conflicts, pressures, changes and self- imposed stress. In addition to measuring these stressors, the Student- Life Stress Inventory also measured reactions to those stressors, which included physiological, emotional, behavioral and cognitive reactions. The hypothesis that undergraduate students will have a stronger reaction to stress was not supported in the results. However, results from a MANOVA indicate that women further along in their studies scored higher in measures of frustration ($F(5.6)=.010$, $p<.05$), physiological responses ($F(3.7)=.041$, $p<.05$), and the overall stress score ($F(5.1)=.014$, $p<.05$). A Pearson's correlation was used to determine if there was a correlation between the nine subscales and the demographic variables. It was found that non-Caucasian's scored higher in the measures of pressure ($r=.304$, $p<.05$), self-imposed stress ($r=.045$, $p<.05$), physiological reactions ($r=.008$, $p<.01$), behavior ($r=.373$, $p<.01$), cognitive ($r=.313$, $p<.05$), and finally the overall sum ($r=.355$, $p<.01$). Pearson's correlation also determined that women scored higher than men for stress levels in self-imposed stress ($r=.401$, $p<.01$), cognitive ($r=.349$, $p<.01$), and the overall sum ($r=.396$, $p<.01$). The findings of this study may have important implications for gender and stress reactions.

Previous research has examined the perceptions of stress among undergraduate students, but not much has focused on graduate students. While all students experience academic stress, there may be differences in stress at the undergraduate and graduate levels.

Undergraduate students may be faced with an upcoming exam on five chapters and not feel like they have had adequate time to prepare due to the enormous course content. In addition, it may be their first time away from home and they may experience some problems adjusting to their new environment. These problems may include: increased or total freedom to do what they please, dorm life, parties and roommates. This can be a big adjustment for an undergraduate student and they may find themselves stressed while adapting to a new way of life.

Graduate students may have a uniquely different set of stressors in their lives while working towards their degree. Often times, graduate students are older than undergraduate students and may have added responsibilities, such as maintaining their families, working part or full time, and also making sure the bills are paid. Graduate students often take courses at night, and it may be a lot to juggle, leaving them feeling like they cannot get it all done.

The question, therefore, that needs to be explored is, do undergraduate and graduate students react differently to stress?

Previous research has focused primarily on the various stressors in a student's academic life. There are few studies that compare a student's reaction to stress at the various academic levels, such as undergraduate students' versus graduate students' stress reactions. We know the

stressors in an undergraduate student's life. Some stressors include: comprehensive exams, term papers, adjusting to a new environment, and newfound freedom from their parents. Graduate students are usually older and may have a family that needs taking care of daily, bills that need to be paid, and they may work part or even full time to pay for tuition while taking classes at night. If researchers had more knowledge on how students react to stress at the undergraduate and graduate level, universities and colleges could work to reduce the stress in students' lives by teaching them coping mechanisms to reduce stress therefore making their academic experience a more pleasant and fulfilling one.

Making a life transition can be difficult for any person, let alone a student. Life transitions usually are followed by stress and a reaction to this stress seems almost certain. Many would argue that the transition from high school to college is one of the most difficult life transitions to adjust to. These students must adjust to dorm life, make new friends, and adjust to newfound freedoms to come and go as they please. Undergraduate students must do all of this and take a full course load while learning to make important decisions regarding their future. Zirkel and Cantor (1990) found that there was a significant and positive relationship between early anxiety in college regarding academics and later stress for the students.

Zirkel & Cantor (1990) have also noted some contradictory findings. By the end of college however, there was some indication that students were indeed experiencing more personal control over their college tasks than they had in the earlier years. Further, older students were able to clearly recognize stress and time commitments during later life transitions (Zirkel & Cantor, 1990). Being able to recognize stress in its earliest forms can help ease the burden of academic stress.

While much research has been completed with respect to stressors faced by undergraduate students, it appears not as much has been explored to help graduate students with the stressors they may face. As previously stated, graduate students have a uniquely different set of stressors than undergraduate students. Most graduate students work part or full time while taking a full course load at night. Kirby, Biever, Martinez, and Gomez (2004) surveyed social work graduate students and found that 16% of respondents felt tired and busy as a result of working while going to school, which increased their stress levels while some students (21%) felt like the full course load was taking time away from work. Similarly, satisfaction with school was a predictor of work stress.

While many graduate students are faced with the above stressors, as well as others, research has seemed to show that there can be factors that mediate their impact. For instance, it appears two of the most likely sources of social support for graduate students are their families, as well as the peers and faculty in their academic program. In a study of graduate psychology students, social support from their peers and faculty was directly related to lower levels of stressful events, as well as to lower levels of physical and psychological symptoms of stress according to (Goplerud as cited in Mallinckrodt & Leong, 1992).

Even with social support, it seems as though women in graduate school bear the brunt of multi- faceted stress. According to Mallinckrodt and Leong (1992), the quality of living conditions, financial resources, and child rearing were the three significant stressors for graduate students, in particular, for women. When these factors were positive it was shown to reduce the stress levels among graduate students, however if they were negative, it made a graduate student's life much more stressful.

Another source of stress in addition to those previously mentioned is that of the dreaded internship. Most graduate programs require a field placement to satisfy a graduation requirement.

Hudson and O'Regan (1994) have found that the internship is the highest source of student stress for the traditional student; this may be due to new expectations placed upon the student. One might think that a larger family size (more obligations and expectations) may be an indication of higher stress, however these researchers also found there to be no significant difference between numbers of children and level of stress, no significant difference between hours worked and stress level, and no significant difference in stress levels between students who are in a committed relationship compared with those not in a committed relationship.

Hudson and O'Regan (1994) also noted that graduate students with two or more children who were not in a committed relationship had the lowest stress levels. Those students with one child who were not in a committed relationship had the highest stress levels. In addition, female students who were working full time in addition to going to school who were not in a committed relationship were shown to have significantly higher levels of stress than all other students.

Clearly, based on the number of obligations a potential graduate student already faces daily, one might suspect that he/she would not dream of adding more work to his/her life. However just the opposite may be true. Despite the work and increased stress, graduate students seem to value education, if not for the mere fact that they enrolled in furthering their education. This can be for personal advancement or out of the growing demand for degrees beyond the traditional bachelors degree. It is no wonder that graduate students put so much emphasis on perfecting their schoolwork. Saipanish (2003) found in a study of medical students that academic problems were a leading cause of personal problems, probably because education and academic achievement have always been a top priority in studies regarding medical students. Students with stress also reported significantly more academic problems than students without stress.

Not surprisingly, exams were rated as one of the most stressful aspects of a graduate students academic life. The other sources, such as falling behind in reading, large amount of content to be learned, difficulty understanding the content, heavy workload, lack of time to review, and the competitive nature of graduate school were some of the top academic problems listed among medical students (Saipanish, 2003).

Despite the stressful aspects of the requirements of higher education, as stated earlier, graduate students are typically very driven and highly motivated. Graduate students have unrealistic expectations or irrational beliefs as to what constitutes good grades. Most students strive for all A's. Saunders (1993) reported that when she assessed graduate students, they scored highest for high expectations, need for acceptance and approval, feelings of guilt (for effects of school on significant others), feelings of deprivation (for effects of school in their own life), and the need for social acceptance by other students and faculty. It is also likely that more successful students might perceive greater external expectations for their continuing success from faculty, family members, friends and peers (Nelson, Dell'Oliver & Koch, 2001).

These beliefs may cause a graduate student to take on more work than they can handle. Graduate students may simply be suffering from overload. They juggle family, work, and courses while trying to maintain their sanity. Overload seems to be particularly important for older students and women, who have the strain of multiple roles (Saunders, 1993).

Whether or not a graduate student can handle these difficult times may be related to stability of a person's self- esteem. If students have more confidence in themselves, they seem to be much less likely to suffer from debilitating stress. Kreger (1995) found that (a) scores on depression were inversely correlated with those on self- esteem, (b) are correlated with self-ratings of stress, and (c) scores on self-esteem are inversely correlated with self- rated stress, which (d) is unrelated to years of preparation for graduate study.

In addition to having a higher self-confidence, graduate students usually handle stress and other difficulties facing them by developing coping mechanisms. The most successful students were likely to be women and reported an increased use of focus on and venting emotion to cope. While this seems like it might be a good idea, Nelson, Dell'Oliver and Koch (2001) warned in their research that focusing on and letting out such emotions may be maladaptive to situations requiring active coping. This could be true for students who vent out all of their emotions pertaining to academic stress. Students may find themselves in a situation where they could normally cope by venting, however that time venting did not help to change the situation and may result in new coping mechanisms being formed.

In addition to what has been discussed already, several other studies have been conducted that have examined factors or behaviors that may mediate the affect of stress on academic performance in students of higher education (Akgun and Ciarrochi, 2003; Chemers, Hu, and Garcia, 2001; Macan, Shahani, Dipboye, and Phillips, 1990; Struthers, Perry, and Menec, 2000).

In a longitudinal study of first-year undergraduate students conducted by Chemers et al. (2001), the idea was posed that optimism and self-efficacy, that is, confidence, in one's capabilities, assist one in his/ her ability to transcend life's adjustments and challenges, specifically in the areas of academic performance and personal adjustment. In this study, the consequence of academic self-efficacy and optimism on the student participants' academic performance, stress, health, and dedication to stay enrolled in college were observed. Findings appeared to support that academic self-efficacy and optimism in first-year undergraduate students were linked to academic performance and adjustment. While these variables were found to be directly related to academic performance, they were not found to be directly related through expectations and coping perceptions (i.e. viewing college as a challenge rather than a threat) on academic performance, stress, health, and general contentment and dedication to stay in college. Instead, they were only found to be indirectly related in these respects. Overall, results appeared to suggest that individuals with higher academic performance suffered from less stress and were generally better-adjusted students.

In addition, Akgun and Ciarrochi's (2003) research found similar results with regards to academic performance and stress. They hypothesized that individuals high in learned resourcefulness would be better able than other individuals in managing their negative emotions, as well as tackling stressful challenges. As such, the general purpose of their research was to study the impact of learned resourcefulness on academic performance with a sample of first-year college students. Results supported their hypothesis. Findings appeared to show that high academic stress in low resourcefulness students negatively affected the grades of these students, but had no consequence on the highly resourceful students.

Struthers et al. (2000) conducted related research on undergraduate college students, studying the degree to which their academic coping style (i.e. performance-focused or emotion-focused coping) and motivation intervene between academic performance and stress. Similar to the abovementioned studies, the Struthers et al. study results appeared to find that academic stress was conversely related to course grades, meaning that students who experienced more academic stress had lower course grades, but the students that utilized a problem-focused coping style were found to have a greater likelihood of performing superior and being more motivated than the student that utilized a emotion-focused coping style. Further, Struthers et al. proposed that their results had implications for college professors in their motivation of students. They suggested that college professors who promote the use of study guides and good time

management skills, for example, could help to increase motivation and performance in their students.

Struthers et al.'s (2000) suggestions seem to support Macan et al.'s (1990) previous research findings regarding time management, academic performance, and stress among undergraduate students. Specifically, Macan et al. queried a group of college students by use of a survey that evaluated students' time management behaviors and attitudes, stress, and self-perceptions of performance and grade point average. Findings appeared to show that student participants that perceived having control and management over their time had significantly higher appraisals of their performance (also supported separately by higher measured GPAs), better work and life satisfaction, lesser amounts of role ambiguity and role overload, as well as lesser job-induced and somatic tensions.

In addition to the above, some students find other ways to cope with their stressors. Day and Livingstone (2003) conducted intriguing research with respect to perceptions of stress and the social supports that male and female students of higher education seek out. Interestingly, Day and Livingstone found gender to be influential in their research, finding it to have an effect in the evaluation of perceived stress and use of social supports in their sample of undergraduate students. In the five written set-ups that the students were asked to evaluate the perceived stressfulness and identify types and sources of social support they would use, females perceived a greater number of scenarios as significantly more stressful than the males in the study, suggesting that when females and males are presented with stressful experiences, they analyze them in their own unique ways. Also worth note and perhaps not surprising, females as compared to the males in the study reported a greater likelihood of searching out emotional support, generally from a loved one or a friend, to cope with a stressful situation.

In addition to seeking out support from peers and loved ones, college students often look at their professors as a mentor, someone to go to for assistance in stressful situations, primarily for academic assistance or guidance. Reactions to stressors can vary from individual to individual, and as such, so does their ability to express and cope with these stressors and whom they choose to go to for support. Sometimes, reactions can be misinterpreted and adequate support may not be found. With this said, however, with the responsibility of being a mentor to their students, comes the added responsibility for professors to recognize when their students are in need of help. However, if there is a mismatch in perceptions of stress among students and professors it can cause miscommunication or misinterpretation of situations between the two. Misra, McKean, West, and Russo (2000) suggest that a professors' sympathy and acknowledgement of their students' academic stress is key and can assist them in helping their students by providing stress reducing techniques to manage academic stress or in providing other referrals for assistance. This suggestion was made after their completion of research studying the perceptions of academic stress among college students. Misra et al. (2000) compared professor and student perceptions of the students' academic stress. Intriguingly, their results showed that professors and students did not match in their perceptions of students' stressors and reactions to stressors, with professors perceiving students to suffer greater levels of stress and showing reactions to stress more often than the students perceived. Here too, Misra et al.'s (2000) research suggests gender differences in female and male perceptions of stress, concluding that males are more likely to perceive life events as less stressful then females, and thus react in a more positive way to academic stress.

Additionally, similar to American undergraduate and graduate students, international students, too, must adjust to the stressfulness of the new social and educational environment of

the college experience. Though, international students have to face added frustrations to those typically experienced by American students, such as adjustment to the American culture and way of life. Misra and Castillo (2004) investigated American and international students' perceptions of academic stress and their reactions to these stressors. Results showed that American students reported higher academic stress and more reactions to stressors than the international students in the study. In addition, American students reported greater academic stress from pressure and conflict, reported greater levels of academic stress from self-imposed stressors, and more behavioral reactions to stressors than international students. As with much of the literature reviewed for this study, support of gender differences among study participants was found. Male participants appeared to display greater levels of stress related to conflicts, whereas females, both American and international students, appeared to report more behavioral and physiological reactions to academic stress.

In another study, Misra, Crist, and Burant (2003) studied a population of international college students, again, examining the association of academic stressors and reactions to stressors, but this time the influence of perceived social support on these variables was examined, as well. Results showed that life stressors predicted academic stress and reactions to these stressors. More specifically, increased levels of academic stress were predicted by increased levels of life stress and decreased levels of social support. Further, high academic stressors levels appeared to predict stronger reactions to stressors. Additionally, findings showed that academic and life stressors did not significantly vary by gender, although, female participants were reported to have greater reactions to stress than male participants in the study.

A number of gaps in knowledge were revealed by review of the literature on the topic of stress among students in higher education. Most notably was the fact that it appears that very little, if any, research has been completed that compares the differences in stress at the undergraduate and graduate levels. The purpose of our current research was to examine this subject further and observe whether there would be any differences in the stress reactions of the two groups, as this might provide us, as well as institutions of higher education, with a direction in terms of service provisions.

Based on previous research, we hypothesized that undergraduate students would react more strongly to stress than graduate students in general. We expected this because undergraduates are typically younger and may be less experienced in dealing and coping with stress or deadlines. In contrast, graduate students characteristically tend to be more mature and often have greater life experience, which we suspected would make them better able to deal with stressful situations, deadlines, and exams

METHOD

Participants

Participants were 56 Monmouth University undergraduate and graduate students majoring in communications (31 undergraduate students and 25 graduate students). Two undergraduate and two graduate classes were selected based on availability and willingness of professors and students. The mean age of the undergraduate students was 21 years (SD=1.18) and the mean age of the graduate students was 29 years (SD=7.12). Participants consisted of undergraduate students and graduate students of both sexes, but the majority of the students

participating in the study were female (21 undergraduate and 18 graduate students). The ethnic makeup of the students participating in the study was primarily Caucasian (31 undergraduates and 20 graduates). Table 1 shows a summary of all participant demographics.

Table 1: Demographic Characteristics

Variable	Total Sample (n = 56)	Undergraduate (n = 31)	Graduate (n = 25)
Age	23.90 (6.31)	20.25 (1.18)	28.62 (7.12)
Gender			
Male	17	10	7
Female	39	21	18
*Race			
Caucasian	51	31	20
African American	0	0	0
Hispanic	0	0	0
Asian	0	0	0
Other	3	0	3
Marital Status			
Single	47	31	16
Married	7	0	7
Separated/Divorced	2	0	2
Widowed	0	0	0
Year in College			
Freshman	0	0	0
Sophomore	16	16	0
Junior	12	12	0
Senior	3	3	0
Graduate	25	0	25
High. Lev. Ed. of Prim. Breadwinner			

Note. Standard deviations are in parentheses.
*Two participants failed to indicate race.

Instruments

Two instruments were used in this study. The first was a short demographic questionnaire utilized to acquire descriptive data about participants. Questionnaire items requested information on age, gender, race, marital status, year in college, and highest level of education completed by primary breadwinner in the family.

A second instrument was utilized to determine each student's reaction to stress; the Student-Life Stress Inventory (Gadzella and Baloglu , 2001) was given to each student participating in the survey. The Student- Life Stress Inventory contains 51 questions, which are all answered in a Likert scale response. The scale ranges from 1 (never), 2 (seldom), 3 (occasionally), 4 (often), and 5 (most of the time). This inventory measures five categories of academic stressors, which are measured by the subscales Frustration, Conflict, Pressure, Change,

and Self- Imposed. In addition, four categories describing reactions to the aforementioned stressors are measured by the following subcategories: Physiological (which includes sweating and trembling), Emotional (which includes anxiety and anger), Behavioral (which includes crying or drug use), and Cognitive (which measures the student's ability to analyze and think about stressful situations and effective strategies to reduce them) (Misra, Crist, & Burant, 2003).

Gadzella (1994) has described each subscale in great detail. The Frustration scale measures include problems due to delays, daily hassles to reach goals, and failure to accomplish goals. The Conflict subscale includes academic stress as a result of having two or more desirable and undesirable goals and impacts. The Changes subscale assesses any academic stress due to planned or unplanned changes, which may disrupt a student's life. The Self- Imposed subscale measures stress in areas such as competitiveness and desire to be loved. The Pressure subscale includes academic stress as a result from deadlines and course content.

Once the participants completed the inventory, each inventory was summed to get a total score on all of the nine sub categories. A lower score indicates lower stress and reaction to stressors. Inversely, a higher score indicates a higher stress level and reaction to stressors. This instrument has shown to be reliable, with Chronbach's alpha ranging from .59 to .82 (Misra, Crist, & Burant, 2003). The Student- Life Stress Inventory was designed to measure the stress reactions to academic issues in college students. This is similar to the current population that was surveyed; however this study also included the use of graduate students.

Procedure

A convenience sample was utilized for this study. Two undergraduate classes and two graduate classes were selected based on availability of students and professors. Data was collected only after Institutional Review Board (IRB) approval was received. Researchers made arrangements with professors by phone or email as to which days to come in and obtain data from participants. No incentives were provided. Questionnaire packets were handed out to participants, which consisted of the informed consent statement, demographic questionnaire, and the Student-Life Stress Inventory. Participants read, signed and returned the informed consent statement prior to their completion of the demographic questionnaire and the Student-Life Stress Inventory. The informed consent statement briefly outlined the purpose of the study, the participants' involvement, and confidentiality matters. Also, included in the informed consent statement, participants were advised that it was anticipated that the survey would take no longer than 10 minutes to complete, that the study results would be recorded anonymously, with informed consent statements being filed separately from responses, and that participants were free to leave their questionnaires blank or stop filling them out at any time, with no penalty or adverse consequences to them of any sort.

Also, as indicated in the informed consent statement, the participants' professors were asked to step out of the room until the participants completed and handed in their questionnaires, so that participants would not feel any pressure to participate by their professors, as their professors would not know who did or did not participate. Subsequent to completion of the questionnaires, participants were provided a debriefing document by researchers. Additionally, participants were provided with the opportunity to ask any questions regarding the study at that time.

RESULTS

An independent samples t- test was run and failed to determine any significance between the stress reactions of undergraduate and graduate students, t= .646, p= .521, which did not succeed in supporting our hypothesis that undergraduate students would have a greater reaction to stress than graduate students.

A multivariate analysis of variance (MANOVA) was run to determine if there were any significant effects from the demographic variables (e.g. sex, race, level of education, marital status). The MANOVA indicated that women further along in their studies at either academic level (undergraduate or graduate) scored higher in the measures for frustrations, physiological reactions and the overall score for stress, $F(5.6)=.010$, $p<.05$, $F(3.7)=.041$, $p<.05$, and finally $F(5.1)=.014$, $p<.05$.

The MANOVA also yielded significance for sex and marital status. It was determined that single women scored higher on the changes subscale than did those students who were married, $F(4.9)=.038$, $p<.05$. Sex played a large role in determining stress reactions. Women scored higher in the pressure and physiological subscales than did men, $F(7.8)=.010$, $p<.05$ and $F(10.6)= .004$, $p<.05$. Table 2 shows a summary of significant MANOVA results.

Table 2: Manova Results

IV	DV	Mean Square	df	F	Significance
Sex	Pressure	72.4	1	7.8	.010*
	Physiological	656.1	1	10.6	.004*
Sex & Marital Status	Changes	34.7	1	4.9	.038*
Sex & Year in College	Frustration	69.9	2	5.6	.010*
	Physiological	229.6	2	3.7	.041*
	Final Sum	4262.7	2	5.1	.014*

* $p<.05$

A Pearson's correlation was used to determine if there was a correlation between the nine subscales and the demographic variables. It was found that non-Caucasians scored higher in the measures of pressure ($r=.304$, $p<.05$), self-imposed stress ($r=.045$, $p<.05$), physiological reactions ($r=.008$, $p<.01$), behavior ($r=.373$, $p<.01$), cognitive ($r=.313$, $p<.05$), and finally the overall sum ($r=.355$, $p<.01$). Pearson's correlation also determined that women scored higher than men for stress levels in self- imposed stress ($r=.401$, $p<.01$), cognitive ($r=.349$, $p<.01$), and the overall sum ($r=.396$, $p<.01$).

DISCUSSION

The results of this study failed to support the hypothesis that undergraduate students would have stronger reactions to stress than graduate students. However, results appeared to show a strong implication for gender with respect to stress experienced by students in higher education. Women appeared to have higher stress levels and reactions than men. This might have been due to underreporting by the male participants or perhaps because the female participants might not have had as high a tolerance for stress compared to the male participants. Much literature has focused on gender and the implications for student stress reactions.

Gender can have a mediating affect alone or in combination with other factors, which can have additional implications in terms of stress for students in higher education. Abouserie (1994), as well as others (Day and Livingstone, 2003; Michie, Glachan, and Bray, 2001) have pointed to clear and evident gender differences when it comes to the sexes viewing stressful experiences, which is consequently important to mention, as these differences can influence recommendations for how each gender may better handle academic stress or other life stressors.

Specifically, Abouserie (1994) observed a sample of second-year undergraduate students to examine their life and academic sources of stress and resulting stress levels, all with respect to self-esteem and locus of control, additionally examining gender as a possible influence in the process. Saipanish's (2003) more recent research with medical students, which indicated exams as the greatest source of stress seems to support Abouserie's previous findings, as the same was found true in his research. Further, results from Abouserie's research showed that more than three quarters (77.6%) of the students in the study fell into the moderate range of stress, whereas fewer fell into the serious category (10.4%), with females being more apt to experience stress than males in the study.

Michie et al. (2001) has also found evidence to support Abouserie's (1994) earlier findings. Gender differences in academic stress were also observed in Michie et al.'s work. Michie et al.'s (2001) research aimed to investigate the differing experiences of direct and re-entry undergraduate college students (Direct entry students were traditional college age students who entered directly into college from secondary education, whereas re-entry students were those students who had taken time off between secondary education and higher education). Females were once again found to show higher academic stress levels than males. More specifically, Michie et al.'s (2001) study found that the female student participants were generally less confident about their peers' evaluation of their abilities than males. Furthermore, females in this study also indicated poorer self-concepts than males, in addition to female direct entry students displaying the highest academic stress levels of all the students in the study, suggesting to one that females in higher education clearly have differing needs than males in higher education and making one wonder whether age or experience may also play an influential role in academic stress levels of college's diverse student populations.

Based on the results of this study, it appears evident that students at both the undergraduate and graduate levels experienced stress due to various factors. Although, it was not the main focus of the present research study, it seems necessary before closing discussion that the question of how to reduce student stress be raised to help college and universities in their implementation of appropriate services for their students. What can be done to alleviate or significantly reduce stress for students? Several suggestions for treatment or rather management of stress among students of higher education have been provided in earlier studies

(Dziegielewski, Turnage, and Roest-Marti, 2004; Lumley and Provenzano, 2003; Sheehy & Horan, 2004) on the topic of stress in this population.

Interestingly, some research has discussed stress' impact on academic performance and achievement (i.e. exam grades, GPA, etc.). Understandably, stress in its various forms can play a significant role in students' academic achievement and performance in higher education. Some research has been completed on the utility of stress management techniques assistance in improving academic performance, such as research completed by Lumley and Provenzano (2003). Lumley and Provenzano's (2003) research findings on the topic of stress management techniques appeared to show that written emotional disclosure, in other words, writing about a stressful event, could lead to better academic performance and improved GPAs among a college student sample population, as demonstrated by their sample. Their research was based on the logic that when individuals do not let themselves experience the emotions of a stressful event, that is when he/she will fail to resolve the stress inducing experience. Thus, stress management techniques, such as written emotional disclosure, can be helpful in improving functioning in the individual, academic or otherwise.

Ways to help reduce academic stress and student burnout at the undergraduate level have also been shown. Dziegielewski, Turnage, and Roest-Marti (2004) found that seminars and training on stress management and prevention of burnout were effective in increasing understandings about stress and in teaching strategies in dealing with stress, thereby allowing individuals to better cope with stressful situations. The most effective seminars consisted of psychoeducation, cognitive strategies, and concrete methods for decreasing stress levels, including relaxation exercises.

Finally, yet other stress management research has focused on stress inoculation training (SIT) to manage or alleviate stress. The SIT technique was tested on a population of law students. SIT began with an education phase, which focused on anxiety, stress, and various stressors. Instructors then reviewed potential reactions to stress among students. The second phase introduced coping skills to the students. Students learned relaxation techniques, time management, study skills, and learned cognitive restructuring to combat any irrational beliefs (Sheehy & Horan, 2004). Sheehy and Horan (2004) found that SIT in their law student population proved to be effective in reducing stress. SIT helped reduce irrational beliefs, anxiety, and stress when interviewed once before the training began and once it was completed. SIT training was also shown to positively impact the student's grades. There was a significant increase in class rank for those students who received the training, which could have an important impact on student academic performance.

The findings of the aforementioned research studies provide suggestions and techniques to manage stress (i.e. written emotional disclosure, stress management seminars, relaxation training, and SIT) that could be useful in helping to assist universities, including the university from which the current sample was chosen for this study, in providing treatment services to their students that could teach students how to better manage or alleviate stress levels.

There were a number of limitations restricting the generalizability of this study. To begin, the results of this study were limited by the relatively small sample size. It is completely possible that a larger sample might have resulted in more significant findings. Additionally, the causal comparative research design and convenience sample of communications majors used to collect data on participants made it difficult to control for external or extraneous variables. As such, matching of groups on all variables was not precise. Further, since a convenience sample of communications majors at both the undergraduate and graduate levels was utilized for this study,

participants may not have been representative of Monmouth University undergraduate and graduate students of other majors as a whole or even generalizable to the general population of undergraduate and graduate students outside of Monmouth University.

It is feasible that students from another typically difficult major, such as Chemistry, for example, could have displayed greater stress reactions than the current sample of communications students. The uneven diffusion of ethnicity among participants, as well as class levels in the undergraduate student sample could well have limited this study's findings, too. However, it should be noted that an ethnically diverse sample was hard to achieve at Monmouth University, as it is an already less ethnically diverse college compared to other colleges in the area, such as one of the surrounding state universities. In addition, in terms of discussion regarding class level, there were no freshman students included in the undergraduate sample, which could have limited results, as well. It is quite possible that inclusion of freshman students in the study could have impacted or changed current study results, since freshman students might have experienced greater stress reactions than more advanced undergraduate students with more academic experience.

Further to the above study limitations discussion, it is additionally possible that a more ethnically diverse sample might have shown significant results in one ethnic group compared to another. Finally, in addition to the aforementioned limitations, a disproportionate amount of female students were included in this study, which could have limited extension of research results. Future researchers would be wise to preserve a balance of participants with respect to year in college and gender. Finally, also worth note, participants were requested to self-report their stress reactions as part of their agreement to participate in the study, which could have limited study findings. Potentially, participants may have answered questions in a socially desirable way to circumvent the shame of disclosing personal shortfalls. Any future researchers wishing to examine the present study's topic further would be wise to evaluate this study's research design and other aforementioned shortcomings to make appropriate adjustments to improve generalizabilty of future studies' results.

Future researchers might also consider examining the influence of socialization differences between male and female students of higher education with regards to stress levels. It might be possible that the influence of women's socialization may encourage them to take on more roles than men. Perhaps, their balancing act may appear to look easy from the perspective of outsiders, but stressful from the women's perspectives based on their circumstances. It might also be beneficial for future researchers to use a control group (for example, students receiving stress management techniques) when measuring student stress levels.

This study adds to the body of knowledge on the topic of undergraduate and graduate stressors and reactions to stressors. Although, no significant findings were found based on the initial hypothesis, further analyses of data obtained on study participants appeared to show interesting findings, which might have implications for research in the area of academic stress among students in higher education. In summary, based on the present study's findings, it is suggested that future research in the area of discussion might include control groups, be completed on a larger, more ethnically diverse student population, when available, as well as include further detailed analyses regarding the possible influences of gender or socialization differences between men and women with respect to varying academic stressors amongst differing class levels.

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Relationship Between Gender-Role Identity and Self-Esteem

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Many studies have examined the relationship between gender identity and various aspects of human behavior. The literature suggests that gender seems to be strongly linked to sex-role stereotypes in both males and females. Some research shows that masculine characteristics are associated with higher levels of self-esteem. This study examined the relationship between gender role identity and self-esteem. It is likely that individuals with high levels of identity with their own gender or high levels of identity with both genders may have higher levels of self-esteem. Further, individuals that have high levels of identity with the opposite gender or low levels of identity with both genders may have lower levels of self-esteem. An independent sample t-test revealed no relationship between gender role identity and level of self-esteem. Further, an ANOVA did not reveal any relationship between gender role identity and level of self-esteem. High levels of individuals scoring as androgynous and sex typed were noted. Suggestions for future research are provided.

Gender identity refers to an individual's personal identification with masculine or feminine gender characteristics. Bem divided gender identity into four categories: sex-typed, sex-reversed, androgynous, and undifferentiated (Bem and Stanford, 1974). Many studies have examined the relationship between gender identity and various aspects of human behavior, for example, personality dimensions (Francis and Wilcox, 1998, & Alumbaugh, 1987), self concept (Gana, 1996), attitudes (Archer and Rhodes, 1989), sexual dysfunction (Dwyer, Amberson, and Tensley, 1988), and social desirability (Lara-Cantu and Suzan-Reed, 1989). The relationship between language, culture and Bem score has also been examined (Huang, 1989).

People that are sex-reversed may constitute a unique group with regard to gender identity because their gender identity is not in accordance with their biological sex. Consequently, they may experience rejection from individuals of their same sex. This rejection may impact their self-esteem. Is there a relationship between gender identity and self-esteem?

In an article written by Naffziger and Naffziger in 1974, the development of these stereotypes was examined. Since the beginnings of time humans have filled many different roles, similar humans had similar roles. Thus, men had male roles and women had female roles. These roles have become imbedded in society's idea of what is desirable for a man and a woman. It is desirable for a man to be aggressive, independent and not at all emotional whereas, it is desirable for a woman to be tactful, gentle and aware of other's feelings (Naffziger & Naffziger, 1974).

In a study by Broverman, Broverman, Clarkson, Rosenkrantz, and Vogel (1970), mental health professionals were asked to rate characteristics of a healthy individual, a healthy male or healthy female. It was found that the healthy male and the healthy individual were rated very similarly in characteristics. The healthy female was not. Traditionally male characteristics were seen as healthy, whereas traditionally female characteristics were less likely to be seen as

healthy. This suggests that mental health professionals were more likely to view a male client as healthy then a female client. Broverman et.al. (1970) identified this as the sex bias in mental health.

Traditionally, masculine characteristics were seen as mentally healthy. These masculine characteristics were attributed to males (Broverman et. al., 1970). A person was seen as either masculine or feminine, with no in between (Naffziger & Naffziger, 1974). These identities were taught in the schools. It was thought that if an individual learned the appropriate sex role identity, their quality of life would be better. The possibility that an individual could have both masculine and feminine characteristics was not widely accepted. Perhaps, having both masculine and feminine characteristics is the healthiest.

Bem (1974) looked at masculinity and femininity as co-occurring in individuals. That is to say, that an individual may have masculine traits and feminine traits. These traits may manifest themselves in different situations. Bem (1974) introduced the idea of psychological androgyny, where an individual may be both masculine and feminine, that females did not necessarily suppress masculine traits and men did not necessarily suppress feminine traits based on what they learned from society. An androgynous person would have high levels of both masculinity and femininity.

Bem (1981) elaborated on this theory and developed the Gender Schema Theory. This theory suggests that an individual who is said to be gender schematic has a strong gender role identity. This identity is congruent with his or her sex. These individuals display traits that are socially accepted for individuals of their gender. Individuals who are gender aschematic display both traits that are masculine and feminine, regardless of society. There are also individuals that are cross-sex-typed. These are individuals that exhibit traits that are typically associated with the opposite sex.

Janet Spence (1993) discussed the socialization of individuals into society's accepted roles. Spence's theory suggests that individuals develop their first idea of gender identity in early childhood. It further states that this identity continues to be an integral part of self throughout an individual's life. Even if an individual has a strong gender identity, they still exhibit some characteristics of the opposite sex. Spence (1993) supported Bem's (1974) idea that individuals are not just masculine or feminine, but somewhere in between.

Thalma E. Lobel's (1994) research on fifth and sixth grade boys looked at feminine and masculine males and their perceptions of sex-typed, sex-reversed, undifferentiated, and androgynous peers. Lobel found that regardless of their own personal gender identity orientation, the boys identified peers who exhibited feminine traits or chose to play feminine games as the least popular. This suggested that self-perception of gender identity does not necessarily carry over to perception of others, as boys who were categorized as sex-reversed perceived other boys negatively for demonstrating feminine characteristics as well. Boys that were rated the most popular were those who played masculine games with other boys, or neutral games with girls were perceived as popular.

The idea set forth by Broverman et. al. (1970) is challenged by Beckwith (1993). Beckwith (1993) found that only a small percentage of characteristics were judged differently for a healthy female and a healthy male. There was little substantiation of a gender stereotype in this study. Perhaps, the Broverman (1970) study was limited by looking at masculine or feminine, rather than a possible interaction of both. Many recent studies have looked at the relationship between gender role identity and psychological functioning.

Gianakos (2000) examined the relationship between gender identity and coping with stress. It was found that androgynous individuals, those with high levels of both masculine and feminine characteristics, utilize coping skills more than undifferentiated individuals, those with low levels of both masculine and feminine characteristics. Undifferentiated individuals are likely to change jobs if there is stress in the workplace. Masculine and feminine individuals were both associated with control–related mechanisms when coping with stress. However, they were almost as likely as undifferentiated individuals to not ask for help. Thus, this study found that androgynous individuals exhibit the healthiest stress coping mechanisms, followed by masculine and feminine individuals, and finally undifferentiated individuals.

Kopper (1993) examined the relationship between gender role identity and anger expression. This study found that individuals with masculine gender role identity are more likely to express anger outwardly, and individuals with feminine gender role identity are more likely to hold in anger. Further, those with feminine gender role identity are more likely to be depressed than their masculine counterparts. This study did not discuss ambiguous or undifferentiated gender role identities.

A study by Baucom and Weiss (1986) looked at control and gender role stereotype, finding that masculine women and ambiguous women were likely to seek control when working in groups. It was found that the group allowed these types of women to have control in a variety of settings. However, feminine women were not likely to seek out control, therefore were more likely to feel little control. These women were also likely to exhibit more depressive symptoms. Androgynous women seek control and handle lack of control with minimal depressive symptoms.

Feminine women represented a high percentage of individuals with Borderline Personality Disorder in a study by McKay, Gavigan, and Kulchycky (2004). This study found that in their sample of women with BPD, the women were more likely to have a feminine gender role identity. It further found that in the same sample, women who self mutilated were more likely to have an undifferentiated gender role identity.

Gender role identity has also been associated with eating disorders. In a study that looked at eating disorders and desired gender role identity it was found that individuals being treated for eating disorders are more likely to rate their desired self high in femininity (Pettinati, Franks, Wade, & Kogan, 1987). These results suggest that individuals that suffer from eating disorders desire traditionally feminine attributes.

However, a study by Cantrell and Ellis (1991) challenged this idea. Their results showed that for their sample women with masculine gender role identity were found to score high on an eating disorder inventory. Feminine women showed signs of low self –esteem and concerns about weight. Masculine and androgynous individuals also showed signs of obsession about self and concerns about weight. This suggests that all gender role identity categories have concerns with weight and physical appearance. However, only feminine women showed significant signs of low self-esteem. This may be due to the specific population of women with eating disorders.

Terror Management Theory states that individuals are motivated to develop high self esteem levels as a protective barrier against social rejection and ultimately facing the reality of one's own mortality. (Pyszczynki et al 2004). The authors maintain that individuals use self-esteem to protect themselves against the ultimate fear of death that is a basic function of human existence. When an individual maintains high self esteem, his or her anxiety is minimized and is able to function reasonably effectively in the world, with minimal internal struggle resulting

from challenges to one's sense of competence and belongingness. Similarly, low self-esteem threatens one's defenses against such anxiety, causing one to struggle to regain a sense of balance and mastery.

Research shows that characteristics one may define as masculine, such as willingness to take a stand, assertiveness, leadership abilities, and individualism lead to higher self esteem in both males and females. Vonda Olson Long (1989) found that masculinity was a predictor of high self-esteem for both men and women. Long explains that this is not surprising, as masculine characteristics tend to be valued higher in this society. Long (1989)further discusses the possible implications of this finding in counseling, indicating that encouragement of more typically masculine behaviors in both male and female clients may be an effective therapeutic technique.

Hooberman (1979) similarly identified, in his research on homosexual and heterosexual males that high self-esteem was not a result on one's sexual orientation. Rather, it was correlated more strongly with masculine traits. Action-oriented attributes are traditionally identified as masculine characteristics. Hooberman (1979) found that men that possessed these attributes were more likely to have higher level of self-esteem than their counterparts.

The differences between males and females with regard to self-esteem and self worth have been explored in psychological research. Crocker, et. al. (2003) explored the concept of self worth in college students and maintains that there are differences in how men and women individually evaluate their sense of self worth. A high self worth rating score for the male participants in this study was correlated with the participant's view of themselves as more important and more knowledgeable than others (Crocker, et. al. 2003). In addition, male participants were more likely to report that they develop a higher sense of self worth as a result of feeling superior to others. Conversely, a high self worth rating score from the female participants showed that they typically based their sense of self worth on the approval they receive from others.

Much research has also been done in the area of gender identity and its relationship to self-esteem. Egan and Perry (2001) explained that by adolescence, children develop conceptions of the a) degree to which they are similar to other's of the same gender, b) their feelings of comfort with their gender, c) whether they are encouraged to reach out beyond the stereotypical roles and interests of their own gender group to explore other options, and d) whether their own sex is viewed as superior (Egan and Perry 2001). The authors looked at the multidimensionality of self-esteem in pre-adolescence, and hypothesized that a strong identification with one's gender and being content with this identification would lead to higher self-esteem. Conversely, the authors believed that strong pressure for conformity to one's gender for an individual that does not relate to one's sex-type would lead to negative a self-concept. The authors felt that this would result in feelings of being outcaste, inadequacy, and separation from one's group. This, in turn, may lead to anxiety, social withdrawal, and other internalized distress. (Yunger, et. al. 2004).

Further, sex-reversed children and adolescents who feel pressure to resort to sex-typed interests and traits may not explore interests that would be considered atypical of their gender group, therefore possibly limiting themselves and leading to a lack of satisfaction and personal fulfillment. (Yunger, et. al. 2004). Children likely to be the most affected by this conflict are possibly those who feel the most pressure to conform while identifying themselves as gender atypical, or sex-reversed, as they frequently find themselves experiencing discomfort as a result of falling short of expectations placed on them.

There has been much research on sex role stereotypes and gender identity (Naffizer & Naffziger, 1974). It was thought that individuals were socialized to identify with characteristics that were traditionally associated with their biological sex (Naffziger and Naffziger, 1974). In the past, masculine traits were associated with mental health and higher-levels of self-esteem (Broverman et al., 1970; Long, 1989). This suggests that women are socialized to be mentally unhealthy and have low-levels of self-esteem.

With the introduction of gender role identity, where an individual may have masculine and feminine characteristics, these ideas were challenged (Bem, 1974, 1981). Research now shows that individuals that have high levels of both masculine and feminine characteristics are likely to cope better with stress, however individuals that identify with their biological sex also cope well with stress (Gianakos, 2000). Undifferentiated individuals were found to avoid stressful situations, not deal with them (Gianakos, 2000). Undifferentiated individuals were also found more likely to self-mutilate in a population of individuals with borderline personality disorder (McKay, 2004).

High levels of self-esteem allow individuals to function better in society, being comfortable with one's self and experiencing less anxiety (Pyszczynki et al., 2004). Research suggests that males and females derive their self-worth in different ways, males in more traditionally masculine ways and females in more traditionally female ways (Crocker et al., 2003). Other research suggests that this idea of self-esteem develops early in childhood, and is related to society's pressure for children to conform to society's accepted roles for their sex (Egan & Perry, 2001). This research further suggests that individuals that do not conform would have a negative self-concept (Egan & Perry, 2001). This research only looks at conformity as two dimensional; it does not examine the ambiguous and undifferentiated identities that Bem (1974) discussed. Could the gender role identity of an individual be related to ratings of self-esteem?

Based on a review of the literature, gender seems to be strongly linked to sex-role stereotypes in both males and females. Interestingly, some of the research shows that individuals identified as having masculine characteristics have higher levels of self-esteem and cope more effectively with stressors. Most significantly, the way that peers perceive one another seems to have a significant impact on self-perception and a sense of self-worth.

Hypothesis:

This research paper examined the relationship between gender role identity and self-esteem. Since prior research has suggested that there may be a relationship between self-esteem and gender identity, it is likely that individuals with high levels of identity with their own gender or high levels of identity with both genders may have higher levels of self-esteem. Further, individuals that have high levels of identity with the opposite gender or low levels of identity with both genders may have lower levels of self-esteem. That is to say, individuals that are sex-typed or androgynous will score higher on a scale of self-esteem than those individuals that are sex-reversed or undifferentiated.

METHOD

Participants

Forty- four individuals participated in this study, with ages ranging from 18 to 43, with a mean age of 22.90. The sample was predominately white and middle class, with mostly female

participants (14 males and 30 females). Participants were all Monmouth University students, both graduate and undergraduate. Participants were gathered from undergraduate communications classes and graduate counseling classes.

Instruments

A survey packet was distributed to each participant containing the two measures and a demographic questionnaire. The first measure, published by Bem in 1974 was the Bem Sex Role Inventory. The second measure, published by Rosenberg in 1965 was the Rosenberg Self Esteem Questionnaire.

The Bem Sex Role Inventory (BSRI) is an instrument that obtains a measurement of the extent to which an individual identifies him or herself with traditional masculine or feminine characteristics (Bem, 1974). It can be completed in 15 minutes. The BSRI is a 60-item questionnaire that contains three scales, masculinity, femininity, and social desirability. Participants identified how much each item describes themselves on a 7-point likert scale, 1 being never true about self and 7 being always true about self. Three scores were derived from this inventory: masculinity (average of the 20 masculine items), femininity (average of the 20 feminine items), and social desirability (average of the 20 filler items). These scores ranged from 1 to 7.

To assign participants to sex role groups a median split procedure was employed (Lenney, 1991). Medians from the sample are the most accurate, but medians from Bem's large normative study (1977) may also be used (Lenney, 1991). The medians from Bem (1977) are masculinity, 4.89 and femininity, 4.76. This study used the normative sample medians. Male participants with masculinity scores over the normative value and femininity scores below the normative value, and female participants with masculinity scores below the normative value and femininity scores above the normative value were classified as sex-typed. Male and female participants with masculinity and femininity scores above the normative value were classified as androgynous. Male participants with masculinity scores below the normative value and femininity scores above the normative value, and female participants with masculinity scores above the normative value and femininity scores below the normative value were classified as sex-reversed. Finally, male and female participants with masculinity and femininity scores below the normative value were classified as undifferentiated.

Internal consistency reported by Bem (1974) was high. Internal consistency was examined using a sample of Stanford University undergraduates and a sample of junior college students. In the Stanford sample, all three scales were shown to be highly reliable: masculinity alpha = .86, femininity alpha = .80, and social desirability alpha =.75. In the junior college sample all three scales were also shown to be highly reliable, masculinity alpha =.86, femininity alpha=.82, and social desirability alpha= .70. The measure of androgyny was also examined. In both samples it was found to be reliable, Stanford students androgyny alpha =.85 and junior college students androgyny alpha =.86.

Bem (1974) also examined test-retest reliability and found a high reliability over a 4-week period. Test retest reliability for masculinity was r=.90, femininity was r=.90, androgyny was r=.93, and social desirability was r=.87. Rowland replicated this study in 1977 over an 8-week period with similar results of high reliability. Bem (1974) stated that there is a minimally significant to insignificant relationship between the masculine and feminine scales: Stanford students r=.11 for masculinity and -.44 for femininity, and in junior college the relationship is r=-

.02 for masculinity and r=-.07 for femininity. It is important that the scale measures androgyny, not just socially desirable characteristics. Bem (1974) looked at this relationship. The scores ranged from r= -.07 to .12. This shows that the scale is measuring androgyny and is valid.

The Rosenberg Self-Esteem Scale (RSE) was developed by Morris Rosenberg and was originally published in1965. The RSE was originally standardized on a population of 5,024 high school Juniors and Seniors in ten randomly selected high schools in New York State. The test consists of ten questions to be rated by the participant on a four point Likert scale. Scores range from 0-30, with a score of 30 indicating high self esteem.

Silbert and Tippett (1965) examined the test-retest reliability of the RSE in a population of 28 college students. They found a test-retest reliability of .85 when participants were asked to retake the RSE following a two-week interval.

Silbert and Tippett also found that the RSE demonstrates significant covergent validity with a similar measure of self-esteem at the time called the Health Self-Image Questionnaire with a Pearson r score of .83. They also found a score of .67 when scores were correlated with results of the Kelly Repertory Test . Crandal (1973) found a Pearson r score of .60 when results were correlated with the Coopersmith Self-Esteem Inventory, another highly validated and reliable measure of self esteem.

Procedure

All of the data was collected as a group in undergraduate and graduate classes at Monmouth University after receiving IRB approval. Before data was collected, permission was obtained from the individual professor. The professor was asked to leave the room during the collection so that each student could decide freely whether or not to participate. No credit or reinforcement was given in exchange for participation.

The procedure was standardized for each class. The experimenter distributed packets containing a demographic questionnaire, the BSRI, and the Rosenberg Self-Esteem Questionnaire. Before the students begin, informed consent was read, signed and collected from each participant. Students were informed that their participation was voluntary and that they could opt to discontinue at any time without repercussion. Students were also be informed that results are anonymous. They were further informed that the surveys will take approximately 20 minutes to complete.

The participants were then be asked to begin and remain quiet throughout the data collection. The experimenter asked the students to read the directions on each paper and answer each question as honestly as possible. The experimenter explained that details of the study would be revealed at the end, as to not influence the answers. The experimenter was in the front of the room while the participants completed the questionnaires.

After 20 minutes the experimenter asked participants to turn over their packets. The experimenter then walked around the room collecting packets. The experimenter then read a debriefing statement explaining the current study. Participants were given the opportunity to ask any questions.

RESULTS

An independent sample t-test revealed no relationship between gender role identity and level of self-esteem (t= .066, p=NS). Sex-typed and androgynous individuals were grouped

together and sex-reversed and undifferentiated were grouped together. An analysis of variance was performed to examine the relationship of each gender role category with level of self-esteem (F=.212, sig. .888). This analysis of variance revealed no significant differences (see Table 1). A Pearson correlation revealed no significant relationship between masculinity or femininity score and Rosenberg self-esteem score.

Table 1: Results of ANOVA

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	18.354	3	6.118	.212	.888
Within Groups	1125.832	39	28.867		
Total	1144.186	42			

DISCUSSION

Based on a review of the statistical data, we accept the null hypothesis indicating that there was no significant relationship found between sex-typed and androgynous individuals and a high self-esteem score; and between sex-reversed and undifferentiated individuals and a low self-esteem score. This may due to a variety of factors.

The design of this study employed group data collection in a classroom. The experimenters were not able to control for external influences, including student interaction during survey administration. During some of the collection students talked and laughed with one another while the surveys were being administrated, possibly creating an intervening variable that may have altered their responses. A student who was worried about what his peers might think if he took the survey "too seriously" may have rushed through or answered without much thought. If the surveys had been administered individually, this might have been avoided.

In addition, the experimenters and participants were often held to time constraints, as professors agreed to allow the data collection only during the beginning of their class. It is possible that some of the participants felt rushed to answer the numerous questions that were asked, thereby possibly altering some of their potential responses.

Data was collected from participants during class time. Some participants finished the survey quickly with relatively little thought. All of the undergraduate students used were taking Communications courses. These students may not ever have been asked to participate in a psychological study before, and not have been educated in the importance of providing researchers with genuine responses.

In addition, a very small sample of approximately 44 participants was gathered. The participants were primarily females between the ages of 18 and 24. Approximately 2/3 of the females were Caucasian. Similarly, the majority of our participants was not married and came from middle to high-class socioeconomic background. These are both typical characteristics of college students at a relatively expensive university. The participants are not representative of a

sample that can be generalized outside of this context. In addition, as a result of a difficulty in finding participants, the majority of our results reflect BSRI and RSE scores of undergraduate communications students.

One may conclude that a population of middle-upper class Caucasian college students, mostly females, may not be representative of the larger population on a whole. This sample may also not be representative of universities students as a whole. It may be reasonable to assume that being from a higher socioeconomic status, primarily Caucasian, and having the resources and social support to attend college would lead to an overall higher self-esteem. These confounding variables may have jeopardized the integrity of our findings.

Interestingly however, 36 out of the 44 participants scored in the categories of androgyny and sex typed. Out of 29 female participants, 25 scored either androgynous or sex-typed, and out of 14 male participants, 11 scored either androgynous or sex typed. This finding may be due to the population that was employed, a change in societal influences for males and females, or sampling error. It may also indicate that gender role identity does not have a relationship with level of self-esteem.

Although not directly related to our research question, the implications of this finding are extensive. It is possible that individuals in our age bracket have been affected by the ever-changing culture of young academics, which currently seems to be encouraging youth to demonstrate a range of positive qualities, both masculine and feminine in nature. With regard to female participants, it is possible to assume that those who have elected to further their education would have been affected by this societal shift toward assertiveness and other more traditionally masculine characteristics.

It is also possible that the fact that the BSRI was published in the 1970's, when the trend toward androgyny was only beginning, that there are concerns with the validity of this tool. Bem designed the BSRI based on societal gender role expectations of that time. It has been over thirty years since then, and many of the participants of our study have lived their entire lives since them BSRI was created. Perhaps an updated standardization would have accounted for changes and trends with regard to views on masculinity and femininity. The BSRI may benefit from a re-standardization on today's population of adults to determine if it is still appropriately categorizing individuals. Is it possible that there has been an overall shift for both males and females toward androgyny, indicating that both masculine and feminine characteristics are seen as positive or desirable traits?

Future research may address this possible trend and determine whether there has been a change in this area. Is it more socially acceptable now for females and males to be high in both masculinity and femininity? Is this a trend for a population such as young college females, pursuing communications degrees, a highly business-oriented field? Or, is it possible that college students have already acquired the social skills necessary to pursue that avenue and have therefore become a self-selected group of androgynous individuals? Have society's pressures and expectations become less gender specific?

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Eating Disorders in Preadolescents and Adolescents

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Eating disorders is a growing phenomenon and there has been extraordinary research on this topic in adolescents. However, there is an increase in the prevalence among school age children, or preadolescents. This paper examines the increase of eating disorders, and more specifically anorexia nervosa and bulimia nervosa in both preadolescents and adolescents and the similarities and differences of these disorders in these two populations. The definitions, causes, and risk factors of eating disorders will be discussed, as well as treatments and prevention programs. Included in the discussion are implications for school counselors.

Research on eating disorders in adolescents has increased in the past decade, however, there is still little research being done on eating disorders in preadolescents. Studies show that eating disorders are prevalent in childhood and preadolescents and Rickards (1982) noted that the number of children diagnosed with anorexia nervosa doubled in each decade between 1950 and 1980 (as cited in Ryne-Winkler, 1994). Nevertheless, The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) does not recognize eating disorders that arise in middle childhood. The only criteria the DSM – IV has diagnoses for children is feeding disorders in infancy and early childhood which includes food refusal and growth deficiency in infants and young children. While The DSM -IV also has criteria for diagnosing anorexia nervosa and bulimia nervosa, these do not generally fit the depiction of eating disorders in mid-childhood (Chatoor, and Surles, 2004). Cavior and Lombardi (1973) report that by the age of six, children begin to acquire the cultural criteria used by adults for judging physical attractiveness (as cited in Gabel and Kearney, 1998). There is a lack of understanding about preadolescents and their trouble with eating disorders, and ways to prevent this phenomenon early so it does not appear in adolescents. This paper will address eating disorders in preadolescents and adolescents, treatments and prevention strategies for school counselors.

PREVALENCE

Preadolescents

Several studies reported that eating disorders are present and increasing in preadolescents. These studies noted that eating disorders can develop relatively early in a child's life. Gustafson-Larson and Terry (1992) presented a study of fourth graders in rural Iowa where they discovered more than 60 % of the children very often or sometimes wished they were thinner, worried about being fat, and weighed themselves every day. About 50 % felt guilty when they ate foods that they thought might make them fat (as cited in Gabel and Kearney, 1998). Hill, Koff and Maloney (1994) reported that children today not only are unhappy with their weight, but also have symptoms of disordered eating including food restriction, binge eating and vomiting (as cited in Vander Wal, and Thelen, 2000). Maloney (1989) also found

among children in grades three through six 6.9 % scored in the anorexic range on a self-report inventory of eating concerns (as cited in Vander Wal, and Thelen, 2000). Childress, Brewerton, Hodges, and Jarrell (1993) noted that eating and body image concerns tend to be more salient among upper elementary school girls than among lower elementary school girls (as cited in Vander Wal, and Thelen, 2000).

Adolescents

A similar survey found that adolescents reported that they had started dieting as early as eight years old (Olsen, L., 1984) as cited in Maloney, and Daniels, 1989). Children at this age have found to be knowledgeable of their body shape and more recognizably of body fat. The dieting questionnaire showed that 45 % of the children expressed a desire to be thinner. Thirty-seven percent reported they had tried to lose weight. Twelve percent of the children from the same survey admitted to restricting calories while another ten percent binged and one percent vomited to control weight (Maloney, and Daniels, 1989). Edelman (1982) found children as young as five years of age displayed motivation to avoid obesity and that children realized a relationship between eating and obesity (as cited in Maloney, and Daniels, 1989).

Hill et al. (1994) found that in a group of girls, ages 9-10, the prevalence of highly restrained eating was 20% across all weight categories (as cited in Schur, Sanders, and Steiner, 2000). Maloney et al. (1989) reported that 6.9% of children in grades three through six were found to have distorted eating patterns suggestive of anorexia nervosa and 37% of children reported having tried to lose weight (as cited in Schur et al., 2000).

Adolescents

This disorder is also growing in adolescents. Eating disorders rank as the third most common chronic illness among adolescent females in the United States and estimates of anorexia nervosa range from 0.2% to 1.0 % among adolescent females and young women. Bulimia nervosa diagnoses range from 1 to 3 %. Also more than 50% of adolescent girls consider themselves overweight and have attempted dieting (Neumark-Sztainer, 1996).

DEFINITION OF EATING DISORDERS

Preadolescents

While there are no specific criteria in the DSM-IV for eating disorders in preadolescents, children with anorexia nervosa are often intensely afraid of gaining weight, attempt to lose weight, and exhibit a significant disturbance in the perception of the shape or size of their body. They also have less body mass and may enter a state of starvation rather quickly. The criteria for bulimia are binge eating and inappropriate compensatory methods to prevent weight gain. This binge eating and behaviors must occur at least twice a week for three months. The binge is defined as eating a discrete period of time an amount of food that is larger than most individuals would eat. It also needs to be combined with a sense of loss of control. Such compensatory behaviors include vomiting, abuse of laxatives, fasting, and excessive exercise (Chatoor and Surles, 2004).

Adolescents

These disorders look similar in adolescents but have criteria in the DSM-IV. A definition of an eating disorder is there is a definite disturbance of eating habits or weight control behavior. The behavioral disturbance should not be secondary to any general medical disorder or other psychiatric condition. Anorexia nervosa is an over evaluation of shape and weight. Anorexia nervosa is shown as a loss of weight primarily from severe and selective restriction of food intake. There is an active maintenance of an excessively low bodyweight. This food is viewed as fattening and unwanted (Fairburn, and Harrison, 2003). Females, who are postmenarcheal, must miss three consecutive periods, amenorrhea, to be diagnosed with anorexia nervosa. It also requires body image distortion and fear of being or becoming overweight, which are usually not present in other medical conditions (Eating Disorders, 2004).

There are two types within anorexia. The first is restrictors. These individuals are more likely to have obsessive-compulsive personality disorders. The second type is binge/purge. They often exhibit borderline and antisocial traits (Fairburn and Harrison, 2003).

Bulimia nervosa is different from anorexia nervosa. There is still an over evaluation of shape and weight. But there is repeated binging with bulimia. During a binge large amounts of food are eaten. Following a binge there would be compensatory behavior including self-induced vomiting or misuse of laxatives. This is under the criteria of extreme weight control behavior. To fit under the definition of bulimia nervosa a person can not meet any other diagnostic criteria for anorexia nervosa (Fairburn and Harrison, 2003).

Binge eating occurs, by definition, during an episode of overeating in which the person experiences a lack of control while eating and feels that eating cannot be stopped even though its cessation may be desired. Both binge eating and compensatory behaviors must occur, on average, at least twice a week for at least three months (Eating Disorders, 2004).

There are also two types within bulimia. The first is purging. This refers to the compensatory behaviors noted earlier, like self-induced vomiting and/or use of laxatives. The second type is nonpurging. This group fasts or uses excessive exercise in the absence of any purging behaviors but would still be considered compensatory behaviors (Eating Disorders, 2004).

ETIOLOGY

Preadolescents

Early childhood has factors that exist that may cause disordered eating or lead to disordered eating in the future. Schur, et al. (2000) found that by ages 8-13 some children already believe it would be better to weigh less, even though they do not necessarily attempt to lose weight. Another study by Killen (1994) of fifth and sixth grade girls showed weight concern to predict onset of eating disorder symptoms (as cited in Schur, et al., 2000). These studies indicate risk factors for eating disturbance and depression that may be acquired early on in childhood. High BMI was also found to be consistently associated with higher levels of body dissatisfaction and eating concerns. This indicates a population that may be at risk later in adolescence (Schur, et al., 2000).

Kelly, Ricciardelli, and Clarke (1999) summarized four factors that girls portrayed for eating disorders. The first one is dieting. This is associated with poor body image and girls dieting to improve their image. The second factor is food preoccupation. This describes consistent thoughts about food and a lack of control over eating. Social pressure to eat is the third factor. This is a perceived pressure from others to gain weight, often initiated by a family member. The final factor was restricting and purging which is the point at which an eating disorder may be found.

The style of eating is also seen as a risk factor for preadolescents. Polivy and Herman (1985) suggested that a cognitive style of eating as opposed to a physiological regulated eating pattern causes disinhibition and increases vulnerability to binging and overeating. This theory would suggest that childhood alterations in eating attitudes could make a child more or less at risk for an eating disorder throughout their life (as cited in Schur et al., 1998).

Parental factors and family have been shown to be a risk factor in children with eating disorders. Parents may make more direct contributions to children's eating disorders by creating an environment which emphasizes thinness, especially in girls and women. Parents may make comments on their child's body shape or they may model weight concerns and disturbed eating (Smolak, Levine, and Schermer, 1999). As children get older the more likely they are to get criticized about their weight from their parents (Striegel-Moore and Kearney-Cooke, 1994, as cited in Smolak et al., 1999). Pike and Rodin (1991) noted that maternal eating attitudes and dieting were related to high school girls' bulimic symptoms and that high school girls with a dieting parent were more likely to diet (as cited in Smolak et al., 1999).

Adolescents

There are many factors that have been studied that are correlated with eating disorders associated with adolescents and young women. The role of puberty is seen as a primary factor. Puberty is a complex stage of development in which many physical and psychological changes and challenges have to be negotiated. Tanner (1989) noted that in girls the mean proportion of body fat rises from 8% to 22% after puberty and body weight rises by about 40 % from age 11 to 13 (as cited in Schmidt, 2003).

Risk Factors

Some other factors associated with eating disorders are psychological, behavioral, and cultural risk factors. Psychological factors include body dissatisfaction and low self-esteem (Garner and Garfinkel, 1982, as cited in Taylor et al., 1998). Behavioral factors include excess dieting and binging (Leon, et al., 1992, as cited in Taylor et al., 1998). Socio-environmental risks include peer pressure to diet and to be thin (Walts and Ellis, 1992, as cited in Taylor et al., 1998). Cultural norms also play a role, especially society's glamorization of thinness (Striegel-Moore, 1986, as cited in Taylor et al., 1998). Taylor et al. found the importance that peers put on weight and eating was most strongly related to the development of excessive weight concerns. The American Association of University Women (1991) reported that girls experience a marked drop in confidence from elementary to middle school which is a psychological factor (as cited in Taylor et al., 1998)

Social support from the family and high relative use of escape avoidance coping also has been found to constitute a risk for later development of eating disorders among young adult women (Ghaderi, 2003). Ghaderi found that in a study of 807 women, ranging in ages of 18-32

these risk factors where associated with eating disorders. Also the study noted these factors were in combination with low self-esteem and high body concern.

Other risk factors for development of eating disorders is depression and a history of substance abuse, physical abuse, or sexual abuse. French et al. (1994), found that weekly or daily alcohol or tobacco use was about one and a half times more prevalent in those who always dieted compared with never dieters (as cited in French et al., 1995). Connors and Moore (1993) found suicide risk, sexual intercourse, and physical or sexual abuse each increased in prevalence with increased frequency of dieting. Delinquent behavior such as stealing has also been observed to be more frequent in studies of bulimia patients (as cited in French et al., 1995).

The media can also contribute to a set of messages supporting the phenomena called a thinness schema. This includes the belief that a successful woman can and should transform and control herself through fashion, dieting and rigorous exercise to conform to the desired lean look (Kater, Rohwer, and Levine, 2000). This idea which Tinning (1985) called the cult of slenderness is when psychological responses to puberty are reinforced by cultural imperatives, creating a community ethos (as cited in Sands, Tricker, Sherman, Armatas, and Maschette, 1997).

Heredity and genetics may also be a factor that can lead to eating disorders. Eating disorders have been seen to cluster in families and studies suggest that relatives of individuals with anorexia nervosa or bulimia nervosa have an increased risk of developing eating disorders. It also seems that eating disorder symptoms whether behavioral or attitudinal are also heritable (Lilenfeld et al.(1998) as cited in Schmidt, 2003).

The final factor that could be a risk for an eating disorder is neurobiology. This is a relatively new idea and has not been thoroughly tested yet. However this is a complex ideas dealing with disturbances of neurotransmitters, neuropeptides and neuroendocrine systems. These have been reported in ill and recovered persons with anorexia nervosa and bulimia nervosa, but the significance is still being studied (Schmidt, 2003).

CONSEQUENCES

General Findings

There are several consequences that arise from eating disorders. These can be severe, and mortality rates among cases can range as high 10% due to starvation, cardiac arrest, or suicide. Mortality rates in anorexia nervosa are among the highest recorded for psychiatric disorders. Other consequences are less severe but still important. Dieting associated with eating disorders can cause mental and physical symptoms such as fatigue, anxiety, constipation, amenorrhea, mental sluggishness, impaired performance in school, and impaired growth. Dieting may also be associated with eating behaviors that lower intake of calcium and iron, which are of particular importance to adolescents (Neumark-Sztainer, 1996). Frequent dieting in adolescents may be harmful because of its association with higher levels of smoking initiation. There is also an association with alcohol or other drug use (French et al., 1995). Childbearing and pregnancy is another concern. While eating disorders improve during pregnancy, birth weight can be abnormal and there is a higher rate of caesarean section in individuals with eating disorders than in those without. Also in a small proportion of cases, childbearing is impaired,

with secondary effects on the child's feeding and growth (Franko, and Spurrell (2000) as cited in Fairburn and Harrison, 2003).

Another consequence is depression. This can stem from an inability to control binge eating and purging (Pople et al., 1983, as cited in Killen et al., 1994). Killen et al. found that disordered eating among 11 and 12 year-olds were associated with higher scores on both measures of depression. The scores for girls were high and approached or exceeded established cut points for depression on both measures (Doerfler, et al., 1988, as cited in Killen et al., 1994). Sometimes, with this depression is a subgroup that self-injures (Fairburn and Harrison, 2003).

Anorexia

Anorexics experience specific consequences along with the general consequences. Along with the lack of menstrual periods, there may be abdominal pain, low or high levels of energy, low blood pressure with dizziness, and slowing of the heart rate (Eating Disorders, 2004). Patients who are anorexic often lose interest in the outside world and typically will become socially withdrawn and isolated. Also patients with anorexia can experience osteopenia and osteoporosis, which is especially common in longstanding and severe cases of anorexia nervosa. This is associated with a substantially increased risk of fractures (Grinspoon et al., 2000, as cited in Fairburn and Harrison, 2003).

Bulimia

Similarly children who are bulimics may also experience medical complications. These include hypokalemia, gastric disturbances, and dehydration due to purging. Some other conditions include electrolyte imbalance, and cardiac arrhythmias. All these complications could result in hospitalization (Chatoor, and Surles, 2004).

TREATMENTS

Basic Treatments

Outcome studies of anorexia nervosa have reported good results in 50% to 67% of patients. Some studies have reported that onset at earlier than eleven years of age is associated with poor outcomes whereas other studies found that the older the age of onset, the poorer the outcome (Walford, and McCune, 1991, as cited in Chatoor and Surles, 2004).

There are several treatments used with eating disorders. The first type of treatment involves mainstream principles. There are four aspects to management. The first is to help patients see that they need help and to maintain their motivation thereafter. The second aspect is weight restoration. This is needed to reverse the malnutrition and of itself usually leads to substantial improvement in the patient's overall state. The next facet of management is addressing over evaluation of shape and weight, their eating habits, and their general psychosocial functioning. The final aspect of management is the use of compulsory treatment, which is only relevant in to a few cases (Fairburn and Harrison, 2003).

Anorexia

One type of treatment for anorexia nervosa states that the initial goal of treatment is the restoration of physical health, which is slightly different than the first treatment. This treatment may require some children to be hospitalized for refeeding. Early discharge with low discharge weight has been shown to confer high risk for relapse and a poor prognosis (Baran, et al., 1995 as cited in Chatoor and Surles, 2004).

Treatment for anorexia nervosa can and should also include cognitive, behavior and family therapy. Cognitive therapy often has been added to behavioral treatment with the goal of overcoming dietary restriction and body image distortion. Family therapy focuses on improving parent-child and sibling relationships and enabling the child to meet his or her needs within the family (Eating Disorders, 2004). Family therapy seems to be another pivotal treatment in eating disorders in children. A study by Russell et al. (1987) found that family therapy encourages the family to take charge of the patients eating and seems to work well with the younger children (as cited in Chatoor, and Surles, 2004).

Bulimia

Cognitive therapy has also been very successful in the treatment of bulimia nervosa. This therapy aims to restructure distorted cognitions, limit cues triggering a binge-purge episode, develop alternative coping behaviors, gradually reintroduce three meals a day, slowly introduce "feared" binge foods, and delay vomiting. Another treatment for bulimia is antidepressant medications. These have led to some improvement in bulimic symptoms. Interpersonal psychotherapy may also be used. This focuses on personal problems and improving communication skills (Eating Disorders, 2004). A study by Wilson and Fairburn (2002) shows that therapy typically involves about 20 individual treatment sessions over five months and results in substantial improvement with a third to a half making a complete and lasting recovery (as cited in Fairburn and Harrison, 2003).

Alternative Treatment

Another type of treatment for patients with anorexia is biofeedback. While there is little research yet on this treatment, one study suggested that this had a significant improvement. Biofeedback applied to the patients comprised real-time registration of the electrodermal response on the left hand. This was a relaxation procedure that was used to cope with stresses that were triggers for anorexia (Jordanova, 2000).

DISCUSSION

Eating disorders is a growing phenomenon, especially in preadolescents. There is an increase in prevalence in both preadolescents and adolescents. Many risk factors have been recognized as possible causes and there are many more that have not been researched extensively. While the consequences are known, it does not seem to be deterring girls and women from dieting and developing an eating disorder. Therefore, many treatments have been evaluated and there is more ongoing research to find out whether the results are significant.

Because of the growing number of school age children developing, schools need to perform primary prevention to try to reach these children before the disordered eating starts.

The first thing that would help schools develop programs for eating disorder prevention is for the American Psychiatric Association Manual to add eating disorders for preadolescents. If counselors knew what an eating disorder looked like in preadolescents more students would be reached at an earlier level. The hope is that if students are reached early or before an eating disorder arises, there would be a decrease in consequences and an increase in full recovery. But counselors do not know what they are looking for because there are no specific criteria, therefore, they can not speculate, especially since the criteria for adolescents and young adults may differ from that of preadolescents.

Another idea that would help is to install prevention programs in the schools. Two programs have been researched and appear to have a good success rate. One program has the school counselors initially assess their personal feelings about body weight. After the self-evaluation the counselors can help students accomplish three things. The first is to identify cultural and societal influences on beliefs and attitudes about body image and weight. The next is to learn coping skills for teasing. Finally, the students will increase personal knowledge about nutrition, exercise and self-acceptance. These tasks can be completed by role playing, providing information about nutrition, exercise and self-acceptance. Also counselors and teachers should promote reasonable goals in the classroom for improving appearance through healthy and active lifestyles (Gabel and Kearney, 1998). All these issues that this program focused on were researched risk factors for developing an eating disorder.

Another program has a goal to intervene in the unhealthy developmental sequence that is currently prevalent among American adolescent girls that begins with the internalization of an unrealistic thin ideal and progresses to body dissatisfaction and dietary restraint. The program is designed to help prepubescent children enter the period of adolescence with a strong, positive sense of self-respect and integrity regarding body image, and to teach the incentive of eating for health and satisfaction of hunger. This program is comprised of ten separate lessons with four of the ten lessons emphasizing the biology of what cannot be controlled regarding body size, shape and hunger. Four more lessons emphasize influence weight and body image and offer choices, as well as choosing a realistic role model. The last two lessons are sociocultural in nature. Students receiving the program in grades four to six will receive booster lessons until ninth grade. The thought is that if students can be helped to develop a healthy body image early and receive reinforcement the thinness schema will be prevented (Kater et al., 2000).
It is difficult to determine what the perfect target audience for these prevention programs is, and more research needs to be done to evaluate this.

No matter what program is used, it is relevant for the prevention of eating disorders in school aged children. If children are all learning about body image, and teasing in their peer group, a prevention program would appear to work better. Schools need to play a bigger role in the primary prevention, especially in the younger grade levels because it is shown that there are patterns of disordered eating earlier than what may have been thought.

While it is seen there are several things that can help children and adolescents learn to adapt to the risk factors thrown at them, like puberty and body image, counselors should also be aware of the cultural factors associated with eating disorders. This is another area that needs to be addressed so the students do not get influenced and affected by their surroundings.

Counselors need to continue their education in this matter. As the prevalence is growing, counselors need to step in and work with other professionals in the school district. They will not

be able to work on prevention programs if they are not up to date with the risk factors, consequences, and treatments. As research continues to grow, new findings dealing with eating disorders are evident. Counselors continuing their education will be able to be up to date on the latest findings, which will undoubtedly add to the prevention in schools.

Further research should be done in several areas regarding eating disorders in preadolescents. Even though the prevalence of eating disorders is continually increasing among preadolescents, there is still little research done on this population. While there is some research done concerning this population, the definition of an eating disorder is difficult to find. This may be due to the lack of criteria in the DSM-IV, but also more research should be done to see how an eating disorder in this population is assessed. There is also little research done about eating disorders in boys of any age and continuing research should address this population. Hopefully with more research, we will gain a further understanding about this growing phenomenon and we will be able to come up with a prevention plan that will work to address the factors that are causing disordered eating.

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Birth Order and Risk Taking Among College Students

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This study examined the effects of birth order on risk taking behavior. The sample consisted of 58 undergraduate students both male and female. The likelihood to engage in risk taking was measured my Zuckerman's (1979) Sensation Seeking Scale. It was expected that middle/later born individuals would score higher on the scale than first born or only born children. It was found that birth order had no effect on risk taking behavior. Further analysis of the findings, however revealed a significant relationship between sex and likelihood to engage in risk taking. Authors discuss suggestions for future research.

There is a great deal of research that examines the connection between birth order and a variety of personality characteristics. These findings, however, are often confusing and contradictory. Previous studies have suggested, for instance that first-born children tend to achieve higher professional status and tend to conform to societal norms (Zweigenhaft & Von Ammon, 2000). A number of studies have suggested that later-born children tend to be irresponsible, rebellious, liberal, and agreeable (Paulhus, Trapnell, & Chen, 1999; Seff & Gecas, 1993).

Differences in personality traits imply that there may be corresponding differences in behavior that may impact, among other things, education, achievement, and career choice. It has also been noted that one's likelihood to take risks may be related to a variety of factors including gender, culture and personality variables (Zinkhan & Karande, 1990; Levenson, 1990). Few studies, however, have examined whether there is a demonstrable relationship between birth order and one's willingness to engage in risk taking behavior. The purpose of this study is to investigate whether such a relationship exists.

Seff and Gecas (1993) point out that "much of the appeal to study birth order stems from the common observation that children occupying different positions in the sibling order experience different socialization environments" (p.221). Veronie and Fruehstorfer (2001), in there study examining the role of family dynamics in role identification for children of alcoholics, note that the primary means for socializing children is through involvement in family interactions. These differences in how children interact within the family can be expected to have an impact on personality development. Daniels and Plomin (1985) concluded that the different environments experienced by each ordinal position operate in such a way as to make siblings in the same family different from rather than similar to each other.

Though research findings are sometimes contradictory or inconclusive, there is some agreement among researchers regarding personality characteristics associated with each birth order position. In a study examining whether knowledge of birth order may have an effect on a counselor's clinical judgment, Stewart (2004) summarized findings in regard to birth order and personality attributes. He noted that first-borns are frequently depicted as leaders with dominant personalities who adhere to rules and enjoy structure in their daily routines. They are seen as responsible, conservative, and serious. They are often credited with being the family scholars

who strive for achievement. First-borns have been observed to have higher self-esteem than later-borns.

Stewart (2004) further noted that the middle-born child is frequently viewed as not fitting in or neglected and overlooked. The middle child consequently may not readily develop an identifiable role in the family of origin or may take longer to develop a role. Middle children may develop the attitude that they have been slighted. This may explain why middle children are often associated with being extroverted and seeking attention (Romeo, 1994). In his study that asked subjects to list adjectives that describe characteristics of each birth position, Nyman (1995) noted that the middle birth position was the only one that was not described as spoiled. It was the only position that was described as neglected and overlooked.

Stewart's (2004) also suggested that the youngest child is often viewed as being pampered or spoiled. They tend to be seen as agreeable, charming, carefree, rebellious and immature. They may experience feelings of dependency and entitlement and tend to be most submissive in their interpersonal relationships in comparison with other birth positions. He also noted that some studies have linked the youngest child to increased risk of alcohol and drug abuse.

The only child is frequently thought of as being spoiled or indulged, with a tendency to be insecure or dependent. Only-borns have reported feeling less autonomous than first-born children (Stewart, 2004). Stewart argues that negative stereotypes of the only child have persisted since the earliest literature on birth order in spite of more recent literature that contradicts them.

Morales (1994) points out that the commonly held belief that is implied in these findings is that personality characteristics related to birth order greatly influence a person's behavior. It is assumed that knowledge of these personality and behavior trends has real life applications. She contends that knowledge and understanding of birth order theory and has applications in a cooperative learning environment. She argues that there are social behaviors that are necessary to ensure student success while working in cooperative learning groups. Knowledge of birth order therefore may help teachers to group their students accordingly to provide growth and learning opportunities.

Romeo (1994) also discusses the implications of birth order as related to an educational setting. She too notes that the child's position in the family greatly determines that child's personality characteristics. She points out that if teachers took more notice of a child's birth order, many of his/her behaviors could be explained. Knowledge of birth order, she argues, could aid teachers in dealing with certain behaviors in the classroom.

Similarly, Bradley and Mimms (1992) contend that knowledge of birth order and family systems theory is valuable in terms of career planning. They suggest that there has been a shift in career counseling recently to include a more contextual view involving the influence of family, birth order, and sibling dynamics. They describe a college career-planning course that integrates these ideas.

Numerous studies have sought to identify a relationship between birth order and other behaviors. A review of the literature by Moore and Cox (1990), for instance, suggests that birth order may influence a wide array of variables including education level, personality traits, choice of mate, and career choices.

Eaton, Chipperfield, and Singbeil (1989) examined the connection between birth order and activity level in children. They noted that activity level is a key aspect of infant and childhood temperament or personality. They found a correlation, with first-borns having the

highest level of activity. They suggested that there might be several explanations for this phenomenon. Perinatal factors were discussed. They noted that previous studies had found that early-borns had higher levels of progesterone in umbilical-cord blood than did later-borns. This is one potential factor contributing to the variance. They also discussed within-family social processes and parental behavior as potential explanations. They noted that each of these factors differentiate the experiences of early and later-borns and may contribute to differences in activity level associated with birth order.

Bogaert (2003) suggested a biological explanation for birth order differences found in his study. He examined the interaction of fraternal birth order and height in male sexual orientation. He found a relationship between fraternal birth order, stature, and sexual orientation. He noted that fraternal birth order effect was linked to the relatively stable biological marker, height. He interpreted these findings to suggest that birth order effect may reflect a biological mechanism that affects not only sexual orientation but also aspects of physical growth and development.

In a comprehensive review of the literature, Hertwig, Davis, and Sulloway (2002) also attempt to explain the mechanisms involved in birth order differences related to self-esteem, personality characteristics and educational attainment. They explained these differences in terms of parental investment. They argue that parents' attempts to be fair and equitable actually produce inequality. For example, if resources are equally distributed among children each year, the cumulative resources are not the same for each child. They contend that first-borns and last-borns have an advantage over middle-borns because middle-borns, theoretically, never have the opportunity to be the only child in the household at any point in his life. They argue that this "resource handicap" may explain some birth order differences.

Several studies examined the relationship between birth order and factors that may be considered conceptually similar to risk taking. Jobe, Holgate, and Scrapansky (1983), for example, researched factors related to one's likelihood to volunteer for a hazardous experiment. They found that later-borns were over represented among those who volunteered for a hazardous combat situation. They posited that those who volunteered were greater risk-takers than non-volunteers.

Zweigenhaft and Von Ammon (2000) looked at the relationship between birth order and civil disobedience. They were seeking to test Sulloway's (1996) theory that later born individuals are more likely than first-borns to challenge the status quo. They found that among the college students in their study, Later-borns were more likely than first-borns to get arrested for engaging in civil disobedience in a labor dispute. They suggested that these findings supported earlier assumptions regarding birth order and rebelliousness.

Another factor that is conceptually similar to risk taking is participation in dangerous sports. There have been several studies that have examined the relationship between dangerous sports participation and birth order. Yiannakis (1976) examined the relationship between birth order and the preference for three types of dangerous sports. These were individual contact sports, team contact sports, and individual non-contact sports. The results suggest that first-borns were more likely to avoid participation in dangerous sports than the later-born individuals. The discriminating factor was the perceived risk of physical injury related to participation in the sport. If the severity of the injury was perceived as high, first-borns were less likely to participate in the sport. This was also the case if peer support was perceived as low. Casher (1977) also found that birth order was significantly related to participation in dangerous sports. She questioned, however, whether this suggested that first-borns avoid dangerous sports or that later-borns seek dangerous, exciting activities.

The findings of Seff and Gecas (1993) do not support those of Yiannakis (1976) and Casher (1977). They also investigated the effects of birth order on participation in dangerous sports. They examined specific risky activities such as parachute jumping, hang gliding, and scuba diving and measured self-efficacy along with birth order. Surprisingly their findings did not support their expectations of a birth order effect. They had noted that some of the more consistent finding in the birth order literature was with regard to participation in dangerous sports. They could offer no explanation for their study not supporting previous findings except that birth order continues to be a frustrating area of research. They did find, however, that self-efficacy was related to participation in dangerous activities, but not related to birth order. Perhaps their findings differed from other studies because they obtained their answers from an overwhelmingly middle-class, white, male, young, and college educated sample.

There has been very little research that investigates a direct relationship between birth order and the likelihood to engage in risk taking behavior. In one of the few studies that sought to investigate a link, Cecil (1972) examined seven variables that could influence risk-taking attitudes in undergraduate students. He did not identify birth order as significantly influencing risk- taking.

Other researchers have examined the relationship between birth order, risk taking, and other variables. Eisenmann (1987) for instance, looked at the relationship between creativity, risk taking, and birth order. He found that risk taking and creativity are related and that creativity is associated with birth order. This suggests the possibility of an indirect link between these two variables.

Weller, Eytan, and Sollel (1976) examined risk taking behavior and birth order and the differences between city youth and youth raised in a kibbutz. Their hypothesis was that birth order would have an effect on risk taking among city youth but not kibbutz youth. This was thought to be because family interaction differs between the two cultures. The mother relates to the children in different birth order positions differently. It was found that the city youth did display a birth order effect on risk taking but not the kibbutz youth. They argued family atmosphere is the underlying mechanism for the workings of the birth order differences.

It is apparent that birth order continues to be a frustrating area of research. Researchers have suggested various mechanisms that account for birth order effect. They include biological factors, social process, parental behavior, and family interaction. Most agree that numerous mechanisms account for the differences. Others have suggested that birth order effect occurs primarily in conjunction with other variables. Travis and Kohli (1995), for example stress the importance of socioeconomic factors in birth order research. Regardless of what mechanisms are involved, it is generally accepted that there is at least some birth order effect in a number of areas.

Because of the dearth of recent research that investigates a direct relationship between birth order and the likelihood to engage in risk taking behavior, it seems reasonable to investigate if there is such a connection. Past research regarding personality characteristics and birth order suggests that first borns tend to be more responsible and later borns tend to be more extroverted, rebellious and attention seeking (Stewart, 2004; Romeo, 1994). These personality characteristics imply that later borns would be more likely to engage in behavior that may be unconventional and provide greater arousal. Other research suggests a relationship between birth order and concepts that are conceptually similar to risk taking, for example, volunteering for hazardous experiments (Jobe, Holgate, & Scrapinsky, 1983), and participation in dangerous sports (Yiannakis, 1976; Casher, 1977). The findings of prior research provided the foundation for the

hypothesis that later born individuals are more likely to engage in risk taking behavior than first-borns or only children.

METHOD

Participants

The sample of the present study consisted of 31 females and 27 males ranging in age from 18 to 45 (M=20.4). The distribution of subjects for each birth order position was 30 first borns, 9 middle/later borns, 16 last borns, and 3 only children. Participants were mostly white (82.8%) and single (94.8%). Socio-economic status was assessed by inquiring about the education level of the primary breadwinner of the household. Forty-one percent had some college, 25.9 % had a bachelor's degree and 20.7% had a graduate level degree.

Participants were selected through convenience sampling. This was done by contacting English department professors of the university via e-mail and requesting the use of their classes for a graduate research study. Professors that were willing to assist in the study contacted the researchers with available class times. Four classes were utilized to collect the data. All participants were undergraduate students enrolled in 100 level English courses and data were collected as a group.

Instruments

The measure utilized in this study was Zuckerman's (1979) Sensation Seeking Scale. This measure assesses the degree to which one is interested in partaking in risky behaviors. This scale has four subscales that measure thrill and adventure seeking, experience seeking, disinhibition, and boredom susceptibility. The directions ask the participant to choose "A" or "B" and each are followed by a statement dealing with the subscale topic. An example of a question under the experience seeking subscale is, "A. I would not like to try any drug which might produce strange and dangerous effects on me. B. I would like to try some of the new drugs that would produce hallucinations." In some items "A" indicates the sensation seeking choice while in others "B" does.

The scores consisted of the sum of the ten items that comprised each subscale, then the overall score for the sum of the four subscales was calculated. The internal reliabilities for this measure for males and females respectively were as follows: thrill and adventure seeking (.77) and (.77), experience seeking (.61) and (.61), disinhibition (.74) and (.76), boredom susceptibility (.57) and (.56). The total score internal reliabilities ranged from .83 to .86. Test retest reliability for the scale at a three-week interval was .94. Most of the scale's subscales correlate with one another indicating internal validity. The correlations for experience seeking and disinhibition, and experience seeking and boredom susceptibility ranged from .21 to .47.

An additional demographics questionnaire was distributed prior to the administration of the Sensation Seeking Scale. This was done to obtain information on age, gender, ethnicity, and socio-economic status. One question included requested that the participant provide their birth order which was stated as, "check one of the following: first born, middle/later born, last born, or only child.

Procedure

Data were collected on four separate occasions. The data collection procedure was the same each time. A researcher entered the classroom and was introduced. The implied consent was then handed out to each student. Participants were asked to read it quietly as it was being read aloud. Participants were assured that all information provided would be anonymous and confidential. Participants were also informed that they were able to discontinue participation at any time during the study without consequence and a brief description of the study was given. The implied consent forms were then collected and the measurement was distributed. Completion of the measure required about 20 minutes. The measures were collected when all participants were finished and filed separately from the consent forms. A debriefing handout was distributed including the researchers' contact information along with a more in depth description of the nature of the study. They were asked to read quietly while the statement was read aloud. Participants were offered the telephone number of a counseling service if necessary, thanked for their participation, and asked if they had any questions. The researcher then exited the classroom.

RESULTS

An analysis of variance revealed that there was no significant differences based on birth order ($F= .453$, $p=$ NS) (see Table 1.). Further analysis of the data, however, revealed that there was a main effect due to sex (see Table 2.). The results indicate that males had a higher score than females on subscale one, Thrill and Adventure Seeking ($F= 7.043$, $p< .010$); subscale four, Boredom Susceptibility ($F= 4.944$, $p< .30$); and full scale ($F= 8.501$, $p< .005$). While the differences associated with sex are compelling, the researchers' hypothesis that later born and last born individuals would be more likely to engage in risk taking behavior was not supported by the analysis of the data.

DISCUSSION

The authors expected to find that later born individuals would be more likely than only children and first born individual to engage in risk taking behavior. The results of the present study did not support that hypothesis. The results were so insignificant, for that matter, that they call into question whether or not birth order differences can even be clinically useful. Previously mentioned studies have demonstrated birth order differences in areas that are conceptually similar to risk taking. Others, however, have failed to demonstrate differences. These confusing and contradictory findings, along with the results of the present study, have led the authors to agree with Seff and Gecas (1993) that birth order continues to be a frustrating area of research.

One possible reason that birth order effects continue to be elusive may be the abundance of variables that are difficult to control for. This is surely a limitation if the present study. The authors investigated birth order but were unable to control for such things as family size, parenting styles/ level of attachment, number of years between siblings, and whether there were divorced, separated or blended families. All of these variables along with birth order must have an impact on how one's personality is formed and how one develops socially. The area of family dynamics is so complex that it becomes vexing to attempt to isolate a single variable such as birth order.

Table 1: Results of ANOVA for Birth Order

		Sum of Squares	df	Mean Square	F	Sig.
sub1	Between Groups	9.195	3	3.065	.428	.734
	Within Groups	386.460	54	7.157		
	Total	395.655	57			
sub2	Between Groups	1.426	3	.475	.088	.966
	Within Groups	292.660	54	5.420		
	Total	294.086	57			
sub3	Between Groups	39.609	3	13.203	2.249	.093
	Within Groups	316.960	54	5.870		
	Total	356.569	57			
sub4	Between Groups	10.802	3	3.601	.628	.600
	Within Groups	309.422	54	5.730		
	Total	320.224	57			
fullscale	Between Groups	67.793	3	22.598	.453	.716
	Within Groups	2691.793	54	49.848		
	Total	2759.586	57			

Table 2: Results of ANOVA for Sex

		Sum of Squares	df	Mean Square	F	Sig.
sub1	Between Groups	44.150	1	44.150	7.034	.010
	Within Groups	351.505	56	6.277		
	Total	395.655	57			
sub2	Between Groups	8.464	1	8.464	1.659	.203
	Within Groups	285.622	56	5.100		
	Total	294.086	57			
sub3	Between Groups	20.806	1	20.806	3.470	.068
	Within Groups	335.763	56	5.996		
	Total	356.569	57			
sub4	Between Groups	25.978	1	25.978	4.944	.030
	Within Groups	294.246	56	5.254		
	Total	320.224	57			
fullscale	Between Groups	363.713	1	363.713	8.501	.005
	Within Groups	2395.873	56	42.783		
	Total	2759.586	57			

The findings did suggest, however, that there is a difference in likelihood to engage in risk taking behavior between males and females. It is not entirely surprising that the results suggest that males are more likely than females to seek thrills and adventure, are more susceptible to boredom, and score higher overall on sensation seeking. Presumably, auto insurance companies are aware of this tendency when they set their premiums.

In addition to insurance rates, these findings may have implications in terms of health care, education, mental health counseling, and primary prevention practices. In terms of education, one may seek to examine the implications of boredom susceptibility in the classroom. Researchers interested in primary prevention practices may want to investigate the implications of sex differences in regards to targeting specific behaviors related to risk taking.

These findings must be interpreted cautiously. It is difficult to make generalizations based on such a small, homogeneous sample. Only 58 participants were surveyed, which severely limited the pool of individuals in each birth order position. Of the 58, only 9 were middle/later born and only 3 were only children. All of the subjects were undergraduate students at the same university. In addition, 88% of the students were 21 years old or younger. Caucasians and non-married individuals were significantly overrepresented. Clearly this sample is not representative of the general population.

Perhaps the interaction of numerous variables that account for family dynamics is an area to research further. It is foreseeable that a comprehensive, well-designed study may be able to investigate how birth order, sex, family size, and attachment all combine to impacts one's behaviors. It may be compelling to research the mechanisms involved in how these family dynamic variables impact one's personality development. The complexity of this subject area provides creative researchers a multitude of directions to explore. Further research could provide insight that may have applications from marriage and family therapy to industrial organization.

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Body Image and Perfection: Differences Between Men and Women

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This study examined the relationship between perfectionism and body image and differences in men and women. Participants were selected from four different undergraduate classes at Monmouth University based on which professors were willing to allow their class to participate in the study. Participants included 75 college students, 42 women and 33 men. Participants completed two scales: The Almost Perfect Scale – Revised (APS-R; Slaney et al., 1999) and the Body Image States Scale (BISS; Cash et al., 2002) as well as a demographic questionnaire. The APS-R is a 23-item questionnaire that was created to assess three aspects of perfectionism (Vandiver & Worrell, 2002). The Body Image States Scale (BISS) consists of six items and assesses satisfaction or dissatisfaction with physical appearance, body size and shape, weight, and physical attractiveness. It was expected that those participants who scored high on the Almost Perfect Scale-Revised would be more likely to have a negative body image. Furthermore, given previous research on gender we hypothesized that women would be more dissatisfied with their body image than men. A 2 x 3 x 3 x 3 factorial ANOVA was computed to determine the relationship between body image and perfection and a correlation was computed to determine sex differences. The results concluded that there was no significant relationship between body image and perfection, however, results were significant for sex differences.

Several studies have examined the role of sex differences in body image. Females are known to be obsessed with thinness, while males are known to pursue muscularity. In addition, the media depicts an "ideal" body image, which often leads to obsessiveness and the desire to be perfect. Individuals who are obsessive are more likely to magnify their own imperfections. Social pressure from peers and family can add additional pressure to be "perfect" that can start as early as adolescence. This early pressure for perfection can lead to maladaptive behavior as these young men and women leave for college and may fall victim to even more pressure to achieve perfection. These pressures to achieve perfection may also affect their body image. Consequently, is there a relationship between perfectionism and body image and is this relationship different for men than it is for women?

Looking your best is an admired quality in our society as well as around the world. The media has been known to have a significant impact on what men and women perceive to be the “ideal” body. According to Heinberg, Thompson, & Stormer (1995), the ideal body image for both men and women is largely determined by social norms, which are often transmitted by the media. Cullari, Vosburgh, Shotwell, Inzodda, & Davenport (2002) indicate that media influence leads to most women wanting to lose weight and to men wanting to gain more weight or more muscle mass. The pressure the media places on individuals to be thin often leads individual’s to have a negative body image. It is estimated that this trait is more noticeable in women as magazines, news shows and other forms of media (i.e.: popular movies, music videos, etc.) directly advertise the “ideal” body.

Research has shown that when compared to males, females, particularly undergraduate students, have a higher tendency to have a negative body image (Muth & Cash, 1997). In a study by Cullari, Vosburgh, Shotwell, Inzodda, & Davenport (2002), women were significantly more dissatisfied with their body image when compared to men. Furthermore, when the females selected an image of their ideal body weight, it was significantly smaller than their actual body weight. The males indicated that their real and ideal body weight was virtually the same.

In a study about changes in body image, it was noted that with regards to cultural expectations, there may be an apparent shift in the ways in which college women perceive themselves. Perhaps this has to do with one's growing maturity, both emotionally as well as cognitively. It seems that as we age, we are less likely to view our image in a poorer light. It has also been indicated that the very same messages that were once perceived as impossible now appear attainable. The research states that these shifts in media influences now make men and women feel empowered, not pressured to live and eat healthily (Cash, Morrow, Hrabosky & Perry, 2004).

In a study on adolescents and their potential risks for health problems or body dissatisfaction, it was noted that, "Adolescents who perceive that (a) their eating and activity behaviors are unimportant to peers and parents and (b) their friends and parents are not healthy about eating or activity are less likely to have positive attitudes or intentions about healthy eating and activity" (Wood-Baker, et al., 2003). It also went on to state that boys perceive it as the norm among their friends to be physically active, whereas girls do not. Equally important is their finding that the parents themselves have the most influence concerning their children's behavior and attitudes about eating right and exercising. This is especially important to the raising of girls, which would further emphasize the importance of building a child's confidence early in life. Confident children are more likely to make better choices that will benefit or protect them in the future (Wood-Baker, et al., 2003).

In a study concerning eating pathology in children, it was noted that if the weight problem in children is pre-existing they are more likely to develop an eating disorder, as well as develop maladaptive attitudes about eating. This study also indicated that maladaptive behaviors on eating are more present for children whose parents are also experiencing problems of their own (Tarovsky-Kraff, et al., 2004).

Demarest and Allen's (2000) study revealed age differences in body shape distortion. Participants younger than age 25 had distorted views of what the opposite sex considered most attractive, whereas those over 30 years old were more accurate in selecting, which figure the opposite sex considered most attractive. Another study that focused on body image concerns, specifically to the dietary practices of young women found that women are more likely to follow a modeling of behavior/attitudes about eating. It also was reported that women could become more disturbed about their body image as they become more sexually appealing or unappealing to others. It is also stated that problems or concerns regarding body image can promote disordered eating, as well as if they perceive the need for thinness amongst significant others (i.e.: friends, family, partners) (Tylka & Mezydlo Subich, 2004).

Another investigation in the area of body dissatisfaction and eating disorders asks which variable(s) are the most significant in understanding symptomatology of these problems. The study determined that those women who are preoccupied with their appearance (overly concerned or obsessed) are more likely to engage in unhealthy strategies for weight loss (i.e.: eating disorders). This is further complicated whenever a close friend or family member shares this outlook or supports or condones the behavior. It is also noted that regardless of high or low

body dissatisfaction, if women had high levels of impulse regulation they had higher desires for thinness (Tylka, 2004).

In a recent study about the influence of socioeconomic status on weight related attitudes and behaviors, it was demonstrated that the higher the social status, the more likely one was to become concerned about their image on the physical level. This was significant for children in higher SES populations since they amassed the ability to define or recognize someone or something as being overweight, thus further promoting the concerns of the public perception of weight. "The results of the study indicate that social background may promote attitudes toward weight that have the potential to influence body image and concerns about weight, in both developmentally healthy and less healthy ways" (Wardle, et al., 2004).

In a similar study in which the socio-economic status (SES) of different college groups was studied for the prevalence of bulimia, it was discovered that the transition into college can be stressful for some due to being away from home, having more freedom and living in a more demanding environment. This stress is only compounded with the growing concern and desire to look one's best. It was noted that these stressors impact both men and women yet more so for the women, due to the simple fact that more attention is placed on thinness for women. This inevitably causes more body image dissatisfaction since being overweight or even obese is not tolerated by many in our society. This was the case for Caucasian women as well as Hispanic women, whereas African-American women did not feel as much pressure to embody the goal of ultimate thinness, as most of "their women" were not represented that way in the media. (Cashel, Cunnigham, Landeros, Cokley, & Muhammed, 2003). This was further researched in a study by Rozin, Bauer & Catanese (2003) that claimed, "The main male-female difference has to do not with the positive potential of food as a source of pleasure but the degree of negative feelings that conflict with the positive feelings. The male-female difference extends across behaviors, attitudes and modes of thinking" (Rozin, Bauer, & Cantanese, 2003).

Studies about body image have often focused predominantly on women; however, most recent studies have begun to examine body image dissatisfaction in men (Green & Pritchard, 2003). According to Muth & Cash (1997), men are now complaining that they are "too skinny" or "too fat". Although gender differences exist, women appear to have more concerns about their shape and weight than do males (Tiggerman, 1992). According to Demarest and Langer (1996), men typically have more positive body images than women do.

In a study by Fallon and Rozin (1985), men and women were asked to record their current figures, their ideal figures, and the figures they considered most attractive to the opposite sex, using a set of nine figure drawings ranging from very thin to very heavy. Results of the study showed that women rated themselves as being larger than their ideal image and larger than the figures they considered most attractive to men whereas the men were generally satisfied with their body sizes. The men, however, misjudged what the members of the opposite sex would consider most attractive (Demarest & Allen, 2000).

In a another study (Demarest and Allen, 2000), 120 male and female college students used figure drawings to determine body image differences among gender, ethnicity and age. Their findings indicated that women were much more dissatisfied with their current body shapes in comparison to men. However, the men had a distorted view of what body shapes women found most attractive. Men thought that women would find bulkier men most attractive and women thought that men would find thinner women most attractive (Demarest & Allen (2000).

In a study by Green and Pritchard (2003), adult men and women were surveyed on body image dissatisfaction. Results indicated that body dissatisfaction in women was due to media

influence and that body image dissatisfaction for both men and women was due to age, family pressure and self-esteem. Furthermore, although women scored lower than men on measures of body satisfaction, men were experiencing concerns about their body image. Peters and Phelps (2001) indicated that females often strive for unrealistic emaciated perfection, however, those women who are bodybuilders exhibit a "muscular ideal" rather than a "thin ideal". They completed a study on college age bodybuilders to assess body dissatisfaction and body distortion and sex differences. Results indicated that there was a gender difference: females rated themselves as less muscular than their objective raters and males exhibited no body image distortion. These results are similar to research on non-bodybuilding females who report being heavier than their actual size.

In another study that addresses men's concerns about their image, it was noted that men are described by specific "scripts that tie to presenting issues likely to show up when working clinically with men" (Mahalik, Good, & Englar-Carlson, 2003). These scripts are labeled as follows: the Strong and Silent types, which is expressed as a more reserved, quiet personality, one who is more likely to repress their feelings. There is the Tough Guy type, which is expressed as a more forward or courageous individual and keeps problems to themselves. There is the Give 'em Hell type, which is expressed by a physically aggressive personality and one in which fighting is necessary to gain respect. There is the Playboy type, which is expressed by the individual who engages in casual sex with multiple partners to prevent any committed relationships from forming. This type also feels more masculine as they are proud of their many conquests and often brags about them. The next type is the Homophobic type, which is characterized by an avoidance of relationships with other men. There is also the Winner type, which is characterized by a competitive, controlling personality, and lastly the Independent type, which may be a manifestation of a relationship with the mother whereby the man, as a boy, was forced to distance himself from her too early in his development. All of these types of are used in the identification of the presenting personality type in the initial stages of treatment.

Ricciardelli and McCabe, (2004) stated that while the pursuit of thinness for women can lead to disordered eating behaviors, the pursuit of muscularity in males can lead to the disordered behavior through the use of, "Steroids, extreme body-building behaviors and other attitudes and behaviors associated with muscle dismorphia" (Labre, 2002). Both men and women experience disordered eating and will try dieting or other weight loss behaviors such as not eating, eating only very little, obsessively exercising (a.k.a.: exercise dependence) or imploring the use of diet pills, they can also engage in binge eating. It was also stated that for boys who reach puberty first (ahead of other boys their age) that they may become more focused on weight loss as being first can make any young person/adolescent feel different and therefore alienated or depressed.

Both genders can experience low self-esteem or depression in addition to having a negative body image; however it is more prominent that with men, there is a higher likelihood they will self-medicate with drugs and/or alcohol, have multiple sexual partners or have a higher prevalence of suicidal ideation. More specifically, homosexual men have been more identified as having a higher incidence of body dissatisfaction and desire a lean body image. Failure to achieve this ideal can manifest feelings of shame of poor self worth, which could lead to an eating disorder. "This preference for a lean and muscular body develops somewhere between the ages of six and seven years, increases with age and reaches a peak between early adolescence and the commencement of adulthood" (Spitzer, Henderson, & Zivian, 1999). Men may also exhibit symptoms of reverse anorexia, which occurs when feelings of being weak of too small occur in spite of being quite well built. This can occur in men around the age of 19 or even

earlier in adolescence. These symptoms may stem from a history of depression or problems with the mother or from media influences (i.e.: movies, T.V., magazines all depicting a lean, muscular male image). It has also been noted that men who are more of a perfectionist tend to desire a more muscular image.

With the quest for the ideal body image an ever-present concern for many, a study on perfectionism indicated that when perfectionism is focused on in a negative way, (i.e.: maladaptive) people tend to be more self-critical. "These findings correspond to previous research that has linked negative aspects of perfectionism with critical attitudes and the feelings of distress associated with one's perfectionism" (Frost et al. 1995). This intense level of perfectionism can lead to low levels of self-esteem.

Morrison, Morrison & Hopkins (2003) discuss the ways in which men strive for bodily perfection. Media's description of the ideal male body image is positively associated with the drive for muscularity. Furthermore, this drive to become more muscular is intensified due to comparing oneself socially to others. It was also stated that men believe that there are a number of aspects that can contribute to the desire to become more muscular. The most important of these aspects were the social and physical benefits of being muscular.

A study by Gulker, Laskis, & Kuba (2001) that assessed the relationship between obsessive-compulsiveness, eating disordered behavior, and excessive exercisers concluded that there is a relationship between obsessive-compulsiveness and perfectionism. The researchers indicated that perfectionist tendencies find outlets in both men and women who worry about their appearance. Women have been known to strive for a slender body whereas men want to lose fat and increase muscle. The researchers concluded that strict dieting and concerns with physical appearance typically reflect characteristics such as body perfectionism and obsessive-compulsiveness. According to Blatt (1995), obsessive-compulsive traits are very often associated with heightened efforts to achieve perfection. Gulker, Laskis & Kuba (2001) add that this relationship is exacerbated in a culture that overvalues traits such as physical attractiveness and slenderness.

A study by Sherry, Hewitt, Besser, McGee, & Flett (2003) researched the relationship between self oriented and socially prescribed perfectionism. It was concluded that women who demonstrated high scores on the scale for both depression and perfectionism had a higher preponderance of eating disorders. In an additional study (Monarik & Ahrons, 1996) similar results were established as it suggested that for patients with eating disorder symptomatology there is a concurrent concern about making mistakes, as well as feeling pressured from parents through criticism. It also indicated that for patients suffering from symptoms of depression, there is also a potential for maintaining low standards.

In their study, Vohs, Bardone, Joiner, & Abramson (1999) found that perfectionism combined with weight dissatisfaction and low self-esteem increases the risk of the development of symptoms of bulimia. In a study by Moulton, Moulton, & Roach (1998), 535 college students who completed the Eating Disorder Inventory (EDI) and the Revised Martin-Larsen Approval Motivation Scale (MLAM), results indicated that as the eating disorder symptomatology increased, so did the need for approval.

Hewitt et al. (2003) indicated that people who maintain perfectionism are committed to displaying a self-image that is ideally unblemished in public. Furthermore, it was stated that this same perfectionistic attitude and image is derived with the public viewpoint in mind. It was also revealed that for those who maintained this perfectionistic attitude, there was a reluctance to share any mistakes that one had made personally for fear of being criticized. "Overall, the

analyses confirmed that perfectionistic self-presentation involves facets of self-monitoring and defensiveness in regard to self-related information and that it is associated with lower self-esteem." (Hewitt, et al. 2003)

In an article that describes the relationship between perfectionism and anorexia, (Bastiani, Rao, Weltzin & Kaye, 1995) it was postulated that anorexics crave perfection, which does not weaken long after a healthy weight has been reestablished. This perfectionistic behavior is characteristic in anorexics since it has been suggested that after recovery, there is still the disturbance of, "increased neuronal serotonin activity. Reduced serotonin activity has been associated with aggressive and impulsive behavior, which is opposite in anorexics" (p. 151). Perfectionistic behavior is not something that is easily treatable. It is still uncertain if this aspect of anorexic behavior is due to a "biological vulnerability", which is also related to similar components such as obsessiveness. These aspects of anorexia could be used to determine why the relapse rate of these patients is so high.

In another study about perfectionism, perceived weight status and bulimic symptoms were analyzed (Joiner, Heatherton, Rudd, & Schmidt, 1997). The researchers concluded that for women with bulimic symptoms, perfectionism could be a risk factor if the perception of being overweight was a concern. In a similar study by Joiner, Heatherton, Rudd, & Schmidt (1997) it was theorized that, "binge eating may serve as an escape from painful self-awareness. Binge eaters are acutely sensitive to standards, and when they fall short of these standards, binge waters view themselves negatively and assume that others do as well. These painful self-perceptions, accompanied by attendant emotional distress, cause and escape response, characterized by disinhibition and, thus, binge eating." Joiner concludes that these very same aspects of perfectionism may be the cause of the onset of an eating disorder in women who hold the perception of never having had their needs met.

A study by Hewitt, Flett, & Ediger (1995) studied a sample of 81 female college students to assess the association between perfectionism and measures of eating disorder symptoms. The participants were asked to complete the Multidimensional Perfectionism Scale, the Perfectionistic Self-Presentation Scale, the Eating Attitudes Test, the Bulimia Test, the Body Image Avoidance Questionnaire, and two measures of self-esteem. The results of the study indicated that self-oriented perfectionism was related to anorexic symptoms and that social facets of perfectionism were related to eating disorder symptoms, body image avoidance, and self-esteem. It was therefore concluded that there is a relationship between perfectionism and eating disorder attitudes.

A study by Davis (1997) assessed body esteem, perfectionism, and neuroticism. Participants included 123 female patients who were admitted to an eating disorder program and who were diagnosed with either anorexia nervosa, bulimia nervosa, or an eating disorder not otherwise specified. They completed five different scales: the Body Esteem Scale (BES); the Multidimensional Perfectionism Scale (MPS); the Neurotic Perfectionism Scale (NPQ); and the Eysenck Personality Questionnaire-Revised. Results of the study indicated that when neurotic perfectionism is low, normal perfectionism is positively related to body esteem.

According to Davis, Claridge, & Fox (2000), perfectionism and weight preoccupation are positively associated. In their study, 203 female university students were given four questionnaires: the Drive for Thinness, Body Dissatisfaction, and Bulimia subscales of the Eating Disorder Inventory (EDI); the Self-Oriented Perfectionism subscale of the Multidimensional Perfectionism Scale; the Neurotic Perfectionism Scale; and the Eysenck Personality Questionnaire- Revised. The participants' body mass index was also calculated by

measuring their height and weight. As predicted, the researchers concluded that the attractive women in the study reported a significantly higher degree of weight preoccupation when compared to those who were rated less attractive. Furthermore, results concluded that neuroticism and perfectionism strongly influenced weight preoccupation.

Research on the performance of high achieving females (Inzlicht & Ben-Zeev, 2003) have found that when females are under intense scrutiny in a publicly competitive environment, they are more likely to experience self-conscious behavior and make mistakes. It also states that this can happen when one is performing privately, which indicates that if women perceive themselves as outnumbered in a highly competitive situation, they are more likely to fail.

Several studies have indicated that even children are becoming more affected by this desire to be "perfect" from as early as age seven. The quest for perfection inevitably leads towards dissatisfaction, causing many individuals to become concerned about weight gain and/or exercise rituals. Society's unrealistic ideals in defining the "ideal body" are believed to be a major predictor of the development of eating disorders. The pressure for individual's to engage in extreme measures in order to achieve that "ideal body" often results in eating disorder symptomatology (Freedman, 1984 as cited in Moulton, Moulton, & Roach, 1998).

One study that focused on the magnitude of weight loss strategies in children noted a significant number of boys and girls who desire thinness and are already exhibiting dieting behaviors or are on diets. The study further concluded that the lower the self-esteem of these children, the more unhappy they were with the present condition of their appearance. This was notable for both the factors of weight and muscularity. The opposite results were found for children who did not perceive their weight as a problem and were overall satisfied with their appearance (McCabe & Ricciardelli, 2003). The results also discussed the fact that due to limitations in emotional development and maturity, children were less likely to be able to control their behavior when it came to making healthy choices about diet and exercise, thus further giving strength to the growing concern for positive role models in the lives of young children.

Children are eager to learn, be accepted and have successful experiences. One of the first places this happens for them is in the home environment. Beyond that, the biggest and most influential environment for a child is in school. Along with learning the skills to succeed in life, they also learn about socialization: enter the peer relationship. In a recent longitudinal study on body image among boys and girls, conversations about one's appearance ranks high among social settings in children. These conversations can sometimes lead to teasing, which can threaten the acceptance of peers and lead to further problems in adolescent development. "For example, high school girls who thought that their peer relationships would improve through weight loss also felt negatively about their bodies" (Paxon, et al., as cited in Jones, 2004).

The more that girls engage in conversations about their appearance with other members of their social group the more likely they are to compare themselves to others. This comparison to others can lead to a more detrimental self-perception, which can potentially lead to body dissatisfaction, becoming a "misery loves company" situation. As for the boys' results, these concerns are more internalized and their "perfect" body image is based on strength and muscularity. It could also be that since most boys enter puberty at a later stage than girls, the importance placed on appearance does not take place for them until high school and in some cases, college. (Jones, 2004).

Another study on perfection studied a sample of 42 female high school students. Participants were asked to complete the Multidimensional Perfectionism Scale and the Eating Disorder Inventory. Results indicated that body dissatisfaction was associated with

perfectionism. Further results suggested that stress may stimulate behaviors related to eating disorders in individuals with a perfectionistic personality (Ruggiero, Levi, Ciuna, & Sassaroli (2002).

In summary, the purpose of this study was to demonstrate a relationship among perfection and body image, based on previous research relating or examining factors relating to body dissatisfaction in young males and females. Participants were asked to complete two questionnaires and we expected that those participants who score high on the Almost Perfect Scale-Revised will be more likely to have a negative body image. We expected that males and females with high levels of perfectionism would have a higher incidence of developing a negative body image. Given previous research on gender we hypothesized that women will have a higher occurrence of negative body image than others.

METHOD

Participants

Participants were selected from four different undergraduate classes at Monmouth University based on which professors were willing to allow their class to participate in the study. Participants included 75 college students, 42 women and 33 men. All participants were approached and voluntarily agreed to participate in the study. Their ages ranged from 18 to 52 years old and the sample included students of Caucasian, African-American, Hispanic, and Asian ethnicities.

Instruments

Participants completed two scales: The Almost Perfect Scale – Revised (APS-R; Slaney et al., 1999) and the Body Image States Scale (BISS; Cash et al., 2002) as well as a demographic questionnaire. The APS-R is a 23-item questionnaire that was created to assess three aspects of perfectionism (Vandiver & Worrell, 2002). Items featured on the scale include statements like, "I rarely live up to my high standards" and "I expect the best from myself." (Grzegorek, Slaney, Franze and Rice, 2004). The first subscale, the High Standards subscale, consists of seven items that assess expectations for personal performance. The second subscale, the Order subscale, assesses concern with organization and neatness and consists of four items. The Discrepancy subscale or the third subscale on the questionnaire assesses perceived failure to live up to his or her standards. This subscale contains 12 items.

Recent studies have indicated that scores on the High Standards subscale, as well as the Order subscale suggest levels of perfectionism (Rice et al., 1998; Rice & Slaney, 2002; Slaney et al., 2001; Suddarth & Slaney, 2001). It has also been suggested that the Discrepancy subscale highlights the negative components of perfectionism and submits to "the perception that one consistently fails to meet the high standards that one has set for oneself" (Slaney, Rice & Ashby, 2002).

All questions are answered on a seven-point Likert scale ranging from Strongly Disagree (1) to Strongly Agree (7). The scale was developed using a sample of 347 college students and was cross validated using an independent sample. Internal consistency estimates for the subscales were in the high range (.85 to .92) across two independent samples (Vandiver &

Worrell, 2002). Previous studies by Slaney and his associates maintain the reliability and validity of the APS-R. "Concurrent validity of the APS-R has been demonstrated through significant positive correlations with other measures of perfectionism, and through expected correlations with theoretically related constructs" (Grzegorek, Slaney, Franze, & Rice, 2004, p. 194, Rice et al., 1998; Slaney et al., 2001; Suddarth and Slaney, 2001).

The Body Image States Scale (BISS) consists of six items. The first item refers to dissatisfaction-satisfaction with physical appearance; the second refers to dissatisfaction-satisfaction with body size and shape; the third item asks about dissatisfaction-satisfaction with weight; the fourth item refers to feelings of physical attractiveness or unattractiveness; the fifth item refers to feelings about one's looks relative to how they usually feel; and the sixth item asks about how one feels about their personal appearance relative to how the average person looks (Cash et al., 2002). Responses to each item were based on a 9-point Likert-type scale. For half of the items, the scale was presented in a negative-to-positive direction and vice versa for the other half of the items. The instructions stated: "For each of the items below, check the box beside the one statement that best describes how you feel "Right now, at this very moment. Read the items carefully to be sure the statement you choose accurately and honestly describes how you feel right now" (Cash, et al., 2002).

Cronbach's alphas were used to compute the internal consistency of the BISS, thus concluded that the BISS was internally consistent across a range of contexts. Test-retest reliability was calculated for the BISS over a 2 to 3 week period. The coefficient was .69 for women and .68 for men (Cash et al., 2002). A comparison of means was computed for men and women indicating that women reported less favorable body image states than men, $F=10.2$, $p<.002$. When a 2x2 analysis of variance was completed, results yielded a significant main effects for sex, $F=12.64$, $p<.001$. The demographic questionnaire assessed the participants age, sex, marital status, and level of education

Procedure

Permission was obtained by the university's Institutional Review Board (IRB) to complete the study using undergraduate students at Monmouth University. Data was collected after receiving approval from the IRB. Researchers approached professors in various undergraduate majors to ask permission to come into their classrooms to obtain data from their students. After receiving approval, arrangements were made to come into their classes on a specified date. Researchers asked the professor to step out of the class so that the students did not feel any pressure to participate in the study. Students were read aloud the Informed Consent before the questionnaires were distributed. They were informed that the study was about self-perception and that they would receive detailed information about the exact nature of the study upon completion of the questionnaires. In addition, participants were told that they should not put their names on either survey or demographic questionnaire. Students were then informed that if they felt uncomfortable during the study, they could stop at any time without penalty or adverse consequences to them of any sort. Participants were told that their participation is appreciated but that it was not required.

Participants were given two different instruments: one that assessed their body image and the other, which assessed their level of perfectionism. They were asked to complete both measurements in the time allotted, which was ten minutes for both surveys. Participants completed the surveys in their classrooms and results were collected immediately following the

ten-minute time allotted. Data was collected from the class as a group and not from each subject individually.

Researchers then read a debriefing statement to the participants and advised them that no individual results would be available, however, group results would be posted on a website approximately four months after the completion of the study. Each participant received a copy of the debriefing script before it was read aloud to them in class.

RESULTS

A 2 x 3 x 3 x 3 factorial ANOVA was used to interpret the results. The participants' scores on the Body Image States Scale (BISS) were the dependent variable and sex and scores on the Almost Perfect Scale – Revised (APS-R) were the two independent variables. Scores were derived from the three subcategories of the APS-R: standards, order and discrepancy. The standards, order and discrepancy subcategories are scored on a Likert scale of 1-7 (1 being the lowest – strongly disagree and 7 being the highest – strongly agree). These scores were changed from a continuous variable to a categorical variable so that a factorial ANOVA could be computed. Each individual's score for the standards, order and discrepancy subscales was changed to either a 1, 2, or a 3. If the participant's score was between 1 and 3, they received a 1, if their score was higher than a 3 but lower than a 5, they received a 2, and if their score was higher than 5, they received a 3.

Analysis of homogeneity of the clusters revealed that Clusters 1& 2 were composed of perfectionists and Cluster 3 was composed of non-perfectionists. We examined the Discrepancy sub-scores to discriminate between adaptive and maladaptive perfectionists and it appeared that the group with high discrepancy scores (Cluster 2) was, by definition, maladaptive perfectionists, whereas the group with low discrepancy scores (Cluster 1) was adaptive perfectionists.

Results of the factorial ANOVA revealed a significant difference between the sexes ($F=7.082$, $p<.01$). In addition, results of correlating sex and BISS scores revealed a significant relationship between body image and sex ($r =.335$, $p<.01$, one-tailed). There was also a significant correlation between order and standards ($r =.306$, $p<.01$, one-tailed), thus indicating that the more organized a person is, the higher their standards. Furthermore, there was an inverse relationship between sex and order ($r = -.212$, $p< 05$, one-tailed).

DISCUSSION

Our results were consistent with previous research which indicates that women are more prevalent than men to have a negative body image. As determined in our results, women were more likely to have a negative body image. The present results found, as expected, that there is a relationship between sex and body image and that women are more predisposed to being more maladaptive in their thinking than men. These findings correspond to previous research that has linked negative aspects of body image and the desire to be perfect and the feelings of distress that accompany them. Previous studies have also found that age is also a factor with regards to this relationship and that as men and women mature, there is an appreciation or an acceptance of body image, whereas younger generations feel identified socially with regard to their looks.

The present results, combined with the previous findings of Slaney, Mobley, Trippi, Ashby, & Johnson (1996), provide support for the three sub groups (adaptive, maladaptive, and nonperfectionist) following previous research (Parker, 1997; Rice & Mirzadeh, 2000; Rice & Slaney, 2002), who have also employed the use of cluster analysis to classify perfectionism. This research indicates that there may be rising criteria with which toclassify these three subscales on the basis of their configured scale scores on the APS-R. In recent studies maladaptive perfectionist scores were powerfully associated with self-critical depression, but not dependent depression. Adaptive perfectionist scores were associated with higher self-esteem. Additionally, the APS-R includes the discrepancy subscale, which was specifically designed to measure the negative aspects of perfectionism.

The discrepancy construct was defined as the perception that one consistently fails to meet one's standards. The APS-R also includes revised versions of the High Standards and Order subscales, which were designed to tap the positive aspects of perfectionism. Rice and Slaney (2002) have found that maladaptive perfectionists were not the same as the adaptive perfectionists based upon the results of their higher discrepancy subscale scores. Overall studies have suggested that the High Standards and Order subscales are associated with positive aspects of perfectionism. The discrepancy subscale captures the negative aspects of perfectionism.

There was a significant relationship found between men and women, as there is more focus today on the necessity and the desire for women to look good due to exposure to media influences. Additionally, for those who may have been identified as maladaptive perfectionists, it is rare that they would present with this as a problem as most people who are “perfect” are often proud of it and can boast of their accomplishments. One way to identify this might be to focus more on a presenting anxiety or depression. There is also the possibility that people could be influenced by the word “perfection” and associate it with negative connotations. It may have been that there was a stereotype among those tested that perfection meant that they were up-tight or Type A or any other derivation of a negative connotation of that word and thus, results may have been skewed to answer the questions in a way that would make them appear different from who they are.

The homogeneity of the participants (i.e., predominantly White, female, college age) is a limitation of this research. More diverse samples in the future are recommended especially if clinical samples are available. Furthermore, all responses were self-reported and may have been answered too quickly, not taken seriously for the purposes of this study and perhaps answered in a way that would appear to make them other than what they are.

Some other limitations of the study included selecting participants from only four undergraduate classes which may not have been a representative sample. Furthermore, the participants are students at a private university in a suburban area and thus results may not be generalizable to other university students in other areas. Other limitations include using a small sample of subjects and not controlling for extraneous variables.

Suggestions for future research would include using a larger and more representative sample as well as more extensive surveys such as the Multidimensional Perfectionism Scale, the Eating Disorder Inventory, and the Body Esteem Scale. Furthermore, it would be interesting to research other populations to make comparisons between samples, such as comparisons between levels of perfectionism and body image among high school and college students. Other suggestions are to expand the demographics to include height, weight and sexual orientation as was done in previous research.

Overall, this study provides empirical support for the potential of usefulness of using an ANOVA for categorizing perfection as it relates to body image. Further research may yield a stronger correlation, as other measures may be able to specifically identify the relationship between these two variables more closely.

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Spirituality and Stress Tolerance Among Graduate Students in Counseling

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Most of the research on the coping mechanism of spirituality demonstrates that there is a correlation between spirituality and mental and physical health. Today, a number of people are returning to school either to finish undergraduate degrees, or to study in graduate or post-graduate programs. These students may be an at risk group for stress, not only enduring the stress associated with college, but also those stressors associated with other life events. The purpose of this study was to explore the relationship between spirituality and stress tolerance in college graduate counseling students. Participants completed the Spiritual Involvement and Beliefs Scale (SIBS), the Daily Stress Inventory (DSI), and a demographics questionnaire. There was no correlation found between spirituality and stress tolerance. The results suggest that spirituality does not appear to be a common coping device for stress amongst college graduate counseling students.

Until fairly recently, psychology has had an ambivalent attitude towards religion and spirituality (Weaver et al., 1997). However, a majority of Americans view religion and spirituality as an important part of their lives. Approximately 95% of Americans profess belief in a God or higher power while 82% express an interest in spiritual growth (Gallup et al. as cited in Miller & Thoresen, 2003; Weaver et al., 2003). A recent study of mental health care facilities in Los Angeles, California supports these findings while further demonstrating that religious/spiritual beliefs may be utilized by people as a means of coping with daily problems (Tepper et al., as cited in Larson & Larson, 2003). This raised the question: Are personal beliefs such as religion and, or spirituality important factors in the coping, healing, and growth process?

Most of the research on spirituality, as a coping mechanism, pertains to disease and illness along with the stress associated with these maladies. Studies have found that patients suffering with physical illnesses often rely on spirituality as a way of coping (Strang & Strang, 2001; Baldacchino & Draper, 2001); including those patients suffering with psychological problems (Doolittle & Farrell, 2004). Research further demonstrates that patients who are spiritual appear to be healthier, while other studies note that spiritual issues are an essential part of today's health care program (Connelly & Light, 2003; Koenig, 2002).

Recently, studies have been conducted on the relationship between spirituality and such variables as life satisfaction, overall health (Dennis, Muller, & Miller, 2004; George et al. 2000) and psychological well being (Hammermeister & Peterson, 2001). College is a time when one seeks and explores direction in life as well as establishes life patterns for the future (Dennis et al., 2001). It is a time when people often experience a significant amount of stress and challenges as they "question, refine, and consolidate" both their spiritual and religious practices, beliefs and coping skills (Schafer, 1997). In today's society many people are returning to school. In addition to facing the stressors associated with college, they are also

subjected to those stresses associated with other life events, such as raising a family and, or, working.

According to Antonovsky's theory (as cited by Schafer, 1997), three elements that account for preventing stress problems include: comprehensibility: how one makes sense of external stimuli; manageability: how one sees internal and external resources to meet life's demands; and meaningfulness: the amount of commitment and engagement one affords life's demands. Research suggests that an individual's religious beliefs or practices, and, or spirituality, is a coping mechanism to enhance stress-resistance. Since spirituality may help some individuals cope with stress the purpose of this study is to note whether there is a relationship between spirituality and stress perception among graduate counseling students.

Stress is perceived as the body's effort to adapt to non-specific neurological and endocrine response to demands by the environment (Lewis, 2002). It is believed to play a significant role in disease (Nathan et al., 1987) as cited by Lewis, (2002). In the body's effort to adapt to stressors in the environment, it apportions a significant percentage of its energy to coping with the stressors, causing the release of hormones, which may subsequently affect the immune system causing susceptibility to diseases.

Stress as posited by Keith et al. (2nd ed., 2001), is ones effort to regain balance that has been upset. Stress is a response of the mind and body to demands made on them by an arousal (Schafer, 1997). A stressful event is perceived as the result of an interaction between several situations, (e.g. health, lifestyle, psychological stability), and one's coping skills, social support system, cognitive, and personality factors. Certain areas of an individual's life may also be more stressful than others based on the different amounts of exposure, or demands, that specific situations place on them (Brantley et al., 1997). Stress can be persistent; therefore, the way it is handled is vital. People view and react to stress differently, however, it is believed that everyone relates to stress in a general manner. On one hand, stresses are considered common, inescapable, and perceived as "daily hassles"; these are considered minor, annoying or frustrating events. On the other hand there are significant life-altering stressors, which are considered major events, such as the death of a loved one, or the diagnosis of a chronic illness. Stressors may also be clustered as interpersonal or environmental (Brantley et al., 1997). For those stressors that are inescapable and inevitable, how does one cope? Some theories believe that people may need to have different skills in coping with stressful situations than they need to have to prevent stressful situations from developing. For example a friend, support, or religious group, may be able to help one cope with daily stressors/"hassles", but may not be sufficient to help deal with crisis situations (Graham et al., 2001).

Some amount of stress is considered natural and leads to positive changes and growth. This stress is believed to be useful in maintaining motivation, inspiration, and productivity. In spite of this, though, most people would rather avoid all forms of stress. Stress can be found in several aspects of ones life. These include on the job, in ones family (i.e. a failing marriage, a problem child), financial pressure etc. Research posits that stress on the job affects general health, personal relationships, and ability to perform work related duties. Stress is known to cause absenteeism, illness, and has been related to on the job illegal use of drugs and alcohol. According to Paul J. Roson, head of the American Institute of Stress as cited by Keith et al. (2nd ed., 2001, p. 97), "work stress may be America's number one health problem". Similarly, the Public Health Service's 1979 report as cited by Astin (1997) indicates that excessive stress is a serious public health concern for Americans. People feel less stress if they feel safe, happy, and secure in their environment.

The use of spirituality and, or religion may help some individuals cope better with stress. However, while many people may use religion and spirituality as coping mechanisms for stress, research has found it difficult to operationally define and measure these concepts (Weaver et al., 2004; Fitchett, 2000, p. 43). One problem is that many people view religion and spirituality interchangeably (Rowe & Allyn, 2004; Fitchett, 2002, p.16) and therefore studies are designed to measure religion and spirituality as a single construct (Miller et al., 2003; George, et al., 2000). Those studies that do separate religion from spirituality, for the most part, are designed to measure religion rather then spirituality (Weaver, et al., 2004; Miller, et al., 2003; Ballacchino & Draper, 2001; George, et al., 2000; Koenig, 2000). A second problem is that religion and spirituality are abstract concepts that have a myriad of measurable practices, such as inner reflection, finding meaning in life, and believing in a higher power, concepts employed by both religious and spiritual people (Ballacchino et al., 2001).

One cannot define religion without discussing spirituality because spirituality is a central part of the religious belief system. However, religion is more then spiritual beliefs and practices. Religion involves differing tenants of faith, membership qualifications, and institutional goals (Miller et al., 2003). While religious people may define themselves as spiritual, spiritual people may not define themselves as religious. So what is spirituality? Spirituality has been defined as belief in a higher power (Fabricatore et al., 2000); the desire to find meaning in life (Fitchett, 2001, p. 16); the search for wholeness (Cohen et al., p. 31, as cited in Connelly & Light, 2003). Spirituality is one of the components in an individual's system of beliefs (Holland et al., 1998); and is broader and more inclusive then religion (Hatch et al., 1998). Some studies have defined and measured spirituality as the extent to which a person is able to integrate spirituality into one's life, and to use that spirituality as a coping mechanism for handling life's difficulties (Kim & Seidlitz, 2001; Fabricatore et al., 2000; Hatch et al., 1998).

Recent studies conducted on college students have demonstrated the relationship of spiritual practices to wellness. In one study (Hammermeister et al., 2001), it was demonstrated that an inverse relationship existed between spirituality and adverse health practices such as drug and alcohol consumption. This study also noted that those students who scored higher on spiritual measures were more hopeful, less lonely, and had better self esteem. Other studies conducted on college students have demonstrated that spirituality was a resource for students in maintaining well-being in times of stress (Fabricatore et al., 2000); especially when spirituality is combined with optimism and a sense of coherence (Adams, Bezner, Drabbs, Zambarano, & Steinhardt, 2000). A study conducted by Graham, Furr, Flowers, & Burke (2001) on college graduate counseling students found that those students who were spiritual and religious were more aware of preventive stress resources, and had greater immunity to stress, but fared no better in combating stress then those students who considered themselves spiritual but not religious.

Most of the studies on spirituality and coping with stress have been on undergraduate students. Today, though, a number of people are returning to school either to finish undergraduate degrees, or to study in graduate or post-graduate programs. These students may be an at risk group for stress, not only enduring the stress associated with college but also those stressors associated with other life events.

Hypothesis

Since prior research posits an existing relationship between spirituality/religiosity and the ability to cope with stress, this study's hypothesis is that graduate counseling students who are more spiritual have more stress tolerance. Psychological Counseling graduate students were chosen as the subjects of this study because many of them, in addition to attending college, have other commitments such as employment and family concerns which may place them at risk for stress.

METHOD

Participants

Participants for this study consisted of graduate students enrolled in the psychological counseling program at Monmouth University. Thirty-eight graduate students from three (3) graduate classes participated in the survey. Students of both sexes (84% female and 16% male), with a mean age of 44.5 years, and of Hispanic (10.5%), African American (2.5%), Caucasian (79%), Asian (2.5%) or other (5%) ethnicities participated in the study. Data was collected from 3 psychological counseling classes based on availability and willingness to participate and answer both of the study's questionnaires. Participation was voluntary. Only participants who fully completed the study were included in the final data analysis.

Instruments

The Spiritual Involvement and Beliefs Scale (SIBS) was used to assess the participant's overall level of spirituality (Hatch et al., 1998). The SIBS has been cited as an instrument that measures spirituality as a construct different from that of religion (Rowe & Allyn, 2004; Doolittle & Farrell, 2004). This instrument consists of 26 questions, which are divided into a four-factor structure, but only one combined total score is obtained. These factors are: Internal/Ritual, External/Ritual, Existential/Meditative, and Humility/Personal Application. Some of the questions are included in more than one category.

The SIBS is scored on a 5 point Likert-type scale (strongly agree, agree, neutral, disagree, and strongly disagree) and includes such statements as "I can find meaning in times of hardship." The SIBS is scored by summing the item responses and obtaining one total score. For questions that are positively worded a higher score would indicate a higher spiritual response and a lower score a lower spiritual response. For negatively worded questions a higher score would indicate less spirituality and a lower score would indicate higher
spirituality. One total score is obtained from the SIBS scale with a higher score indicating a higher degree of spirituality and a lower score indicating a lower degree of spirituality.

The SIBS has high internal consistency (Cronbach's alpha = .92) while test- retest reliability measures (r=.92). Co-efficient alpha scores for each of the four factors is .98 for factor 1; .74 for factor 2; .70 for factor 3; and .51 for factor 4. Convergent validity for

this scale was established by comparing SIBS with (Spiritual Well Being Scale) SWBS, which yielded a correlation of .80 (Hatch, et al., 1998).

The Daily Stress Inventory, (DSI) was employed in this study to measure participant's perceived stress (Brantley et al., 1997). This scale consists of a 60-item questionnaire, 58 questions ask participants to rate the frequency and magnitude of daily stressful events, which they have experienced within a 24-hour period, on a 7-point Likert-type scale. Two questions ask them to list any stressors that were missed. The DSI produces three scores. The event score is the number of items the participant has experienced during the 24 hour period. The higher the score the more stress events you have experienced, the lower the score the less amount of stress events you have experienced. The second score is an impact score. It is the sum of the perceived stress as rated by the values assigned to each question, so that the higher the number the greater amount of perceived stress, the lower the number the less amount of perceived stress. The third scale is the impact/event score which is the ratio of the impact score divided by the event score. The higher the ratio of impact to event scores the greater the amount of state stress, while the lower the ratio the less amount of state stress.

Preliminary reliability and validity were established for the DSI by evaluating the initial administration of the test to 433 community adults. Data collected was also used to group test items into five content areas: Interpersonal Problems (IP), Personal Competency (PC), Cognitive Stressors (CS), Environmental Hassles (EH), and Varied Stressors. These areas denote specific types of stressors participants may be experiencing. Internal consistency of the DSI as measured by Chronbach's alpha coefficient was (.83) for event scores and (.87) for impact scores. Construct validity for the DSI has also been demonstrated (Brantley et al., as cited in Zalaquett et al., 1997). For example, a correlation was found between DSI scores and the Daily Hassles Scale when measuring anxiety and global stress over a 28 day period. In another study a positive relationship was found to exist between stress severity and changes in cortisol and vanillylmandelic acid (VMA) urine levels. While it is recommended that the DSI be administered over a number of days or weeks, scores from a single day can be examined and measured as state rather than trait measures. This study obtained scores based on one, 24 hour, period.

A demographic questionnaire was also included in this study and sought information pertaining to age, gender, marital and employment status, number of children residing in the household, ethnic background, enrollment status in graduate program, level of education of primary breadwinner, and whether, or not, the participants considered themselves religious, and or spiritual.

Procedure

After the approval of the IRB, data was collected from three psychological counseling classes based on availability and willingness to participate. Professors of graduate counseling classes were approached and solicited for the use of their class time. The professors were informed as to the purpose of the study, and the length of time needed to complete the surveys. They were also shown the IRB approval. Upon receiving the professors' approvals, the informed consent statement was read to the classes of participants prior to the collection of data. The professors were not in the room when the participants took the survey. Participants were advised to ask questions after the survey so as not to bias their responses in any way. They were ensured of their anonymity, confidentiality, and security of the test and its results.

Participants were given the option to not participate in the survey, or to stop participating at any time without consequence of penalty or other adverse effects. Participants were informed that the test would take approximately 20 minutes of their time. Following data collection, students, as a group, were immediately read a debriefing statement and asked if they had any questions.

RESULTS

In order to test the relationship between spirituality and stress tolerance a Pearson correlation coefficient was obtained on the variables (Table 1). Statistical analysis revealed that there was no significance between spirituality and stress occurrence, stress intensity, or between spirituality and the ratio of stress intensity to stressful events. There also was no significance between the demographic variables, spirituality, and stress except for an inverse relationship between believing oneself spiritual and spirituality ($r = 0.37$, $p<.05$). Multiple Analysis of Variance, (MANOVA, Table 2), was then performed on the three stress variables and spirituality but it too did not reveal any significance. In addition, three multiple regression analyses, alpha level .1, were preformed with stress occurrence, stress intensity, and stress ratio as the dependent variables (Tables 3, 4 & 5). Results were non-significant regarding spirituality and the three stress variables, although spirituality approached significance in regards to stress ratio. Age also approached significance with regard to its impact on stress intensity. The only significant impact was believing oneself spiritual and stress occurrence (Beta = ..32, $p = .07$). This study leads us to conclude that our hypothesis. i.e., that there would be an inverse relationship between spirituality and stress tolerance for graduate counseling students is not supported.

DISCUSSION

Spirituality does not appear to be a common coping device for stress tolerance amongst college graduate counseling students. There was no significant difference between the stress ratio scores, a measurement of stress tolerance, and students who scored higher on the spirituality inventory. Also students who tested higher on spirituality did not have less daily stress, nor did they rate their daily stressors any less intensively then the other students indicating that, for this population, spirituality is not a preventative means of coping with daily stress. Interestingly, demographics did not contribute to the significance of this study except to demonstrate that those who believed themselves spiritual scored lower on the spiritual inventory then those who did not believe themselves to be spiritual. However, there were too few participants that rated themselves as not spiritual ($n=5$) to draw any conclusions from these results.

There are a number of reasons why the results of this study may differ from other studies that measure the relationship of spirituality and coping with stress. First, most of the studies conducted on spirituality and coping with stress measure these variables in relation to medical ailments. These studies indicate that for individuals suffering with chronic illnesses spirituality may be influential to psychological well-being (Rowe & Allen, 2004). However, the present study measured participants who were healthy. It is possible that persons who cope with illness use spirituality as a coping device, whereas healthy individuals may not.

Table 1: *Correlations*

Correlations

		AGE	GENDER	MARITAL	CHILDREN	EMPLOYED	HOURS	RELIGIOU	SPIRITUA	STRESS1	STRESS2	STRESS3	SPTBEL	SPLEVEL
AGE	Pearson Correlati	1	.112	-.471**	.362*	.413**	-.087	.174	-.143	-.217	-.261	-.178	-.023	-.082
	Sig. (2-tailed)	.	.503	.003	.030	.010	.661	.296	.391	.191	.113	.285	.891	.625
	N	38	38	38	36	38	28	38	38	38	38	38	38	38
GENDER	Pearson Correlati	.112	1	-.139	.085	.169	.049	-.054	-.258	-.050	.014	.242	-.251	-.227
	Sig. (2-tailed)	.503	.	.406	.621	.312	.805	.746	.117	.765	.932	.144	.128	.170
	N	38	38	38	36	38	28	38	38	38	38	38	38	38
MARITAL	Pearson Correlati	-.471**	-.139	1	-.118	-.238	.157	-.085	-.071	.270	.293	.120	.147	.010
	Sig. (2-tailed)	.003	.406	.	.493	.150	.425	.610	.674	.101	.074	.473	.380	.954
	N	38	38	38	36	38	28	38	38	38	38	38	38	38
CHILDREN	Pearson Correlati	.362*	.085	-.118	1	-.054	.344	.136	.084	-.017	-.071	-.050	.015	.013
	Sig. (2-tailed)	.030	.621	.493	.	.756	.079	.430	.625	.922	.681	.774	.931	.941
	N	36	36	36	36	36	27	36	36	36	36	36	36	36
EMPLOYEI	Pearson Correlati	.413**	.169	-.238	-.054	1	.[a]	-.004	-.152	-.226	-.136	.239	-.238	-.341*
	Sig. (2-tailed)	.010	.312	.150	.756	.	.	.980	.364	.172	.416	.149	.151	.036
	N	38	38	38	36	38	28	38	38	38	38	38	38	38
HOURS	Pearson Correlati	-.087	.049	.157	.344	.[a]	1	.161	.103	.088	.131	.155	-.121	-.132
	Sig. (2-tailed)	.661	.805	.425	.079	.	.	.413	.603	.656	.508	.431	.539	.505
	N	28	28	28	27	28	28	28	28	28	28	28	28	28
RELIGIOU	Pearson Correlati	.174	-.054	-.085	.136	-.004	.161	1	.155	-.221	-.233	-.165	-.110	.098
	Sig. (2-tailed)	.296	.746	.610	.430	.980	.413	.	.353	.183	.158	.322	.511	.557
	N	38	38	38	36	38	28	38	38	38	38	38	38	38
SPIRITUA	Pearson Correlati	-.143	-.258	-.071	.084	-.152	.103	.155	1	-.039	-.096	-.169	-.366*	-.341*
	Sig. (2-tailed)	.391	.117	.674	.625	.364	.603	.353	.	.816	.568	.309	.024	.036
	N	38	38	38	36	38	28	38	38	38	38	38	38	38
STRESS1	Pearson Correlati	-.217	-.050	.270	-.017	-.226	.088	-.221	-.039	1	.871**	-.024	.312	.219
	Sig. (2-tailed)	.191	.765	.101	.922	.172	.656	.183	.816	.	.000	.887	.057	.187
	N	38	38	38	36	38	28	38	38	38	38	38	38	38
STRESS2	Pearson Correlati	-.261	.014	.293	-.071	-.136	.131	-.233	-.096	.871**	1	.383*	.207	.136
	Sig. (2-tailed)	.113	.932	.074	.681	.416	.508	.158	.568	.000	.	.018	.213	.417
	N	38	38	38	36	38	28	38	38	38	38	38	38	38
STRESS3	Pearson Correlati	-.178	.242	.120	-.050	.239	.155	-.165	-.169	-.024	.383*	1	-.130	-.130
	Sig. (2-tailed)	.285	.144	.473	.774	.149	.431	.322	.309	.887	.018	.	.436	.435
	N	38	38	38	36	38	28	38	38	38	38	38	38	38
SPTBEL	Pearson Correlati	-.023	-.251	.147	.015	-.238	-.121	-.110	-.366*	.312	.207	-.130	1	.855**
	Sig. (2-tailed)	.891	.128	.380	.931	.151	.539	.511	.024	.057	.213	.436	.	.000
	N	38	38	38	36	38	28	38	38	38	38	38	38	38
SPLEVEL	Pearson Correlati	-.082	-.227	.010	.013	-.341*	-.132	.098	-.341*	.219	.136	-.130	.855**	1
	Sig. (2-tailed)	.625	.170	.954	.941	.036	.505	.557	.036	.187	.417	.435	.000	.
	N	38	38	38	36	38	28	38	38	38	38	38	38	38

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

a. Cannot be computed because at least one of the variables is constant.

Table 2: *General Linear Model*

Tests of Between-Subjects Effects

Source	Dependent Variable	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	STRESS1	284.326[a]	2	142.163	.882	.423
	STRESS2	1206.768[b]	2	603.384	.343	.712
	STRESS3	3.166[c]	2	1.583	2.024	.147
Intercept	STRESS1	8438.282	1	8438.282	52.332	.000
	STRESS2	79749.712	1	79749.712	45.323	.000
	STRESS3	207.690	1	207.690	265.599	.000
SPLEVEL	STRESS1	284.326	2	142.163	.882	.423
	STRESS2	1206.768	2	603.384	.343	.712
	STRESS3	3.166	2	1.583	2.024	.147
Error	STRESS1	5643.569	35	161.245		
	STRESS2	61584.943	35	1759.570		
	STRESS3	27.369	35	.782		
Total	STRESS1	24408.000	38			
	STRESS2	224253.000	38			
	STRESS3	361.230	38			
Corrected Total	STRESS1	5927.895	37			
	STRESS2	62791.711	37			
	STRESS3	30.535	37			

a. R Squared = .048 (Adjusted R Squared = -.006)

b. R Squared = .019 (Adjusted R Squared = -.037)

c. R Squared = .104 (Adjusted R Squared = .052)

Table 3: *Regression Analysis*

Variables Entered/Removed[b]

Model	Variables Entered	Variables Removed	Method
1	AGE, SPTBEL, RELIGIOU, SPIRITUA[a]	.	Enter

a. All requested variables entered.

b. Dependent Variable: STRESS1

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.412[a]	.170	.069	12.20984

a. Predictors: (Constant), AGE, SPTBEL, RELIGIOU, SPIRITUA

ANOVA[b]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	1008.252	4	252.063	1.691	.176[a]
	Residual	4919.643	33	149.080		
	Total	5927.895	37			

a. Predictors: (Constant), AGE, SPTBEL, RELIGIOU, SPIRITUA

b. Dependent Variable: STRESS1

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	-7.290	26.678		-.273	.786
	SPTBEL	.469	.252	.319	1.862	.072
	RELIGIOU	-4.310	4.191	-.169	-1.028	.311
	SPIRITUA	2.944	6.463	.080	.455	.652
	AGE	-.209	.203	-.169	-1.029	.311

a. Dependent Variable: STRESS1

Table 4: *Regression Analysis*

Variables Entered/Removed [b]

Model	Variables Entered	Variables Removed	Method
1	AGE, SPTBEL, RELIGIOU, SPIRITUA [a]	.	Enter

a. All requested variables entered.

b. Dependent Variable: STRESS2

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.373[a]	.139	.035	40.47685

a. Predictors: (Constant), AGE, SPTBEL, RELIGIOU, SPIRITUA

ANOVA[b]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	8725.320	4	2181.330	1.331	.279[a]
	Residual	54066.391	33	1638.375		
	Total	62791.711	37			

a. Predictors: (Constant), AGE, SPTBEL, RELIGIOU, SPIRITUA

b. Dependent Variable: STRESS2

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	54.552	88.440		.617	.542
	SPTBEL	.804	.836	.168	.961	.343
	RELIGIOU	-13.948	13.894	-.168	-1.004	.323
	SPIRITUA	-5.020	21.424	-.042	-.234	.816
	AGE	-.945	.674	-.234	-1.402	.170

a. Dependent Variable: STRESS2

Table 5: *Regression Analysis*

Variables Entered/Removed[b]

Model	Variables Entered	Variables Removed	Method
1	AGE, SPTBEL, RELIGIOU, SPIRITUA[a]	.	Enter

a. All requested variables entered.

b. Dependent Variable: STRESS3

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.365[a]	.133	.028	.89569

a. Predictors: (Constant), AGE, SPTBEL, RELIGIOU, SPIRITUA

ANOVA[b]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	4.060	4	1.015	1.265	.303[a]
	Residual	26.475	33	.802		
	Total	30.535	37			

a. Predictors: (Constant), AGE, SPTBEL, RELIGIOU, SPIRITUA

b. Dependent Variable: STRESS3

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	6.824	1.957		3.487	.001
	SPTBEL	-.026	.018	-.247	-1.410	.168
	RELIGIOU	-.211	.307	-.115	-.686	.497
	SPIRITUA	-.718	.474	-.271	-1.515	.139
	AGE	-.018	.015	-.202	-1.207	.236

a. Dependent Variable: STRESS3

Second, choosing how to define and measure variables such as spirituality and stress tolerance may have influenced the results of this study. There are very few studies that have defined these variables similarly. Many studies, including those conducted on college students have defined and measured spirituality in terms that included religion or other terminology. For example, in one study that measured spirituality with the psychological dimensions of wellness, the authors chose to define and measure spirituality as a positive sense of purpose in life. The results of this study demonstrated a relationship between optimism, and having a sense coherence and perceived well-ness. The study concluded that these variables may be enhanced by life purpose, i.e., spirituality (Adams et al., 2000). Perhaps, as this study demonstrates, spirituality acts as a catalyst for other coping mechanisms, but is not an effective coping mechanism without them. The results of these studies may differ from the current study because religion was not included in the current study's spirituality measurement not was spirituality measured along with other coping devices. Therefore, while these studies may have some similarities with the current study, their differences may preclude comparison.

Finally, a study by Graham et al. (2001) on college graduate counseling students supports our findings that there is not a significant relationship between spirituality and stress tolerance. In this study while students who considered themselves as spiritual but not religious had greater immunity to stress they fared no better in combating stress. While this is interesting more studies need to be conducted on variables of spirituality and stress tolerance that replicate definition and measurement before conclusions can be drawn.

The results of this study should be interpreted in light of several limitations. For one, there may have been other extraneous variables that confounded the results of this study. For example, individual difference variables such as resiliency and hardiness would have an effect on how one tolerated stress. The current study did not measure other coping mechanisms. Other extraneous variables that could have confounded the results of this study include student presentations or midterm exams that might have increased the number of stressful incidences as well as their intensity. The history of one's spiritual involvement could have also been an influential factor on stress and spirituality especially if one has recently been questioning their faith.

The sample of participants also limits the interpretation of this study. For one, our sample size was small (N = 38) and selection was based on convenience and willingness to participate. Second, a majority of the participants were Caucasian and most of them were women. Our study based on these demographics demonstrates a lack of cultural and ethnic representation. Third, all of the participants were in one of thee graduate programs for psychological counseling. These limitations could be addressed in further research using a more representative and larger sample of the general population. This would allow the study to be generalized to other populations. It would also allow the variables of ethnicity and culture to be addressed relative to spirituality and stress tolerance. One need remember, though, that this study was concerned with spirituality as a coping device for stress tolerance amongst graduate counseling students. Counseling students may differ from other students in the type, and amount of stress, they incur in their program of studies. Therefore, the results should not be generalized to other student populations.

In light of the findings of this study, as well as the study conducted by Graham, et al. (2001), it would be interesting to see if other studies conducted on this population would yield similar results. Such findings would raise a number of questions pertaining to stress tolerance and counseling students especially if these studies combined spirituality with other types of

coping mechanisms. Another interesting future study would be to explore whether a relationship exists between spirituality, other forms of coping, and stress tolerance in other graduate students. Perhaps graduate students in general are an at risk group for stress. Finally, it would be interesting to conduct a longitudinal study on psychological counselors, as well as other graduate students, to determine the long-term effects of stress. Hopefully, future research will help us understand coping devices that could be useful for counseling students and others in reducing stress.

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Community of Men: Factors Which Impact on Counseling Male Clients

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The author examines a broad range of issues that could potentially face men in a counseling environment, with a discussion about how these issues may or may not be gender specific. A subset of these issues have implications for the communities in which the men live, which may lead a counselor to consider strategies beyond the individual or group interactions directly with the clients. The author then discusses those strategies for a specific topic that has significant impact on men, confidence concerns surrounding fatherhood. The author concludes with some hypotheses about how these strategies might be employed in a community counseling agency.

Vive la difference! We have all heard this from some man at some point in our lives, perhaps a rakish Frenchman in an ancient movie or a patronizing sports announcer as the camera scans the stands for beautiful women. Men have every right to appreciate that women are not like men, yet men sometimes fail to realize that they, the men themselves, are also different. This inability to resolve how one is or feels and how one believes he should be or feel is termed gender role conflict. Men are not like what they think they are, it seems, and this has an impact on their psychological well-being.

Issues Facing Men

Hayes and Mahalik (2000) state that "gender role conflict predicted psychological distress" (p.116). Addis and Mahalik (2003) state that "Men are less likely than women to seek help for problems as diverse as depression, substance abuse, physical disabilities, and stressful life events" (p. 5). In fact, society–including many psychological professionals–has long felt that men do not suffer depression at the same levels as women, because men are less likely to seek help (Cochran & Rabinowitz, 2003). Putting these two observations together underscores the poignancy of men's lot: being men generates problems that being men prevents addressing. More to the point, career is a central issue to men, and more traditionally minded men are less likely to seek career counseling, defeating their own prospects of fulfilling their goals (Rochlen, Blazina, & Raghunathan, 2002).

The types of problems that gender role conflict can create are quite numerous in the research. Hayes and Mahalik (2000) found gender role conflict to be predictive of "hostility, social discomfort, and obsessive–compulsiveness" (p.120). Mahalik, Good, and Englar-Carlson (2003) cite a long list of psychological issues facing men who "endorse traditional masculinity ideologies" (p. 124): "poorer self-esteem," "problems with interpersonal intimacy," "greater depression and anxiety," "abuse of substances," "problems with interpersonal violence," and "greater biomedical concerns." DeFranc and Mahalik (2002) were able to connect gender role

conflict in a man to his perception of his father's gender role conflict and his attachment to his father, showing how ingrained this is in our society.

While the studies cited above rely largely on European Americans, this point of view is substantiated in work with men in different ethnic groups (Liu, 2002a; Fragoso & Kashubeck, 2000; Abreu, Goodyear, Campos, & Newcomb, 2000). As one might expect, not only do many of these ethnic groups perpetuate traditional roles for men; men in these groups, to varying degrees, depend on their cultural identity for senses of well-being. In fact, those who tend to feel a greater sense of belonging to their ethnic group tend to have greater gender role conflict and associated psychological distress (Abreu et al., 2000), just as DeFranc and Mahalik (2002) had found with European American men and their fathers. Simonsen, Blazina, and Watkins (2000) also find similar relationships between gender role conflict, psychological distress, and unwillingness to seek help among gay men.

While this problem with being men is well documented and researched; there are also other explanations offered quite convincingly. Some see that gender role conflict does not explain these issues any more than non-gender specific personality traits (Bruch, 2002; Tokar, Fischer, Schaub, & Moradi, 2000). Others have suggested–and rightly so–that there are other factors in the personality and environment that have impacts on men's psychological distress: alcohol and drug abuse in the parents and related abuse of the client as a child (Locke & Newcomb, 2003), social class and classism (Liu, 2002b), impulsivity (Lightsey & Hulsey, 2002), and negative attitude (Shepard, 2002). There are, no doubt, many others.

Community Counseling Strategies

This author assumes that gender role conflict is a fundamental source of psychological distress for men, believing also that other factors such as personality, environment, and neurology come into play. In fact, environment is the very dimension of greatest importance to the community counselor. As Gladding and Newsome (2004) tell us: "Interactions between people and their environments are of particular interest to community counselors because of the way those interactions affect functioning and development" (p. 43). In our look at those environmental factors, we need to be particularly sensitive to those that may reinforce or mitigate gender role conflict.

Very possibly the most important environment for men is the workplace. One of the traditional roles for men is provider, and at least six of the eleven masculine characteristics that have been identified by Mahalik, Locke, Ludlow, Diemer, Scott, Gottfried, et al. (2003) appear to support this role: "*Winning, Emotional Control, Risk-Taking,* Violence, *Dominance*, Playboy, Self-Reliance, *Primacy of Work*, Power Over Women, Disdain for Homosexuals, and *Pursuit of Status* [italics added for emphasis]" (p.3). In an individual session, a counselor must include job status and workplace details in the input. One can also see that a counselor might have tremendous leverage by going directly to the community workplaces, as well as the social institutions that influence it. Career counselors, for example, would be advised to use "a more directive approach to career counseling over a more contextual, emotionally oriented approach" (Rochlen,& O'Brien, 2002, p.9).

Families are important environments, because of their importance in the traditional male role, the direct influence they have on the male client, and the consequences they are likely to have from the male client. For example, a man with an alcohol abuse problem may very likely have been raised in an alcoholic family from which he suffered abuse, abuse which he may likely be reenacting with his own family (Locke & Newcomb, 2003). The role of family will depend on other variables, such as age, ethnicity, sexual orientation, and social class. A community

counselor has many avenues to reach families: schools, women's health and helping organizations, religious institutions, ethnic opinion leaders, and workplaces.

Religious institutions are an environment that may be overlooked frequently, because adherence to traditional male values does appear to be inconsistent with religious activity and sprituality (Mahalik & Lagan, 2001). Spirituality is a developmental aspect (Faiver, Ingersoll, O'Brien, & McNally, 2001), and, while men can find it elsewhere, avoiding religious institutions may impede their personal development. Ironically, the traditional male values espoused by these institutions and taught to boys, girls, men and women may be part of the problem with men staying involved in their adulthood. Community counselors that help religious institutions recognize this may be able to effect increased spirituality and psychological well-being for generations of men to come.

The Traditional Male Role and Modern Fatherhood

To discuss the implementation of such strategies, let us focus on a specific issue that affects many men and may, if they were inclined to seek psychological counseling, drive them to seek help. Fathers today have difficulty reconciling traditional male roles with fatherhood, which Silverstein, Auerbach, and Levant (2002) describe as follows:

> Now that both men and women routinely engage in paid employment and women have more power in both the public and private spheres than they did in previous generations, men are presented with contrasting demands. Men are now expected to participate more actively in child-care tasks, to be more emotionally accessible and less authoritarian toward their children, and to share power and intimacy with their wives. In the context of these competing expectations, attempting to enact the *traditional* [italics added for emphasis] fathering role inevitably leads to strain. (p. 162)

The authors focus on the individual and group counseling conducted in their research and describe a number of effective strategies for dealing with this strain, similar conceptually to the more general gender role conflict described above. Using these strategies as a foundation, this paper will suggest how the community counselor might be effective.

Silverstein et al. (2002) determined that the fundamental solution to the problem they describe is "a loosening of strict gender rules" (p.168). These gender rules are pervasive, as we all know. Movies, books, television, advertising, religions, families, parents, teachers, sports, comic strips, dirty jokes, politicians, foreign cultures, magazines, ancestors, fairy tales, wedding traditions, newspapers, job descriptions, and virtually every communication one encounters will propagate these rules. One's own parents, spouse, and children will reinforce them. This provides the community counselor with thousands of wonderful opportunities to reeducate.

Looking to the three environments discussed above, one can see that strategies nearly create themselves. In the workplaces in the community, the counselor can be certain that laws regarding gender bias are being respected. Having the weight of the law and the fear of lawsuits behind one can make the counselor very persuasive. Helping area human resources professionals, office managers, and operating officers find ways to make certain they are in compliance with the law will provide an opportunity for the counselor. In addition to introducing language and behaviors that do not offend either gender, one can be certain that parent roles are included. Pictures in brochures should show fathers as well as mothers holding children, dropping them off at daycare, and so on.

Reaching families is not quite as efficient, as there is no central medium and each of the many ways to reach them has a different perspective requiring a different approach. For instance, books that parents read to their young children require an appeal to publishers, libraries, and distribution channels. Working with women's health clinics requires a sensitivity to potential victims of male abuse; although, this should be and probably is an important first line of attack for loosening the gender rules. Schools are always needing new material for pro-social programs, and the promotion of gender neutral material will certainly fall on fertile soil in public schools, subject to the same regulations as other workplaces. A community counselor is likely to find willing collaborators in the socially conscious school counselors' offices.

Religious institutions are another central location for large groups of families. Most religions perpetuate traditional roles as a function of basing their beliefs on ancient writings. The Torah, the Holy Bible, and the Q'ran all depict men in traditional roles of dominance and authority. Feminists can certainly find heroines, however, and all denominations have more liberal congregations. The community counselor may find it easier and more productive to work among these more like-minded religionists, using the experience to build momentum and move into the more mainstream and, ultimately, conservative wings. The media would be literature, posters, program flyers, and a call for those interested to join discussion or support groups.

Digging deeper than these three, broad environments, one wants to go where the men are. How can a community counselor reinforce a more forgiving definition of the male gender role in those very same places to which men go to relieve the stress of gender role conflict? Does one move to install changing tables in men's rooms in saloons? Perhaps not, but bowling alleys and sports stadiums might be a good target. A community counselor might be able to convince a Home Depot manager to create a play corner for kids while their fathers are shopping. Another place nearly every father goes is the place where his baby is born, and these environments can always do more to encourage fathers to extend beyond their traditional roles. In every community, there are places where men go, and it should be the job of the concerned community counselor to find a way to make it okay for these men to go and still be fathers.

Conclusion

What any community counseling agency actually does depends on whether they consider the updating of traditional male roles to be a priority, and, if they do, the particulars of the community in which they practice. It is reasonable to assume that a concerned agency would make their commitment evident by what they do. For example, there would be a father-centric perspective, such that the counselors would be able to determine and categorize the multiple environments in which men develop into fathers (Gladding & Newsome, 2004). The physical space of the agency would promote gender neutral language and visualizations, certainly, but also pro-father, pro-mother and pro-nurturing communications, as well.

The community counseling agency that was committed to helping men become better fathers would be involved in the kinds of community institutions suggested in this paper. Their involvement would be specifically oriented to promote and allow men to accept a male role that includes caring for children, willingness to express intimacy, and openness to contributing as more than a material provider. Nor should these efforts minimize the importance of the traditional roles, as these are both important to the stability of many, many families and embedded elements in all male self-images. In short, committed community counselors will accept the men for who they think they are and show them the way to be the men they can be.

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Relationship Between Communication Apprehension and Body-Esteem

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This study examined the relationship between one's body-esteem and Communication Apprehension. This study hypothesized that the students with lower body-esteem would have higher CA. The body-esteem was operationally defined as scores on the Body Esteem Scale (BES) and the CA was operationally defined as scores on the Personal Report of Communication Apprehension (PRCA-24). The scores were obtained from 46 undergraduate university students. The data did not support the hypothesis, indicating a non-significant relationship between the two variables for this sample of people.

Fear of public speaking, also known as Communication Apprehension (CA), has been shown to affect two out of ten people in some degree (McCrosky, 1977). Communication Apprehension is defined as anxiety and/or fear experienced by a person that is associated with a real or merely anticipated communication with another person (McCroskey, 1984). This physiological disorder impairs one's ability to comfortably speak to and address the audience in public situations or in simple two-way exchanges. For example, a person experiencing high levels of CA may have difficulty orally expressing his/her knowledge in a professional or educational setting during groups, meetings and even in dyads.

Much previous research in this area examined the negative relationship between CA and academic and social success. For example, one study concluded that students with CA tend to have a higher drop out rate (McCroskey, Booth-Butterfield, & Payne, 1989: 100). Studies have also found a significant relationship between students' Academic Achievement (AA) and their respective CA scores (Comadena, Prusank, 1988).

Students with CA, who have a lower academic as well as social success, may also have a low self-concept. These individuals may demonstrate a lower self-perception and internalize negative feelings. This can be exhibited by and also reflected in the students' self-esteem and even their respective body-esteem. Body esteem is defined as how an individual feels about their body image (Franzoi & Shields, 1984). The speaker's psychological perception of his or her appearance may negatively influence the speaker's comfort level especially while performing a task that is already considered to be stressful. This leads to the need for the following question to be examined and answered: Is there a relationship between one's body esteem and CA?

Franzoi and Shields in 1984 described body esteem as a part of self-esteem. In developing the body-esteem scale they found that there were many factors that make up body-esteem in young people and they tend to be different for men and women (Franzoi & Shields, 1984). They found that women seem to have three primary dimensions. The first aspect was of functions of the body that are associated with physical attractiveness, the second had to do with changes which entail superficial alterations and the third was about qualities such as stamina, strength and agility (Franzoi & Shields, 1984).

Franzoi and Shields found three primary dimensions as well. The first was physical attractiveness which deals with facial expressions and aspects of the body, the second was regarding upper body parts and functions that can be changed through exercise and the third was based on physical conditions, such as stamina, strength and agility (Franzoi & Shields, 1984).

Interestingly Franzoi and Shields found that men and women have different views on the physical condition. Women are concerned with items like waist, appearance of stomach and appetite, which are concerned with weight control, whereas men are concerned with these body parts for how they will contribute to their physical activity (1984).

Body esteem has also been explored across different cultures to see if it is a culture specific trait. Akiba studied the presence of this phenomenon amongst the young adults of the US and the Iran population (1998). The young Iranians had little to no access to westernized media (Akiba, 1998). The results of this study indicated that the Iranian participants scored reliably higher on the body esteem than the US participants and that the young women of the US population scored lowest for body esteem (Akiba, 1998). Regardless the differences in the different levels of body esteem, this study suggested that body esteem is a valid and measurable trait that can be found in other cultures.

Other studies have shown a link between body-esteem and self-esteem. In 1999 researcher Christine Ahmed examined the culturization of body image and how it impacts men and women. Body image was defined in this study as the picture of physical self that is carried in the minds eye (Ahmed, 1999). Ahmed stated that this can have little to do with how one actually looks or weighs, but is rather the process in which we integrate others' perception through an internal sense as to what is acceptable (Ahmed, 1999). Ahmed suggested that a good body image would seem to be related to overall self esteem and self confidence and that poor self esteem can create an obsession with changing certain features and this can take away ones energy and time from things like education and personal development (Ahmed, 1999).

In a 1999 study, Henriques and Calhoun studied the relationship between self-esteem and body-esteem. Their results supported the existence of a positive correlation between the two variables for both genders and across the White and Black race (Henriques & Calhoun, 1999). The researchers also discussed the implication that a negative body-esteem and self-esteem can have in regards to eating disorders such as bulimia nervosa (Henriques & Calhoun, 1999). It can therefore be derived from this study that a negative body-esteem is a powerful concept that can influence people's behaviors and thoughts in regards to themselves.

In 1985 Mendelson and White in examined the development of self-body-esteem in over weight and normal weight boys and girls. They found that overweight children had lower self-esteem than normal weight children (Mendelson & White, 1985). In another study, Mendelson, Mendelson and White found interesting gender differences (2001). They measured appearance, weight and attribution, and found that females scored lower (they were more dissatisfied with these attributes) than males on weight and appearance, and appearance was the only measure that consistently predicted self-esteem (Mendelson et al., 2001). These findings raise some interesting questions in regards to investigating the relationship of Body-Esteem and other phenomenon such as Communication Apprehension, which has also been shown to lower perceived self or body-esteem.

CA is an important phenomenon has been widely researched and shown to effect 20% of the population (Richmond & McCroskey, 1998). A survey conducted in 1986 on 402 university Iowa students revealed that 281 declared that classroom communication apprehension (CCA) had happened to them and 38% of those who said yes said they experience it at least weekly

(Bowers, 1986). Bowers found that CCA was a widespread phenomenon at this university, where more than a third of individuals that experience it identified with exhibiting physical symptoms such as sweaty palms, flushing, general discomfort and accelerated heart rate (Bowers, 1986). Bowers also found that most people try to avoid the apprehension. He made this observation based on McCroskey's 1978 finding that indicated that students systematically select seats that will require less interaction.

Bowers referred to conventional communication Apprehension as stage fright or speech freight and stated that generally, sufferers of CCA attribute the apprehension to a crowd and to their own characteristics (Bowers, 1986). According to this assumption, if the individual with CA is attributing apprehension to characteristics of the self, it can be assumed that body-esteem is one of the characteristics that are being considered in the manifestation of CA.

Other studies also showed the presence of CA in the professional world. Burk recognized that corporations have been less satisfied with the communication skills of MBA graduates (Burk based on Yates, 1983) and examined whether there was a gap between what masters of business administration (MBA) students learn about communication and what corporations experience upon employing MBA graduates (Burk, 2001). Burk surveyed 122 MBA students and found that MBA students tend to score slightly lower than the national average on the Personal Report of Communication Apprehension-24 test (PRCA-24) (Burk, 2001). Professionals in managerial positions tend to have to have to make presentations, serve as group leaders, conduct meetings and have good interpersonal skills for communicating and consulting with employees (Burk, 2001).

Burk suggested that based on previous research Communication courses have been found to in help the reduction of Communication Apprehension (CA) and that perceived communication requirements may influence major in college and even job choice (Burk, 2001). Burk also suggested that students with CA may find ways to cope in college where communicated exchanges are predictable, hence why their successful admission in MBA programs, however this may also suggest that when MBA graduates enter the work setting they are not prepared for the organizational communication environment of a non-academic work setting (Burk, 2001).

CA has also been measured in terms of characteristics such as consistency across situations and situational-specificity. Biggers & Masterson showed that CA levels do not alter significantly across all situations that required communication, thus claiming that CA possesses situation consistency (1984). These researchers also found that this anxiety felt by the individuals is specific only to situations that require oral communication. The emotional reaction of these individuals to other anxiety-inducing situations that do not have an oral component is different (Biggers & Masterson, 1984). These factors of CA question the findings that indicate that CA is related to personality traits, which assume that the person, who is exhibiting a trait that is related to CA, should also exhibit this trait across all other circumstances and situations.

How personality traits are related to CA has been widely researched. A correlational study by MacIntyre & Thivierge examined this relationship and found that CA was significantly associated with traits of extroversion, intellect and emotional stability (1995). This particular study suggested that CA is related to a specific personality trait.

Another study by Opt & Loffredo have found that students, who exhibit introverted personality traits, reported significantly higher levels of CA in all contexts including group, dyadic, meeting and public (2000). The results of this research study supported the findings of Biggers and Masterson, who stated that CA is consistently measured in all aspects of

communication situations (1984). To explain these results the researchers attributed this finding to the assumption that the introverts focus on the self as the extroverts focus more on the outside world and therefore have a higher need for communicating (Opt & Loffredo, 2000).

In addition to just showing the presence of CA and factors relative to its conditions, this form of social apprehension a lot of attention has been focused on CA in terms of its relationship to students' academic success. Much research has shown that CA is negatively correlated with academic achievement. One study looked to determine whether communication apprehension could potentially hinder the academic success of students (Ericson & Gardner, 1992). The results were partially true to its hypothesis and showed that high CA students had a significantly higher drop out rate compared to low CA students (Ericson & Gardner, 1992). The findings however did not find a significant difference in high CA and low CA grade point averages in the population of students that was studied (Ericson & Gardner, 1992).

Monroe and Borzi studied ninth grade students and the relationship between CA and the students' decisions to drop out of high school (1992). Their results also reported that CA was related to the potential drop out decision and therefore supports the notion of a negative relationship to academic success and achievement (Monroe & Borzi, 1992).

A study by Comadena & Prusank that also measured the relationship between CA and academic success supported the findings of Ericson and Gardner (1988). The results of their study indicated that high levels of CA negatively correlated with academic success. The researchers attributed this phenomenon to the assumption that students with CA withdraw do not participate in class discussions and therefore suffer academically (Comadena & Prusank, 1988). More importantly the researchers also observed and increase in CA with age and state that this may be due to an increased self-consciousness and awareness, which brings about more fear or apprehension to communicate in public situations. (Comadena & Prusank, 1988).
This finding brings about a connection that can be drawn between CA and perceived self-esteem as well as body-esteem.

It has been found that the leading cause for hindering social interactions is negative self-imagery in social anxiety (Hirsch, Megnen, & Clark, 2004). Researchers have found that patients with social phobia have reported that they experience negative images of themselves in social situations (Hirsch et al., 2004). They also found that when patients held a negative image they felt more anxious, they reported using more safety behaviors, they believed that they performed worse than they did and they showed greater overestimation of how poorly they publicly appeared (Hirsch et al., 2004). The results of this study can be related to the issue of CA being tied to feeling anxious while performing or speaking.

Ayers and Huett also attempted to see if high and low speaking apprehensive students visualized themselves differently in a public speaking situation (1997). Their results showed evidence of negative-self-imagery exhibited by the students with higher levels of CA (Ayers & Huett, 1997). In the anxiety-producing situation such as communicating in front of class the high CA students reported producing more negative, less vivid images of themselves and exhibited lower levels of control than did low CA students (Ayers & Huett, 1997). The negative feelings or images that someone with high CA may experience in regards to one-self while communicating may also be transformed into thoughts of negative body-esteem.

In 1995 Rosenfeld, Grant and McCroskey examined the relationship between communication apprehension and self-perceived communication competence among the academically gifted. They found that students that are highly apprehensive about speaking in dyads and groups and those, who also perceived themselves as lacking competence in speaking

to strangers and acquaintances, also did not perform well academically (Rosenfeld, Grant & McCroskey, 1995). It may be concluded that the perceived competence in public speaking may contribute to the level of academic success a student achieves.

Another study that has looked at the academic achievement and its relationship to CA has found opposite effects. Butler, Pryor and Marti looked at this relationship with regards to honors vs. non-honors students in a public speaking class (2004). What they found contradicted the previous findings that support a negative relationship between the variables. The results, which they obtained, indicated that the honors students, which had higher GPA and academic standing, actually demonstrated higher levels of CA. The researchers explained this finding by stating that the honors students were possibly more conscious of their grades on their public speaking assignment and exhibited more apprehension than the non-honors students who were not such high-achievers (Butler et. al., 2004).

A qualitative study by Niki Glanz also explored the relationship between academic achievement and self-esteem in regards to minority at-risk students at an elementary school (1993). The researcher closely analyzed the school's self-esteem program and found that the factors that promoted students' academic success were the same ones that also taught and endorsed self-esteem and form this finding the researcher concluded that the two variables are closely related (Glanz, 1993).

Apprehension does not only affect the academic achievement of people but may also be linked to other issues. Due to how many people are challenged by social anxiety that can be exhibited in CA, much research has been conducted on the implications of socially exhibited fear and on related problems. Abrams, Kushner, Medina investigated one such topic & Voight in 2002 in which they examined whether social anxiety symptoms can lead to increased alcohol use. The results indicated that social phobia and alcohol problems often co-occur (Abrams et al., 2002), which was consistent with their previous research that had also found that alcohol is routinely used as a means to relieve anxiety symptoms (Abrams, Kushner, Medina & Voight, 2001). Accordingly, Stockwell, Smail, Hodgson, & Canter also found that approximately 50% of socially phobic alcoholics stated that they have had alcohol before speaking with an authority figure and before public speaking (1984). These are alarming statistics when research indicates that 20% of the US population experiences CA (Pearson & Nelson, 2001).

Research has shown that CA effects a great portion of the population and has been demonstrated to negatively affect those who experience it. Much research demonstrates that CA is negatively related to academic success. Findings also indicate that one of the ways in which CA affects is that those individuals often times demonstrate a lower self-perception and internalize negative feelings. According to previous studies, this can be exhibited by and also reflected in the individuals' self-esteem and even their respective body-esteem. Thus it can be expected that a relationship will exist between body-esteem and CA. Therefore this study hypothesizes that the students who will exhibit higher levels of Communication Apprehension will also have a lower body-esteem.

METHOD

Participants

Forty-six participants took part in this study. These individuals were obtained from undergraduate classes at Monmouth University. The participants' mean age was 21 years old.

The sample obtained represented 25 males and 21 and represented the following ethnic backgrounds accordingly: 1 Asian, 43 Caucasian and 2 Hispanic. The socio-economic background of the participants, as measured by the highest level of education attained by the major bread winner, ranged from a bachelors degree to a masters degree or higher.

Instruments

The two surveys that were in this study were the Personal Report Communication Apprehension (McCroskey, 1982) and the Body Esteem Scale (Franzoi & Shields, 1984). The Personal Report of Communication Apprehension (PRCA) measures an individual's fear about participating in a range of communication situations. The PRCA-24, developed by McCroskey (McCroskey, 1982) is a self-report paper and pencil instrument that consists of twenty four statements which are rated on a five-point scale ranging from strongly agree to strongly disagree. The suggested administration time for this particular instrument is 15 minutes.

The items on the scale assessed CA in four different contexts, which include group discussions, meetings, interpersonal conversations, and public speaking. An overall score was also obtained using this instrument. The overall scores ranged from 0 to 120. The mean and standard deviation for a population of 25,000 students in 1985 was found to be 65.60 and 15.30, respectively (McCroskey, Beatty, & Kearney, 1985).

This instrument has been shown to be reliable with the alpha measuring around .97 (Bourhis, Allen, & Wells, 1993) & (Booth-Butterfield, & Booth-Butterfield, 1993). The content validity of the 24 items on the PRCA-24 has been measured and the findings show the PRCA-24 to be predictable of 27% to 37% of the variance in an assertive scale (McCroskey, Beatty, Kearney, & Plax, 1985). In addition to this, concurrent validity of this instrument has been tested in two separate studies that have established that a moderate correlation exists between PRCA and self-esteem and self-acceptance (Phillips, 1968) as well as between PRCA and introversion (Bledsoe, 1990).

The second measuring instrument that the participants were administered was the Body Esteem Scale (Franzoi & Shields, 1984). The Body Esteem Scale is a self-report survey on current body esteem (appearance and weight dimensions) and consists of 35 items in which participants rate their body parts and functions on a scale from 1 (having strong negative feelings) to 5 (having strong positive feelings) (Franzoi & Shields, 1984). The higher the participants' total score, which is based on adding each item in the scale, the more positive their body esteem.

Factor analysis of the Body Esteem Scale has found that body esteem is a multidimensional construct and that is different for men and for woman (Franzoi & Shields, 1984). Franzoi and Shields in 1984 found that the body esteem dimensions for males were focused on physical attractiveness, upper body strength, and physical condition and for females they were sexual attractiveness, weight concern, and physical condition. Franzoi and Shields found that there were three aspects of the males body esteem that were more likely to be inter-correlated that those of the females, and they found this to indicate that a greater degree of body esteem differentiation for females than for males.

This scale has an internal consistency in alpha coefficients of .81 for males for the attractiveness factor, .85 for the upper body strength factor, .86 for the general physical condition factor. For females the alpha coefficient was slightly lower for the attractiveness factor was a .78. The female weight concern factor was .87, and the general physical condition factor was .82.

This scale has been deemed as reasonably internally consistent (McLaren & Kuh, 2004). The mean and standard deviation for a population of 964 male and female undergraduate students in 1984 was found to be 38.3 and 6.62, respectively (Franzoi & Shields, 1984).

The participants were also asked to fill out a demographic questionnaire that asked them to indicate their age, gender, ethnicity, marital status, and socio-economic status.

Procedure

After the proposal for the study, which contained details in regards to the intentions of the study, received the approval of Monmouth University's IRB undergraduate professors were contacted via email and were asked for permission to utilize their class time and students in administering this study. The professors, who replied positively to this request, were contacted and the study and the procedure were explained to them. Participants were asked to voluntarily take part in this study. Participants were read as well as handed out a brief introductory statement that included the implied consent statement and were told if they felt uncomfortable at any time during the study they could stop and not hand in their surveys. Participants were told that these are completely anonymous surveys and that they should not write their name anywhere on them.

Participants were each given a packet. Each packet contained a consent form, two surveys, which intended to measure body esteem and communication apprehension, as well as a debriefing form. When all surveys were complete, a student was asked to collect them and give them to the researcher. The consent forms were collected separately as to assure participant confidentiality and anonymity. Finally, the participants were addressed again and thanked for participating in the study and were also handed out and read a debriefing statement that included a more detailed explanation of the study as well as contact information for further questions or concerns.

RESULTS

A Pearson correlation coefficient was used to determine the relationship between the two variables, Communication Apprehension and Body-Esteem, and the results proved to be non-significant (r =-.07, p=NS). The hypothesis of this study was therefore not confirmed. However, a post hoc analysis of the data revealed a significant relationship between subscale scores. A significant negative correlation was found between the interpersonal speaking score of CA and the physical condition score on the BES for the participants (r =-.369 at $p< 0.05$).

DISCUSSION

The results did not support the hypothesis, indicating that there is no significant relationship between students' Communication Apprehension and their respective Body-Esteem. The results of these findings can be attributed to one of two reasons. The first one is that although a relationship has been shown to exist between negative self-esteem or self-image and Communication Apprehension (Hirsch et al., 2004) as well as with one's Body-esteem (Mendelson & White, 1985), this factor of negative self-esteem may not be enough to link the

two variables together. The relationships regarding these variables that have been established are not causal but rather correlational so that it cannot be assumed that lower self-esteem leads to lower body-esteem that in turn leads to higher apprehension. These correlations merely suggest that as one variable changes the other one does as well. Another important thing to note is that the hypothetical constructs such as CA and body-esteem, which were under study, are not one-dimensional. That is, both of these psychological concepts are made up of factors that add up to the cover the whole construct that is being measured. CA, for example can be measured in regards to four different aspects of communicating and body-esteem can also be divided in terms of three different sets of factors relating to how one views him or herself. In a post hoc analysis of the data, this study found a significant relationship between the subscales or dimensions of both variables. The data indicated that students' interpersonal communication apprehension increased as their attitudes toward their physical condition decreased. Thus showing that certain factors of the two variables are related to each other. Perhaps how one perceives his or her physical condition reflects the individual's self-esteem more so than the overall perception of the entire body. Also, it may be the case that interpersonal communication is more related to body-esteem than overall apprehension about communicating because of the direct and personal nature of this kind of exchange of conversation. Someone that is engaging in a direct conversation with another person may be more concerned with their appearance or body-esteem than if speaking to a classroom of strangers. There are many possible explanations of this finding but this study can only speculate the actual reasons, being this relationship was discovered post hoc. Further studies may want to explore the specific subscales of the two measuring instruments and determine if the findings from this study generalize to a more representative sample of the general population. This lack of ability to generalize threatens the external validity of this particular finding and the entire study.

Obviously, the study had limitations, which may have inhibited the relationship between CA and body-esteem from becoming apparent, if in fact it exists. One of the most influential limitations to the validation of any finding or lack thereof in this study deals with the sample that was studied. A very small number (N=46) of participants took part in this study and all of those individuals were obtained using a method of convenience sampling. For this reason the sample that was obtained was not representative of the population at large or perhaps not even very representative of the university at which this study was conducted. The participants that were surveyed were in already pre-existing groups based on factors such as majors which assumingly indicate some sort of similarity among the participants thus limiting the control of extraneous variables that may have impacted the study's results. All the participants were retrieved from undergraduate university classrooms and the participants represented very little ethnic, socio-economic and age diversity.

Another limitation of this study was the time constraints of only having a semester to complete research from start to end therefore research methods were limited to quick self-reported surveys. The timing of the actual surveying and data collecting also may have impacted the participants' effectiveness to thoughtfully self-evaluate themselves.
The students were asked at the beginning of class towards the end of the semester to voluntarily participate in this study, so it is possible that they rushed through their surveys in order to have more class time for finals and end term projects.

Further research might focus on retrieving data from a population that is more diverse in regards to ethnicity, socio-economics, age and geographical location. A population other than college students should also be studied considering college students may have more

communication training than the general population. For research that does examine the university population, it may want to examine students at different stages in their programs and for different majors. Perhaps research conducted in a pre-test, post-test format for incoming freshman versus students with 3+ years of college study may reveal changes in students overall esteem and communication skills. Research that compares the average adult and the college-educated adult may also reveal useful information and is worth exploring.

Additionally data on whether English is the participants primary language may be useful in exploring as well. If participants' primary language is English and the surveys are given in English they may be more comfortable answering survey than participants whose primary language is not English. This may also affect how comfortable one is with speaking publicly.

Additional research is needed in this area that reflects more adequately the general population is encouraged. Further research may also want to explore the area of CA in a more natural setting and in conjunction with asking participants to fill out a body-esteem scale. It is thought that students may not be as aware of how they feel when speak in public and in groups until they actually are required to perform. It also may be useful to ask students if they have ever taken a communication class before.

Overall, this study served several purposes. Firstly, it revealed that a relationship between CA and BE could not be established using the small sample that was obtained. It also may suggest that such a relationship does not exist at all, but this is yet to be determined and requires further evaluation using other methods and populations. Secondly, the study's significant finding of the subscale relationships may serve as a link to determine the existence of a relationship of a certain aspect of the two variables (CA and BE). In conclusion, this study reflects the necessity of further research that examines this particular topic and emphasizes the need for a much more diverse participant population in order to validate any findings.

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An Animal a Day Keeps the Doctor Away: Pet Ownership and Animal-Assisted Therapy Promote Psychological and Physical Health

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Pets have the ability to improve the physical and psychological health of their owners. The purpose of this paper is to suggest the benefits of pet ownership as well as the importance of Animal-Assisted Therapy (AAT), which makes use of the human/animal bond in a therapeutic setting.

Since the beginning of time, animals and humans have co-existed. Throughout history, pets have played an important role in the lives of countless people. Exceptionally interesting, is the idea that the relationship, or the human-animal bond, has been in existence for thousands of years. Pets have helped their owners by serving as protectors, hunters, and friends. Pets are able to bring joy to their owners. Pets have the ability to promote their owner's psychological as well as physical well-being. The presence of a pet can bring people these benefits by: acting as a catalyst for increasing exercise (Whitaker, 1994), decreasing high blood pressure (Allen,1999; Brasic, 1998), improving immune system and reducing health problems (Whitaker, 1994), decreasing psychological stress (Katcher, Segal & Beck, 1984), increasing social interactions (McNicholas & Collins, 2000), improving family functioning (Cox, 1993), and decreasing depression and loneliness (e.g., Goldmeier, 1986; Jennings, 1997; Salmon, 1983).

There have been numerous studies that have proposed a connection between pet ownership and improved physical health. Owning a pet can create opportunities for individuals and families to achieve a healthier lifestyle. Pets can improve their owner's psychological health in ways, such as reducing anxiety by acting as a protector and creating a more positive environment (Katcher et al., 1984). Pets can help improve physical health for their owners in ways such as providing a stimulus for exercise (Whitaker, 1996). Whether at a psychological or physical level, pets have been shown to improve their owners' immune system (Whitaker, 1996). Pets have improved their owner's standard of living in ways such as improving their owners' social interactions. Pets have been shown to improve social interactions between the pet owner and a social acquaintance, to family members, by acting as anything from an "ice-breaker" for conversations to an object of responsibility that improves family cohesion (Cox, 1993; McNicholas & Collins, 2000). These are just some of the examples of how pets can improve the physical and psychological health of their owners. The following will examine these benefits as well as Animal-Assisted Therapy (AAT), which makes use of this human/animal bond in the therapeutic setting.

PETS IMPROVE PHYSICAL HEALTH

Exercise

It is surprising that new dog owners may not take a walk for their own health, but they would easily walk their dog for his or her health (Whitaker, 1996). Whitaker (1996) had new dog owners fill out questionnaires before and after getting the new pet dog. "Pet owners reported substantial improvements in their health, sense of security and amount of exercise, compared to those not owning a dog. The average walking time of the new pet owners increased from 1 hour to 4 hours in the first month, and 5 hours in 10 months." Had not been for the needs of their dog, the owners would not have been motivated to take a walk. Taking the walk, or exercise, was a way that their physical health was improved.

Blood Pressure and Anxiety

Companionship can lead to positive feelings of security. Since pets can act as companions for their owners, the effects of the companionship between dogs and their owners were studied. In fact, physiological health benefits, such as a decrease in high blood pressure, can be affected by pet companionship. High blood pressure has become one of the most common health problems in the country today (Allen, 1999). Many medical doctors have turned to drugs to treat the problem yet pet therapy is worth looking into as a cure or at the least part of the cure.

A study found that caring for a dog or cat may act as a cure for high blood pressure. Allen (1999) assessed the effect of social support on heart rate and blood pressure that was due to mental stress in a group of 48 stockbrokers, all of whom were being treated, with an ACE inhibitor used to treat hypertension. Those given a dog or cat, showed more stable cardiovascular readings during stressful situations than in the non-pet-owner group (Allen, 1999).

In another study, blood pressure and heart rate were examined in connection to interactions with a dog. Participants interacted with the experimental dog by: petting the dog, talking to the dog, petting the dog while talking to it, and resting silently in the absence of the dog. Casual conversations between the examiner and the participants took place both in the presence and absence of the dog. Blood pressure was significantly higher during the two conditions of talking with the examiner and was significantly lower during the petting the dog only and resting conditions (Brasic,1998). These results suggest that petting dogs may lower blood pressure. It is also suggests that pets have a definite physiological effect on their humans.

Petting an animal is a rhythmic and repetitive activity. In doing so, a tranquil and almost meditative focus may be achieved. Cardiovascular, behavioral, and psychological indicators of stress have been reduced through animal interactions. For example, focusing on fish in an aquarium was found to be as effective as hypnosis in reducing anxiety in patients awaiting dental surgery (Katcher et al., 1984).

Reduction of Minor Health Problems

Though many studies have examined how pets improve the health of sick people, one study showed that beneficial changes take place even in healthy people who acquire a pet.

Seventy adults acquired a pet (a dog or cat) from a local animal shelter. Participant information regarding physical health before and after acquiring the pets was examined. An astonishing 50% reduction in minor health problems, which ranged from minor back pains to dull headaches, was reported. The new pet owner's minor health problems did benefit from owning a pet (Whitaker, 1996). Whether this health improvement was at a physical or psychological level, it non-the-less, was their health.

PETS IMPROVE PSYCHOLOGICAL HEALTH

Pet owners also benefit psychologically. As the following studies have shown, pet ownership can improve the owner's social health (McNicholas & Collins, 2000), family functioning (Cox, 1993), and loneliness and depression (e.g., Goldmeier, 1986; Jennings, 1997; Salmon, 1983).

Social Health

Mental health refers to the ability to cope with daily life changes and to maintain social interactions without undue emotional or behavioral problems (Jennings, 1997). McNicholas & Collins (2000) found dogs to act as catalysts for social interactions. The basic purpose of this experiment was to measure the effect that dogs have as catalysts for social interactions. Direct observation was used to record the number of human interactions experienced by a dog handler. The dog accompanied the experimenter on a daily routine for 5 days; and for an additional 5 days the dog was not present. The number and type of social interactions were recorded each day. All of the interactions increased while the dog was present. The type of social interactions that increased drastically were those among strangers. All of the interactions increased while the dog was present (McNicholas & Collins, 2000).

These finding suggest that the presence of a dog may cause the dog-walker to be viewed as possessing more positive traits such as friendliness and approachableness. This study lends evidence to suggest that people who have trouble with social interactions in life (which is a major part of mental health as stated above), may be greatly benefited from becoming a dog owner. The results of this study show that the presence of dogs do increase the number of social interactions and, therefore, mental health as well. Such studies show that dogs serve as social companions, as well an aide in human social interactions by providing a common topic conversation and increased views of approachability. Since social contact may improve self-esteem in people, the socializing effects of dog companionship are among the most important indirect benefits for people.

Improved Family Functioning

In another study, a possible relationship was seen between pets and improved family functioning as well as the family's cohesion (cohesion was defined as the emotional connectedness between family members) (Cox, 1993). The purpose of this study was to investigate whether pet attachment was predictive of family functioning. The importance of pets to family functioning was studied.

To test this thesis, a sample of families were chosen to join the study. Questionnaires (the Pet Attachment Scale (PAS) and the Family Adaptability and Cohension Evaluation Scale) were used to collect data on family characteristics, measures of family functioning, and information on pets in the family. It was also noted that the PAS has been found to provide good discrimination between groups who differ on pet attitudes. Evidence was found to support the author's thesis. Pet attachment was found to hold significant accountability for family adaptability and cohesion. Reasons to support these findings included that a family negotiates family roles, rules, and responsibilities around having a pet in the family. Negotiations give the family opportunities for family-level communication and adaptation. These findings did then support a link between pet attachment and family adaptability. Cohesion was measured by "concepts of emotional bonding, boundaries, coalitions, time, space, friends, decision-making, interests, and recreations" (Cox, 1993). Pet attachment and family cohesion may also exhibit a relationship because it is a measure of the emotional bond between a family and its pet.

Cox's (1993) study explored the idea that an animal/human bond is very powerful. How the human/animal bond is supportive in helping families bond and grow needs exploration. In a world today when so many families encounter hardships, if something as simple as welcoming a family pet gives hope to relief, it is worth looking in to.

Treating Depression

It has been proposed that pet ownership may provide a health benefit by decreasing loneliness and depression. In one study, subjects (all of which consisted of elderly people) received parrots and became the primary caregivers for the pets. Participant mental health and social attitudes were assessed prior to the attainment of the pet, and again after 5 months of pet ownership. As pet owners, participants demonstrated improved attitudes toward other people and their own psychological health (Jennings, 1997). Through this study, pet companionship was seen to play a therapeutic role for elderly people. Pets may decrease loneliness and depression by providing companionship.

The results of another study by Salmon (1983), suggested that dogs satisfied more of the needs of widowed, separated, and divorced people than those of people at other stages of life. Many times, the dogs played roles which were more like a friend or a child than that of a pet. This companionship provided greater feelings of safety and a greater opportunity for exercise than it did for people with undisrupted families (Salmon, 1983). A study of elderly women who were living alone or with other people was conducted. Some participants owned pets while some did not. Pets accounted for a greater psychological improvement in those living alone (Goldmeier, 1986). Among women who lived alone, pets accounted for feelings of increased optimism, less agitation, and less loneliness and dissatisfaction. These studies suggest that the importance of the pet's role can increase as the owner's life circumstances require additional companionship.

ANIMAL-ASSISTED THERAPY (AAT)

Animal-Assisted Therapy utilizes the human/animal bond as part of the therapeutic process. The animals and their handlers must be screened, trained, and meet specific criteria. The therapist acts as a guide between the interaction of the patient and animal and also evaluates the

progress of achieving therapy goals (Gammonley et al., 1997). These measures are well worth it when the benefits of AAT are assessed.

Beck and Katcher (1996), suggest that the component of touch (our ability to touch pets and their ability to touch us) gives the relationship between pets and people an intimacy that is unique to AAT. Animals will make for the best listeners. You can be sure that you will not hear any criticisms or judgments from them! You can also be sure that you will have the power to take the conversation where you want it to go. A dog can jump up and lick you and show physical affection. This can result in a feeling of acceptance for the patient that is nearly impossible to attain in any other therapeutic setting. The dog will also let the patient show returned physical affection. A complicated art in therapy is achieving trust and intimacy between the therapist and client. In AAT, physical affection between the patient and animal is a powerful tool in achieving these feelings.

Pets Love Unconditionally

A unique therapeutic technique of pets is that they lack the power of speech and are therefore unable to offer advice, judgment, or criticism. All the while, they are affectionate and empathic, and thus, their friendship can be seen as sincere, reliable, and trustworthy. Friendship with an animal is also free of the emotional threats possible with human friendships (Serpell,1986).

Pet owners share a special bond with their animals and think very highly of them. In order to assess the satisfaction of dog owners with various pet behaviors, Serpell (1983) had dog owners rate both their own pets and a hypothetical "ideal" dog on 22 different behavioral traits. "The traits with the highest ratings between owners included: expressiveness, enjoyment of walks, loyalty/affection, welcoming behavior and attentiveness." These ratings also matched closely with the owners' "ideal" ratings (Serpell, 1983).

Unlike humans, pets love with no strings attached. They love unconditionally. A pet will unquestionably love you, even those times when you don't love yourself. "An 'invisible cord' often seems to connect a dog to its owner" (Serpell, 1986). In fact, dogs are often more loyal and attentive to their owners than their owners are to them. They have the ability to love and prove faithful in sickness and in health. If a pet can be the cause of something even as simple as a smile, the possibilities are endless.

Types of AAT Interactions

Katcher et al. (1984) found that there are various types of animal facilitated therapy just as the patients' reasons for seeking therapy vary. An assortment of animals are also being used in this type of therapy. Animals from the typical dog or cat to horses and dolphins find a place in AAT. Animal facilitated therapy requires knowledge of the bond between animals and humans. This will ensure the most positive results from the interaction. There are four kinds of animal and human interaction. The first is "individual interaction." This occurs when an animal and his or her owner interact on a full-time basis. A seeing-eye dog is an example of individual interaction. A second form is the "part time companion" interaction. This is when the animal interaction does not occur on a full-time basis. An example of this interaction can be seen in elderly homes where a therapy animal visits the residents on a part-time basis to lift emotions and bring companionship. The third type of interaction is known as "group pet." This interaction can be

seen in prisons or mental hospitals where the therapy animal is the pet of the entire group or community. The final interaction form is known as the "living environment" situation. This occurs when there is an interaction between multiple pets and a community (Katcher et al., 1984).

DISCUSSION

Pets appear to improve their owners' mental and physical health. The health benefits of pet ownership have been well documented. Owning a pet may assist with achieving the goals of increased physical and mental health. Pet owners are not the only ones who may reap the benefits of these animal interactions. Even limited contact with these animals can prove beneficial. Animal Assisted Therapy is one the ways in which pet owners may share these benefits with others. Lending one's pet to help in the therapeutic process is important, free, and inexhaustible.

It is reasonable to discuss extending pet ownership with patients in primary care. An underused dog's full potential may be reconsidered (for example, incorporating walking the dog into their daily routine). Paying attention to furry pets through petting may reduce sympathetic arousal and result in decreases in blood pressure (Allen, 1999; Brasic, 1998). Focusing on fish in an aquarium or birds in a cage can award a relaxing and beneficial effect on blood pressure (Katcher et al., 1984). A pet has the ability to increase the individual's social support system and provide increased feelings of self-esteem. Pets possess the gift of decreasing loneliness and providing a stimulus for conversation (McNicholas & Collins, 2000). The health benefits of pet ownership are far reaching: from individuals living in a group home with a pet in residence, elders living in a nursing home, or homebound individuals benefiting from pet visitation (Goldmeier,1986; Jennings, 1997; Salmon, 1983).

A bond of trust and friendship between the owner and pet is attained. Pets hold the ability to provide companionship and promote a more fulfilling lifestyle, both psychologically and physically. Pet ownership goes hand in hand with increased social support (Cox, 1993), which may lead to more successful coping strategies for one's present and future. Pets are accountable for all of these health improvements. These remarkable benefits are unique to pet ownership.

Ironically, a common reason people give for not having pets, having to care for them, is one of the indirect ways pets can improve their owners' health. If a small pet is placed in the lap of a severely arthritic patient, he or she will move to pet the animal. If it had not been for the pet, the patient would not have been motivated to move (Whitaker, 1996). Pets help you to "extend" yourself when you normally wouldn't. Through the endless rewards of pet ownership, before the pet owner realizes it, he or she will have gone from being the care-giver to being at the receiving end of the care.

Implications for Counseling and Counselor Education

Animal-assisted therapy can be beneficial to the counseling process. The presence of the animal can facilitate a trust-building bond between the therapist and client. The animal relieves some tension and anxiety of therapy and interacting with the animal is entertaining and fun. Talking to the animal while the therapist listens is easier than talking to the therapist for the more

difficult issues. In this way, the animal acts as an object to focus on. Also, animals often help clients focus on an issue as they interact with the animal. For children especially, their attention remains unwaivering if they have an object to focus on. Animals actually help a person to focus on a task because of an interest in interacting with the pet. The animal may help the client get in touch with feelings. Sharing these feelings with or about the animal can initiate the emotional sharing process with the therapist. For the client, the animal is seen as a friend and ally, thus presenting a safe atmosphere for sharing. The animal may also alleviate any awkward silences which may make the client feel uncomfortable. The animal offers nurturance through a presentation of unconditional acceptance and interaction. The experience of a client interacting with an animal can provide knowledge about boundaries and limit setting by observing and imitating the therapist-animal interactions (Gammonley et al., 1997).

Animal-assisted therapy is a useful technique that can be easily incorporated into counseling settings. It is possible to incorporate the animal into whatever professional style of therapy the therapist already enacts. Animals do not discriminate. As a result, AAT sessions can be integrated into individual or group therapy and with a very wide range of age groups and persons with varying ability. Animals in counseling sessions help create an atmosphere of trust, nurturance, and relationship building. The therapy animal is a non-judgmental companion in the process of learning and development.

Animals can open a channel of emotionally safe, non-threatening communication between client and therapist. In therapy settings, animals help present an air of emotional safety. If a therapist has an animal in his/her office, the client may view the therapist as less threatening. The animal's presence may open a path through the person's initial resistance. An important part of therapy is building a relationship with the client. The presence of an animal may give this process a greater outcome.

Individuals who have mental illness or low self-esteem focus on themselves. Animals can help them focus on their environment. Rather than thinking and talking about themselves and their problems, they watch and talk to and about the animals. Also, they may feel less self-conscious because some of the therapist’s attention is focused on the animal.

Children see animals as peers. They can identify better with animals than human beings. Animal psychology is very simple. With animals, what you see is what you get. Humans are not as direct. Humans spend much time and frustration trying to read and interpret “body language.” Children can read an animal's body language.

The benefits of the patient-animal interaction is important in counselor education. Sometimes it is easy to get caught up in the idea that all prescriptions must come in a bottle from a pharmacy. Aspiring counselors must realize that there are many prescriptions available that are drug-free. When incorporating pets into the therapeutic setting or home environment, there are no side effects. The benefits are also instant and the patient does not have to incur any withdrawal because, unlike many medications, it is safe to stay a pet owner forever.

As with any therapeutic practice, it is important that the counselor determines if the intervention is suitable for the client. If any phobias towards animals exist, then obviously another form of therapy should be used. Eventually though, at the client and counselor’s discretion, animals could be brought into therapy to confront the phobia and educate the client about the animal(s).

Future Research

This area of research is still new and additional studies need to be completed to grasp a better understanding of exactly how pets promote health. An interesting study would be on whether pets release any type of chemical that is responsible for a decrease of anxiety and depression in humans. Obviously, animals have ways of giving off warning signs or signals of threat to other animals when in conflict, so it wouldn't be so far *fetch*ed (no pun intended) to think that when animals are in a peaceful mood that they could send out anxiety reducing signals (such as pheromones, for instance).

It would be interesting to see if animal therapy is especially beneficial for deaf or mute patients. While these patients do not possess the senses of sight or hearing, their sense of touch may be stronger. In the case of say, petting a dog in therapy, would these patients especially benefit from the experience? An animal in the therapeutic setting could open up a whole new level of therapy between the counselor and client, through the sense of touch.

Farther research could be applied to answer the question of if all pets produce health benefits. And if so, are some pets more beneficial than others? This research would be important because it would help counselors and Animal Assisted Therapy programs better understand what animals will produce the greatest outcomes for patients.
Also, some people are allergic to animals with fur. Therefore, research should be done to see if hypoallergenic pets, such as turtles and fish, prove as beneficial as other pets.

The question also remains as to if a person can benefit from some, if not all, of the pet therapy benefits if the pet itself is not present. For example, can a child in therapy be comforted by stuffed animals just as he or she would have been, had a real pet been present? Is it possible that the patient will be able to project his or her feelings of pets onto the stuffed animals? This question is important for both people who are allergic to animals as well as counselors who cannot have actual pets in the therapeutic setting. All of these areas of the pet and health phenomena warrant farther research so that counselors may make use of this intervention's full potential.

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Children of Alcoholics: Breaking the Silence

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As a group, children of alcoholics (COAs) have only recently begun to receive increasing attention from counseling professionals. Lack of information available to the professional community has often previously resulted in COAs being misunderstood and misdiagnosed. COAs are at risk for a host of emotional, physical, developmental, and social problems. They also endure a destructive family environment characterized by conflict and other negative factors. The purpose of this paper is to educate counselors about special concerns and issues facing this population. Recommendations are discussed for helping these children to develop and maintain a healthy lifestyle and cope with their disruptive family life.

Alcohol abuse and alcohol dependence are the two most prevalent and deleterious psychiatric disorders not only in the United States, but in the world. Beyond the enormous, devastating effects on both these individuals and society, immediate family members, particularly children, suffer the burdens inflicted by such disorders. Approximately 1 in 4 children younger than 18 years in the United States is exposed to alcohol abuse or alcohol dependency in the family (Grant, 2000). Obviously, this is a serious problem today affecting our young children. Indicating the scope of the problem, studies report that between 7 and 28 million children of alcoholics (COAs) reside in the United States and between 16 and 24 percent of children of elementary school age are from alcoholic families (Wallace, 1987, as cited in El-Sheikh & Cummings, 1997).

Since the turn of the century, many reports have described the harmful influence of parental alcoholism on children and the vast literature on children of alcoholics far outweighs the literature on children of any other drug abusers (Johnson & Leff, 1999). Understanding the effects of parental alcoholism on children is of interest to both practitioners and researchers concerned with family functioning. Relations between parental alcoholism and a wide range of childhood problems have been documented (e.g., Wallace, 1987; West & Prinz, 1987, as cited in El-Sheikh & Cummings, 1997). More than 20 years ago, researchers specifically started noticing that children of alcoholics appeared to be affected by a variety of problems over the course of their life span ("Children of Alcoholics," 1997). In the 1970s and 1980s, the clinical and popular literature began painting a bleak picture of children of alcoholics, one of general mal-adaptation and psychosocial impairment (Sher, 1991, as cited in Walker & Lee, 1998). However, since that time, research has advanced on several fronts and has helped to clarify the nature and extent of problems COAs face as well as the numerous variables that must be considered when attempting to make generalizations about this group (e.g., Sher, 1991; Windle & Searles, 1990, as cited in Sher, 1997).

Researchers on COAs have disagreed over the years on how to approach the study in this field. However, overall, the research acknowledges how difficult it is to make valid generalizations because alcoholics do not represent a homogeneous class of people and considerable variability exists in the characteristics of families (e.g., Johnson & Leff, 1999; Sher,

1997). Additionally, many methodological complexities exist, including the way in which alcoholism is measured in the parent(s), how extensively alcoholism is assessed in other family members, whether parental alcoholism is active or in recovery, the way in which subjects are sampled and ascertained, the sex of the alcoholic parent, and the age and sex of the child. Other factors taken into consideration are age of onset, drinking pattern, severity of dependence, personality traits and family history of alcoholism (Sher, 1997). In 1974, Anthony suggested the possibility that there were different groups of children of substance abusers and that all children of substance abusers could not be considered a single, unitary entity. Similar experiences affect children differently because of individual differences in factors such as temperament, intelligence, and environmental resources (Johnson & Leff, 1999). Although all of these factors influence the data collected on COAs and there is probably no single profile of children of substance abusers, it does not imply that COAs do not endure a host of problems throughout their childhood and adulthood.

Many biological, psychological, developmental, and social risk factors stem from a family with a history of alcoholism. These children are subjected to an extremely disorganized environment, negligent and abusive rearing, economic hardship, and social isolation that accompany attempts to hide the disorder from friends, relatives and others (Grant, 2000). Because substance abuse disrupts families, children are placed in the middle of an unhealthy and unnatural situation. Many children of alcoholics learn to be silent and therefore hidden from discovery. The effects on these youngsters can be devastating. Their feelings, personalities, and social behaviors are affected by this reality more than any other (NIAAA, 1985, as cited in O'Rourke, 1992). Moreover, since only 1 alcoholic in 35 gets help, there is a high likelihood that these children will deal with parental alcoholism for years to come (Martin, 1972, as cited in O'Rourke, 1992). Therefore, it is essential that counselors learn more about this population.

The purpose of this paper is to educate counselors about the various factors influencing children of alcoholics. Risk factors, including vulnerability to alcoholism, emulation of the drinker, and co-dependency are discussed, as well as emotional/behavioral and physical problems. Special attention is given to the family environment in which these children live. Family conflict, abuse and neglect, role reversal and parentification, inconsistent discipline/inadequate structure, lack of trust/isolation, and distortion of reality and self-blame are addressed. Furthermore, the roles adopted by these children are reviewed: the hero, the scapegoat, the adjustor, the caretaker, and the clown. Recommendations for counseling these individuals are discussed as well as the need for further research in this field.

THE AT-RISK CHILD

A person who is addicted to something is, by definition, constantly preoccupied with a task more intense than life's daily activities. An individual who abuses alcohol is constantly preoccupied with alcohol and this obsession interferes with daily living. The search for chemical satisfaction is all-consuming (Feaster, 1996). Children become especially susceptible to these conditions because they depend on their parents for everything, and when a parent is preoccupied with alcohol, children often are not the top priority. When a parent is an alcohol abuser, the parent is neglectful of basic childhood needs: security, nurturing and a healthy environment (Jones & Houts, 1992, as cited in Feaster, 1996). This type of environment paints a clear picture for anticipated problems and future tribulations for this population of children.

Children of alcoholics are therefore considered "at risk." Children may be labeled "at risk" for many reasons. These "risk factors" are presumed to increase the likelihood of future maladaptation and can be environmental, biological, or psychological. Children of alcoholic parents are especially vulnerable to the risk for maladaptive behavior because they have a combination of many risk factors in their lives. The single, most potent risk factor is their parent's substance abusing behavior (Johnson & Leff, 1999).

Vulnerability to Alcoholism

One of the most commonly cited risks for COAs is the development of problems with alcohol and drugs later in life (Walker & Lee, 1998). Children of alcoholics are at substantially increased risk for becoming alcoholic themselves, which appears to be a function of both genetic and environmental factors (Heath, 1995, as cited in Sher, 1997). There is strong, scientific evidence that alcoholism tends to run in families. It has been estimated that up to 60% of children of alcoholics eventually fall into chemical abuse. Alcoholics are more likely than non-alcoholics to have an alcoholic father, mother, sibling or other relative (U.S. Department of Health and Human Resources, 1991). In fact, COAs are considered to be at high risk for developing alcoholism compared to randomly selected children from the same community (Johnson & Leff, 1999). COAs are as much as 2 to 10 times more likely to develop alcoholism than non-COAs. Alcoholic fathers tend to increase the risk for alcoholism in both sons and daughters, whereas the risk associated with maternal alcoholism seems to be more limited to daughters (Pollock, Schneider, Gabrielli, & Goodwin, 1987, as cited in Sher, 1997).

Problem-drinking parents may provide lower levels of parental nurturing and emotional availability, thereby increasing the risk for adolescent drinking. Without the emotional support on which these children depend, it is difficult for them to make the distinction between good and bad choices when it comes to alcohol. In addition, these parents frequently demonstrate a greater tolerance of their children's drinking and other substance use. In this way, they provide implicit approval for their children's alcohol use. Research has consistently found that higher levels of parental tolerance of adolescent drinking are associated with an earlier onset of drinking among offspring as well as with the escalation to higher levels of alcohol use (Windle, 1996).

Parental alcohol abuse may also contribute to poorer monitoring of children's behaviors and activities. The research has consistently shown that higher levels of parental monitoring are associated with lower levels of adolescent alcohol use as well as other forms of delinquent behavior. Furthermore, studies have indicated that higher levels of parental monitoring increase the likelihood that children will select fewer peers who use alcohol or other illicit substances (Dishion & Loeber, 1985, as cited in Windle, 1996). Unfortunately, COAs do not benefit from adequate parental monitoring, so they tend to have higher levels of alcohol use and are more apt to choose friends who use alcohol. In fact, as a group, they are more likely to engage in risky behavior and make unhealthy choices. Because monitoring is decreased in the homes of alcoholics, parental drinking undermines healthy childhood and adolescent adjustment (Windle, 1996).

COAs do not necessarily develop substance abuse problems, however. Many actually demonstrate low levels of alcohol use or abstain altogether. This may be that they fear they will become alcoholics themselves, or because they have seen the negative consequences of their parents drinking (Harburg, DiFranceisco, Webster, Gleiberman, & Schork, 1990, as cited in Walker & Lee, 1998). This would explain why most children of alcoholics do not become

alcoholics and instead, become moderate drinkers (Fingarette, 1988, as cited in Ullman & Orenstein, 1994). COAs like this who seem to be well adjusted may have benefited from a supportive non-using parent. Studies show that supportive parent-child relationships decreased the incidence of COA substance abuse. In fact, secure relationships with non-substance abusing, emotionally stable parents, with conventional attitudes and beliefs, appear to be among the most powerful influences preventing future substance abuse and alcoholism in children of alcoholics (e.g., Birke, 1993; Ullman & Orenstein, 1994; Walker & Lee, 1998).

Emulation of the Drinker

From a review of recent literature, support was found for the hypothesis that the power of an alcoholic parent within a household is related to whether offspring abuse alcohol later in life. Children are more likely to emulate and identify with a powerful alcoholic parent and through these processes, learn that alcohol can make them feel powerful. Assuming that decision making in the alcoholic family is usually unpredictable and erratic, children often begin to feel a sense of powerlessness. Many times, the non-alcoholic parent is so wrapped up in reacting to the needs of the alcoholic that he/she cannot provide a stable environment and is unresponsive to the children's needs. At the same time, these children have a model whose needs for attention and support do get met—the alcoholic (Ullman & Orenstein, 1993). It is easy to see how children can develop the notion that drinking enhances one's ability to get what he/she wants. Children can also grow up under the false pretense that drinking alcohol is an effective way to deal with life's stressful events (Windle, 1996). COAs begin to learn that such behavior is the only way to confront difficult or distressing circumstances.

Some researchers have suggested that many children are simply imitating their parents' behavior by drinking. Interestingly, long before children ever take their first drink, they have seen how to behave when intoxicated (Ullman & Orenstein, 1994). Studies show that higher levels of parental alcohol use are associated with the earlier acquisition and elaboration of knowledge about alcohol use by children as young as preschool age (Dishion & Loeber, 1985, as cited in Windle, 1996). A recent study demonstrated that the younger the child during the alcohol disturbance, the more severe the resulting effects. Even children under the age of 5 recognize different shapes of bottles and associate feelings about the contents (Reily, 1981, as cited in O'Rourke, 1992). Thus, drinking is a learned solution that is adopted at young ages. This is consistent with findings that a desire to feel powerful is an important motivation for both drinking and excessive drinking (McClelland, Davis, Kalin, & Wanner, 1972, as cited in Ullman & Orenstein, 1994).

It is important here to note that exposure to an alcoholic family does not imply causation that children will become alcoholics. In fact, no matter how strongly offspring identify with the drinker, they are likely to be ambivalent and anxious about their own use of alcohol. They have been subjected to the capricious changes that alcohol can produce and have learned to view it as an extremely powerful substance (Ullman & Orenstein, 1994). The fact is obvious, however, that these children are predisposed and exposed to alcohol more so than children with non-alcoholic parents.

Co-dependency

Perhaps the most popular concept to emerge from the COA literature is that of co-dependency. It was first described as a "disease" of "compulsive caretaking" found in spouses of alcoholics (Gordon & Barrett, 1993, as cited in Sher, 1997). A more recent definition has broadened the scope to all members associated with the alcoholic. Co-dependency is a modern word meaning "co-alcoholism." It describes a family member's submissive, compliant or reactive response to an alcoholic. Although a number of alternative conceptualizations of co-dependency can be found, Wright and Wright (1991, as cited in Sher, 1997) note that the most popular notion of co-dependency is as a personality syndrome composed of denial, constriction of emotions, depression, hypervigilance, compulsions, and a number of other characteristics. In any sense, co-dependency takes on a form of its own and consumes the life of the co-dependant.

The co-alcoholic often organizes life around the alcoholic and becomes absorbed in trying to make things "right" (Birke, 1993). This misconception is centered around the idea that if someone you love has a chemical abuse problem, then you also have the problem. Frequently, the spouse assumes the co-dependent role and is unable to separate his/her own behavior from that of the abuser. This can have a detrimental affect on the children in these families as they quickly loose the ability to distinguish what is real and what is not. In addition, children witness no clear delineation of personal boundaries or healthy role modeling of partner responsibility (Feaster, 1996). When the non-alcoholic parent is in the co-dependant role, he/she can ironically prevent a child from being helped. Denial of the drinking problem and attempts to conceal family problems frequently prevent the non-alcoholic adult from seeking outside assistance (NIAAA, 1985, as cited in O'Rourke, 1992). Consequently, children in this case often unfortunately do not receive the help they need.

Emotional/Behavioral Problems

Research shows that COAs have more adjustment problems in home, health, social and emotional domains (Kondandaram, 1995, as cited in Johnson & Leff, 1999). These problems stem from an unhealthy environment in which the child has no choice but to take part. Therefore, COAs do not benefit from healthy development and this affects many aspects of their lives. The U.S. Department of Heath and Human Services (1991) describe this situation:

> Healthy development requires mastering emotional and social tasks at various ages throughout childhood. These tasks include learning how to share, to interact, to engage in problem solving, and to separate from parents. These skills are accomplished though play and fun activities, exposure to recreational and cultural opportunities, and building peer relationships. COA's may be hampered by their in ability to grow in developmentally healthy ways. (p. 2)

Because children do not grow in developmentally healthy ways, they are at risk for a variety of emotional problems including depression, low self-esteem, high anxiety, as well as other psychological disorders in both childhood and adulthood (e.g., Feaster, 1996; Johnson & Leff, 1999; Post & Robinson, 1998).

Evidence suggests that COAs have greater difficulty than non-COAs with identifying emotions and expressing emotions appropriately. This difficulty leads to the use of aggressive coping strategies toward others. In fact, the personality category that appears to be most

associated with being a COA is that of impulsivity/disinhibition, which encompasses traits such as sensation seeking, aggressiveness, and impulsivity (Phil, Peterson, & Finn, 1990; Sher, 1991; Windle, 1990, as cited in Sher, 1997). Earls and colleagues (1988, as cited in Johnson & Leff, 1999) reported recently on the frequency of psychopathology in COAs. His results found that children ages 6 through 17 years of age were diagnosed more frequently with a behavioral disorder, an attention-deficit disorder with hyperactivity, and oppositional disorder, or a conduct disorder.

Researchers have identified two broad classes of psychopathological symptoms in childhood: internalizing and externalizing behaviors. These two categories are used to help identify COAs from other children. Externalizing behaviors primarily encompass "acting out" types of behaviors, characterized by rule breaking, defiance, aggression, and inattention (Sher, 1997). When a child externalizes his/her behavior, he/she may have problems both controlling and managing anger. This may be a result of the fact that COAs have not seen effective coping strategies used by their parents. Therefore, they are not aware of ways to express their emotions in healthy, normal ways. Internalizing behavior leads to depression and anxiety due to difficulty describing and expressing feelings (El-Sheikh & Cummings, 1997). Both of these behaviors are the result of a combination of factors that affect COAs in their daily living.

Other research shows that children of alcoholics tend to have a lack of awareness of the perceived impression of one's behavior on others, lack of insight into personal relations, and lack of empathy for other persons (Jones, 1968, as cited in Johnson & Leff, 1999). This finding is consistent with the fact that COAs not only have little to no control over their environment, but that they also have not been provided with the emotional support and safety that they so desperately need. To illustrate this point further, Black (1981, as cited in O'Rourke, 1992) states, "For children who seldom experience any feeling of extended security, home can be a battlefield. Communication barriers are eventually erected as defense against potentially dangerous people and events. Feelings, mostly negative, are systematically repressed" (pp. 45). This quote truly shows the nature of the environment and the lack of opportunity for emotional growth and well being in the home of the alcoholic. Unfortunately, the negative consequences on the children in these households begin to seep outside of the home and affect the interpersonal relationships that COAs have such a hard time creating and maintaining.

Physical Problems

More recent research has examined the medical and physical health problems in children of substance-abusing parents. Woodside and associates (1993, as cited in Johnson & Leff, 1999) found that COAs spent more days in the hospital, incurred greater hospital charges, and were more susceptible to specific illnesses such as mental illness, injuries and poisonings. Children also have problems as a result of the stress of living with the alcoholic parent. Their ailments ranged from abdominal pain, headaches, tiredness, sleep problems, tics, enuresis, and nausea even though no physical causes for such complaints can be found in these children (Nylander, 1975, as cited in Post & Robinson, 1998). In addition to these complaints, children of alcoholics are more prone to migraine and asthma (Moss & Billings, 1982, as cited in Post & Robinson, 1998). They are more likely to have allergies, anemia, frequent colds or coughs, ulcers, and to be overweight or underweight (Black, 1986, as cited in Wilson & Blocher, 1990).

Because of the alcoholic's inability to take proper care of children, COAs suffer physical problems that they would not otherwise have to endure. Younger children (12 and under) who

must care for themselves are affected the most. Research suggests that during infancy and early childhood, children of alcoholics have more serious accidents and serious illnesses than children from non-drinking homes (Chafetz, Blane & Hill, 1971, as cited in O'Rourke, 1992). The lack of supervision, coupled with an unstable and unpredictable environment, leaves these children of alcoholics with the propensity for physical complaints, illnesses and diseases.

FAMILY ENVIRONMENT

COAs can be described as victims of an alcoholic family environment characterized by disruption, deviant parental role models, inadequate parenting, and disturbed parent-child relationships. These family related variables are thought to undermine normal psychological development and to cause distress and impaired interpersonal functioning, both acutely and chronically (Sher, 1997). Youngsters growing up in a home where alcoholism becomes a central dynamic in the family are often subjected to daily tension and pressure. In fact, life with an alcoholic parent is described by Schall (1986, as cited by Wilson & Post, 1990) as "the most widespread cause of severe stress for school-age children in the United States today" (pp. 98). Alcoholic families are less cohesive, less organized, less oriented toward intellectual or cultural pursuits, and more conflict-ridden (Clair & Genest, 1987, as cited in Post & Robinson, 1998). These types of conditions are certainly do not promote normal child development and general well being. Constant chaos, fighting, and confusion place little children in the alcoholic home in particularly frightening and fragile positions (O'Rourke, 1992).

Often times children find themselves in situations in which they are not prepared to be and are unable to make sense of the confusion, chaos and unpredictable conditions that surround them. Daily life is often organized around the drinking, all members waiting apprehensively for the next drinking episode to begin, and with children being told what to do or not to do in order to influence or control the drinking (Ullman & Orenstein, 1994). This situation creates undue stress and emotional strain on young children. It is easy to see how living with an alcoholic in the family can contribute to stress for all members in the family.

Family Conflict

Alcoholism does affect the *entire* family. All of these children protect a common family secret. Their parents are the victims of a progressive, "equal opportunity" and sometimes fatal disease, alcoholism (O'Rourke, 1992). Alcoholism disturbs family functioning through sabotaging mother-father, father-child and mother-child relationships (Hyphantis, Koutras, Liakos, & Marselos, 1991, as cited El-Sheikh & Cummings, 1997). For every alcoholic, it is estimated that 4 to 5 family members and friends totaling 35 to 45 million persons, are directly affected by this disease (Wilson & Blocher, 1990). Studies show that children living in families with an alcoholic score lower on measures of family cohesion, intellectual-cultural orientation, active-recreational orientation, and independence (Filstead, McElfresh, & Anderson, 1982, as cited in U.S. Department of Health and Human Resources, 1991). These statistics prove how family conflict can truly alter a child's perception of the world.

Higher levels of alcohol use by parents have been associated with higher levels of marital conflict as well (e.g., Leonard, 1993; Reich, Earls, & Powell, 1988, as cited in Windle, 1996). COAs site parental quarreling and arguing as their chief concerns during childhood and worry

about their home remaining in tact (Cork, 1969, as cited in Wilson & Blocher, 1990). In fact, 85 percent of COAs stated that parental quarrels were their major cause of distress, while only 6 percent reported that parental drinking was the most troublesome (Cork, 1969, as cited in El-Sheikh & Cummings, 1997). Inter-adult arguments have been repeatedly found to evoke children's sadness, fear, anger and aggression (e.g., Cummings, Ballard, El-Sheikh, & Lake, 1991; Grych & Fincham, 1993; Hennessy, Rabideau, Cicchetti, & Cummings, 1994, as cited in El-Sheikh & Cummings, 1998). Frequent exposure to both inter-parental conflict and parental drinking problems have been related also to higher levels of depression and anxiety as well. This may be because COAs report higher levels of experienced sadness in response to their parents' fighting, which can be linked to their feelings of depression and problems with affect regulation (Blakeman, 1996, as cited in El-Sheikh & Cummings, 1998).

Children suffer from seeing their parents fighting and family relations can be seriously altered. One way is through the trauma of a divorce. In fact, divorces occur much more frequently in families in which one or both spouses have a drinking problem than in non-alcoholic families. Another is through the spread of tension to other familial relationships, resulting in disharmony and dissention among siblings as well. Finally, children may not be able to complete daily activities such as homework, eating dinner, watching television or sleeping as a result of fighting in the family (Wilson & Blocher, 1990).

Abuse and Neglect

With respect to the overall negative impact of parental drinking, family violence has been one area that has received considerable attention (Johnson & Leff, 1999). Based on clinical observations and research, a relationship between parental alcoholism and child abuse is indicated in a large proportion of child abuse cases. Some reports allege that alcoholism is involved in as many as 90% of all child-abuse cases (Naiditch & Lerner, 1987, as cited in Wilson & Blocher, 1990). In addition, alcoholism is more strongly related to child abuse than are other disorders such as parental depression (Famularo, Stone, Barnum, & Wharton, 1985, as cited in U.S. Department of Health and Human Services, 1991). COAs, as compared with other children, are more apt to be growing up in a home in which there is physical abuse and are twice as likely to be the victims of incest (Black, 1986, as cited in Wilson & Blocher, 1990). In addition to this violence, verbal abuse and aggressive arguments are common in alcoholic families (Nardi, 1981, as cited in Ullman & Orenstein, 1994). COAs not only frequently witness violent scenes between their parents, but they are sometimes forced to share in them. Conflicts occur, as in any home, but the nature, frequency and method of handling these conflicts are different in homes of alcoholics (Glover, 1994).

Since sober partners are often preoccupied and overwhelmed with their own problems, children seldom receive support or nurturing within the home either. Even the least severe forms of chemical dependency result in some degree of emotional or physical neglect (Fox, 1963, as cited in O'Rourke, 1992). In concurrence with this, Windle (1996) asserts, "Heavy alcohol use is an all-too-common factor in the intergenerational transmission of violence, such that alcohol-and-violence begets alcohol-and-violence" (pp. 183). This quote suggests that not only do COAs suffer the affects of living with an alcoholic, but that generations for years to come will experience the evils of alcoholism as well.

Children of alcoholics are also frequently victims of child neglect. Their emotional needs are ignored and their feelings many times go unacknowledged (Booze-Allen & Hamilton, 1974,

as cited in Wilson & Blocher, 1990). Often times, they are trapped in the middle of a horrendous situation and have nowhere to turn. As Estes and Heinemann (1977, as cited in Wilson & Blocher, 1990) have noted, "Children living in alcoholic families often feel their own needs are of little importance. The fact that the neglect is not willful does not lessen the devastation these little children feel" (pp. 99). This powerful statement truly shows the nature of the life of a COA: one corrupted and shattered by the impact of alcoholism.

Role Reversal and Parentification

Children from an alcoholic home tend to be ambivalent toward parents as role models because they are often inconsistent and often contradictory. These children are forced to play inappropriate roles to meet parental needs—roles that children in nonalcoholic homes do not play (Cook, 1987, as cited in Glover, 1994). Research has confirmed the clinical speculation of parent-child role-reversals in families with alcoholic parents (Goglia, Jurkovic, Burt & Burge-Callaway, 1992, as cited in Walker & Lee, 1998). Children are often forced to assume a care-taking role for themselves, younger children, and even for the parents (Feaster, 1996). This situation places children in developmentally inappropriate roles and leads to confusion and lack of knowledge about appropriate behavior.

There may also be role reversal within the family because the alcoholic parent is too erratic to play a role in everyday decision- making (Ullman & Orenstein, 1994). This competition for the scarce source of adult attention can lead to a role reversal and children taking on the role of an adult. Children in chemically abusive homes can be found assuming roles that are very adult in nature such as preparing dinner, deciding on a younger sibling's bedtime, or caring for a parent who is passed out after a drinking binge (Feaster, 1996). COAs deny their own needs by prematurely assuming adult roles and are often put in the delicate position of a confidant, listening to details of a parent's problem or complaints about the other parent (National Institute on Alcohol Abuse and Alcoholism, 1984, as cited in Wilson & Blocher, 1990). In essence, this phenomenon robs children of their childhood because basically they are not in a position to enjoy one. Children in these high-stress alcoholic environments are constantly subject to the tensions created in these families and have no choice but to fill a void by taking on primarily adult responsibilities.

Inconsistent Discipline/Inadequate Structure

Problem drinking by parents may negatively influence parenting skills that serve to nurture and provide guidance for children (Windle, 1996). The environment of COAs has been characterized by a lack of parenting, poor home management, and a lack of family communication skills, thereby robbing COAs of modeling or training on parenting skills or family effectiveness (Patterson & Stouthamer-Loeber, 1984, as cited in Johnson & Leff, 1999). Children are particularly susceptible to these chaotic conditions surrounding them. Because of their physical and psychological chemical addition, parents' moods may be unpredictable, they fail to assert consistent discipline, and they are less able to console and comfort young children (Woititz, 1985, as cited in Feaster, 1996). Preoccupation with chemical addiction causes the continual failure of family communication and positive socialization systems as it takes precedence over child rearing (Schaefer, 1987, as cited in Feaster, 1996).

Children in alcoholic families suffer when either parent is the alcoholic. For example, the child-rearing practices of alcoholic fathers, compared to nonalcoholic fathers, are more likely to include ridicule, rejection, harshness, and neglect (Udayakumar, Mohan, Shariff, Sekar & Eswari, 1984, as cited in Post & Robinson, 1998). The attitudes of alcoholic mothers, compared to non-alcoholic mothers, tend to be less accepting, more rejecting, disciplinarian, or overprotecting, and they have a significantly greater degree of conflicting attitudes (Krauthamer, 1979, as cited in Post & Robinson, 1998). The behavior of either or both parents is usually unpredictable. Children are erratically disciplined and are provided with few concrete limits and guidelines for behavior. At times, children may receive little or no attention and may be allowed to do as they please. Then, unexpectedly, there may be periods of strict supervision and severe discipline (Wilson & Blocher, 1990). The confusion and inner turmoil COAs deal with in the home environment is obvious. Black (1984, as cited in Wilson & Blocher, 1990) described the situation by saying, "Children in these homes are always off balance, never knowing how the parent will behave and what will be expected" (pp. 99).

Perhaps the greatest effect of parental alcoholism is that consistency all but disappears. The alcoholic parent's behavior may shift from maudlin to silent to verbally, physically, or sexually abusive. An undercurrent of fear or anxiety many become a constant (Birke, 1993). A child's need to find structure amid such chaos may result in an exaggerated need to control the environment. For example, temper tantrums, verbal outbursts, or illnesses often elicit predictable responses from adults. In family cases, the parental responses, whether positive (expressions of caring and nurturing) or negative (shouting at or hitting the child), provide the missing environmental structure, and, thus, the child is in control. The attempts by the child to control the environment have thus been reinforced, and the negative cycle continues in a downward spiral (Feaster, 1996).

Such inconsistency in parenting may undermine a child's sense of order, control, and stability in the family environment, reducing both feelings of self-esteem and perceptions of self-competence (Downey & Coyne, 1990, as cited in Windle, 1996). COAs often live a life of double standards and unrealistic expectations. For example, even though substance-abusing parents lack the ability to provide structure and discipline in family life, they simultaneously expect their children to be competent in a wide variety of tasks earlier than non-substance-abusing parents. Unable to do everything perfectly all of the time, these children come to view themselves as failures (Johnson & Leff, 1999). Children raised in alcoholic homes have little sense of power over their own lives as a result. Correspondingly, they rarely ever learn the combination of communication and assertiveness necessary to mold healthy, adult personalities (Barnes, 1977, as cited in O'Rourke, 1992).

Lack of Trust/Isolation

Trust means, "a firm belief in the honesty, reliability, etc., of another; and the responsibility resulting from it" (Merriam-Webster, 1990, as cited in Feaster, 1996). It is important to examine the development of trust in children of chemical-abusing parents because the ability to trust others is the key to healthy relationships. Without trust, no relationship—child-child or adult-child can survive. Trust is learned and becomes permanent in children when they can rely on parents to respond consistently. When reasonable limits are set and consistently reinforced for children, they can develop security and trust in that environment. In turn, personal boundaries and the trust that develops allow children to experiment with their own capabilities in

the relative safety of the family. In the absence of healthy family relationships, a child cannot develop a sense of trust (Feaster, 1996).

Since not much in the alcoholic home is done conventionally, children learn not to trust the adults in their lives. Buffeted by strings of broken promises, disappointments and outright lies, children are conditioned to doubt their own perceptions: first they learn not to trust others; eventually they learn not to trust themselves either (O'Rourke, 1992). Craig (1993, as cited in Feaster, 1996) illustrates the impact of chemical abuse on families by stating three rules that young children in chemically abusing families learn early: "Don't trust. Don't think. Don't feel" (pp. 156). In addition, COAs may grow up not able to trust the accuracy of what they see, hear and feel (Birke, 1993). This inability to trust influences other relationships (i.e., with teachers and friends) that the child is expected to develop (Feaster, 1996). Thus, being reared in a family characterized by parental drinking problems increases the risk for problems in children's interpersonal functioning relationships, including greater emotional insecurity of relationships with parents, friends, and others (El-Sheikh & Cummings, 1997). Therefore, it is more difficult for COAs than other children to develop and maintain healthy relationships with others.

Because COAs cannot depend on their parents for consistency and stability, they do not receive the emotional support to deal with problems and issues as they occur during childhood. Normally, children depend on their parents for encouragement and support until the age when children assume greater responsibility for themselves. However, research indicates that COAs are rarely, if ever, exposed to nurturing and supportive human interactions that lead to taking responsibility (e.g., Craig, 1993; Joanning, Quinn, Thomas & Mullen, 1992; Jones & Houts, 1992, Turner, Cutter, Woroec, O'Farrell, Bayog, & Tsuang, 1993, as cited in Feaster, 1996). Parents who abuse alcohol typically provide less nurturance to their offspring. They are often "emotionally unavailable" as a result of drinking-related consequences, which include hangovers, irritability, and negative mood swings. These consequences disrupt healthy emotional development in children (Windle, 1996).

Children of alcoholics also lack the emotional support to develop an accurate self-perception. For example, having never been given top priority, they do not give themselves top priority, and they subsequently act upon these perceptions as if they were valid. The child's inaccurate understanding of his/her own abilities and contributions result in a lack of trust that many COAs experience. Combined with a devalued self-perception, the lack of trust becomes a poor foundation for growth and maturity (Feaster, 1996).

Children who are without other means of emotional support from anyone else in their lives must deal with their emotions alone. In fact, feelings of isolation and loneliness are extremely common feelings among COA youngsters (O'Rourke, 1992). The family rules of "don't talk about alcoholism," "don't confront the drinking behavior," and "protect and shelter the alcoholic so things don't get worse" serve to isolate members of the family from one another (Worden, 1984, as cited in Wilson & Blocher, 1990). These destructive and stressful patterns of familial interaction can continue operating for years, leaving every member in the alcoholic family "emotionally drained" and their personal serenity "lost to worry and fear" (Neikirk, 1984, as cited in Wilson & Blocher, 1990).

Embarrassment over home situations often leads young children of alcoholics to withdraw from peers and other close relationships. The embarrassment and shame, coupled with the need to maintain the alcoholism as a closely guarded family secret, isolate family members from the community as well. As a direct result, COAs are often reluctant to bring friends home, avoid activities that involve the alcoholic parent, and usually don't confide their problems in

others (Cork, 1969, as cited in Wilson & Blocher, 1990). They become, as Stark (1987, as cited in Wilson & Blocher, 1990) suggested, "co-conspirators in a pact of silence" (pp. 101). Left alone with nowhere to turn within the family or outside the family, these feelings of isolation and loneliness may continue forever.

Self-Blame/Denial of Reality

Denial strategies are used in alcoholic families. Alcoholism itself is characterized by denial and blame. It's no surprise that spouses and/or children of alcoholics believe the alcoholism is their fault (Birke, 1993). Parents and siblings often perpetuate the myth that everything is fine, despite a home atmosphere of "hopelessness and depression" (Musello, 1984, as cited in Wilson & Blocher, 1990). Sexias, (1977, as cited in Wilson & Blocher, 1990) wrote, "The denial system omnipresent in the alcoholic…is just as blatant in the alcoholic family, creating an atmosphere of lies in which the child is forced to conspire" (pp. 99). Consequently, the child may be prevented from taking part in the real world. When entire families organize around the behavior of an alcoholic, individuals are continually kept off balance anticipating drinking behaviors, which are entirely unpredictable anyway (Wilson & Blocher, 1990).

Denial, as well as shame, inconsistency, anger, hatred, guilt and blame are all primary activators in the alcoholic home (Glover, 1994). Family members may attribute drunken behavior to someone other than the alcoholic or encourage children to believe that they can control the parent's drinking through their behavior (Soyster, 1984, as cited in Wilson & Blocher, 1990). Children often worry when they are away from home about the safety of the drinker and many are angry at some level that the sober parent cannot make things better. Compounding feelings of guilt, worry and anger is a deep sense of shame (O'Rourke, 1992). The child's sense of reality is turned upside down in a sense. The young child may even view the alcoholic parent as two different people, one good and one bad (Richards, 1980, as cited in Wilson & Blocher, 1990).

COAs have greater problems regulating their emotional arousal and responding effectively and appropriately to stressful family situations (El-Sheikh & Cummings, 1997). The denial system in the alcoholic family makes it difficult for the child to determine the parameters of reality and to mature as a person who can give and receive love and who can trust (Sexias, 1977, as cited in Wilson & Blocher, 1990). The popular literature on COAs is consistent with this fact as it contends that COAs take too much responsibility for other's problems and often intervene in disputes to mediate the arguments or to triangulate and form alliances with one parent against the other (e.g., Hanson & Liber, 1989; Wilson & Oxford, 1978, as cited in El-Sheikh & Cummings, 1997). Taking on too much responsibility, along with absorbing the blame of alcoholism, results in an increase in internalizing behaviors for these children, especially in females (Cummings, Davies, & Simpson, 1994, as cited in El-Sheikh & Cummings, 1997).

ROLES ADAPTED BY COA'S

Most COAs appear normal, competent, and capable. Behind the mask, however, lives a child who is frightened, ashamed, confused and lonely. All children adopt strategies for living in their families. Particular personality traits develop early and become part of a child's pattern of survival. Most often, COAs form narrow and rigid role structures; the more troubled the family,

the more inflexible the role (Birke, 1993). Since family members are affected as the alcoholic person goes through the progression of the illness, each member reacts with a "survival behavior" or a behavior that causes the least amount of personal stress. The strategies that children have developed to cope with their negative family environment become dysfunctional in relationships outside the home and later in life (Glover, 1994). Children may blend roles or switch them at various points in their lives. Understanding the various roles increases the likelihood of identifying a child in need (Birke, 1993). Here we look at the five roles as outlined by Black (1981, as cited in Webb, 1993) and Birke (1993): the hero, the scapegoat, the adjustor, the caretaker, and the clown.

The Hero

Often the first born, heroes are super-achievers incapable of giving less than their all. They believe they can cure the family problems by being overly responsible. Heroes are generally very organized, helpful and mature. They display positive behaviors both in school and at home. Often, heroes care for needy parents and siblings. Believing that alcoholism is somehow their fault and that they can fix the problem, these children work harder in school and their perfectionist and compulsive behaviors can interfere with their lives. Although they tend to be popular, they are also very lonely. Under all of their accomplishment, there is a deep sense of inadequacy because achievement is not the hero's goal; it is only a means to stop the drinking and earn the love and nurturance that should have been, but is not, his/her birthright.

The Scapegoat

Also known as the "rebel," scapegoats function in opposition to the hero; they adapt to the family by making trouble. Often the second child in the family, these children are blamed unjustifiably for the family's problems. They take responsibility for their family's problems and often engage in self-destructive behaviors such as running away, drug use, promiscuity, and delinquency. Scapegoats use anger and hostility to mask their hurt and feelings of rejection. Fear, guilt and shame continually lie beneath their acting out behaviors. The scapegoat's interpersonal relationships are often superficial and shallow because they cannot trust others. Many times, these children will attach themselves to peer groups early in life, habitually running with the "wrong crowd."

The Adjustor

The adjustor or "lost" child fades into the background, never creating waves. They are generally ignored in the family and are commonly middle children. They are regularly confused about what is going on in the family, because no one is providing an explanation. A lost child does not state opinions, has few friends, and often works in isolation. They cope with stress by withdrawing and consequently grow up lonely, isolated, shy, scared and confused. The adjustor is like an "invisible" child masked by a super-flexible attitude that often goes overlooked. As a result, these children have little effervescence on the outside and are also hurting deeply on the inside.

The Caretaker

The caretaker is a junior model of the codependent spouse. Also known as "placaters," they believe that they can help the family by sacrificing their own feelings of disappointment and hurt. Because they focus on people-pleasing, they are usually well liked and help everyone feel better. These peacemakers' kindness, sensitivity, and nurturing often cause them to be overlooked. Caretakers seldom get what they want or need because they are so focused on other people.

The Clown

The clown or "mascot" is generally the youngest child in the family. These children are overly protected and shielded from the family's difficulty with an addicted member and grow up with a distorted sense of reality. The clown uses humor to relieve the tension and redirect the focus of family problems because even though they are aware of the tension in the household, they are not aware of the source. They will therefore break the tension with clowning behaviors. On the surface, these children are frequently class clowns acting silly, making faces, and telling jokes, but a deeper look shows that they often do not feel liked or accepted.

IMPLICATIONS FOR COUNSELING

Clinicians have only recently come to recognize children of alcoholics as primary patients, deserving treatment in their own right. Yet, youngsters living in alcoholic homes have considerably less access to appropriate services. Consequently, the young child in an alcoholic home is placed in a position of attempting to survive almost unaided. Experts estimate that only 5% of these children receive the help they need (Sixth Special Report, 1987, as cited in O'Rourke, 1992). Most families postpone seeking outside assistance for years. Even if help is received, if it is limited to the treatment and recovery of the alcoholic parent alone, the problems experienced by children may continue (Booze-Allen & Hamilton, 1974, as cited in Wilson & Blocher, 1990). A closer look at ways to help children of alcoholics allows counselors to help these children see the world in a better light, cope with their current situation, and become a functioning individual, outside the destructive family environment they are used to handling alone.

Identification and Screening

The first step to helping COAs is identifying them, which is not always an easy task. Robinson (1989, as cited in O'Rourke 1992) states, "By far the greatest stumbling block to serving children from alcoholic homes is the problem of identifying them" (pp. 46). There are a couple reasons for this. First, students do not readily break deep seated family policies of covering up alcoholism (Lytle, 1987, as cited in O'Rourke, 1992). Second, research on COAs behavior has seemed contradictory at times because of the variation in survival roles that children have adopted in their alcoholic families. Because it is hard to identify children in this group, many do not receive the help that they need. This fact is detrimental to the well-being of these children. Without identification at the elementary level, COAs may reach adolescence and

its vital task of discovering "Who am I?" with a developmental base of mistrust, shame, self doubt and inferiority (Anderson, 1987, as cited in O'Rourke, 1992). Tragically, these children may infer that no one really understands them or cares about significant issues in their lives.

Identification of COAs requires a process of active screening. Dies and Burghardt (1991, as cited in Price & Emshoff, 1997) describe several behavior patterns that suggest a child may have an alcoholic parent. Some of these behaviors included: emotional instability immaturity, conflict with peers, isolation from other children, academic problem and physical complains. Counselors can start by being aware of these signs and looking for children who are in need. In addition, there are several screening instruments used to identify children of alcoholics. Perhaps the most widely used screening instrument is the Family CAGE, a set of four questions regarding the respondent's concern for the drinking habits of a relative. This tool has been adapted to reflect concern for a parent's drinking through the following questions:

1. Do you think your parent needs to cut down on his/her drinking?
2. Does your parent get annoyed at comments about his/her drinking?
3. Does your parent ever feel guilty about his/her drinking?
4. Does your parent ever take a drink early in the morning as an eye opener?

This questionnaire is intended to screen for, not diagnose, family alcoholism; a positive finding on the Family Cage should be following by a complete diagnostic assessment (Price & Emshoff, 1997). Another is The Children of Alcoholics Screening Test (C.A.S.T.). It contains 30 items to be answered in yes or no format that probes the respondent's attitudes, feelings, perceptions, and experiences related to the drinking behavior of the respondent's parent (e.g., Jones, 1982; Sheridan, 1995, as cited in Price & Emshoff, 1997). A major drawback, however, is that children must be old enough to read and write to complete forms. This excludes identification of young children between the ages of 5 and 8 (Robinson, 1989, as cited in O'Rourke, 1992).

Prevention Programs

Children of alcoholics are a major key to the prevention of alcoholism in future adults partially because children of alcoholics are up to four times more likely to become alcoholics than children of non-alcoholics (Malone, 1987, as cited in Glover, 1994). Currently, most prevention programs for COAs use a short-term, small-group format, often conducted with schools. In general, prevention programs target children because of the behavior of an adult caregiver, rather than because of the child's own behavior (Price & Emshoff, 1997). Group settings reduce COAs' feelings of isolation, shame, and guilt while capitalizing on the importance to adolescents of peer influence with mutual support. Children in group settings often learn for the first time that there are other children who have problems similar to their own. Many children benefit from sharing their experiences and emotions in a safe environment with other children. Through mutual exchange, children learn survival skills from the experiences of their peers, gain practice in expressing feelings, and build their social support networks (Price & Emshoff, 1997).

There are various prevention programs today to help children of alcoholics. Roosa and collegues (1989, as cited in Price & Emshoff, 1997) developed a competency-building program called the Stress Management and Alcohol Awareness Program (SMAAP). SMAPP is an 8-week, school-based program for COAs, focused on self-esteem, providing alcohol-related education, and teaching emotion and problem-focused coping strategies. Price and Emshofff (1997) describe two other similar programs. One is titled Students Together and Resourceful

(STAR) and is designed to provide students with accurate information on alcoholism and its influence on the family as well as to increase social competence skills. In STAR, group exercises are directed to help children recognize and express their feelings and to practice specific skills, such as problem-solving, decision-making, stress management, and alcohol-refusal skills. A second is the Strengthening Families Program (SFP) that provides training for parents, children, and families. Sessions focus on children's social skills, feelings, anger-management, problem-solving, communication, and peer resistance.

Intervention Programs

Generally, interventions include alcoholism education, training in coping skills and social competence, social support, and healthy alternative activities. Unlike prevention programs, intervention programs usually target children who have begun to exhibit symptoms themselves, such as depression, poor academic performance, or problems getting along with peers (Price & Emshoff, 1997). The content of COA intervention programs is often based on social cognitive theory. The goals of such programs are to reduce children's stress, increase their social support system, provide specific competences and skills, and provide opportunities for increased self-esteem.

The social cognitive theory emphasizes techniques such as role playing, modeling, practice of resistance skills, and feedback. Price and Emshoff (1997) describe how these techniques help children of alcoholics. They assert that role playing allows the child to rehearse common situation such as riding in the car with an intoxicated parent. Through modeling, children learn appropriate behavior (e.g., effective communication skills) by observing group leaders and peers. Resistance skills help children to cope with peer pressure to drink. Both the group leaders and participants provide the child with positive feedback to reinforce and encourage newly acquired skills. Group facilitators also exercise patience and sensitivity as children adjust to their changing awareness about their parents' drinking, even if the children seem to be coping well. This practice is a result of the fact that many COAs who appear to be coping well are actually in a self-protective state of denial.

A final example of an intervention program operates on a child-centered approach to family alcoholism. It is based on the assumption that children can be helped to understand their feelings and change their behavior whether or not parents are involved in the treatment (O'Rourke, 1992). Outlined by Robinson, (1989, as cited in O'Rourke, 1992) this psychoeducational program for children of alcoholics includes these ten key points:

1. Alcoholism is a disease.
2. Everybody gets hurt in an alcoholic family.
3. Children whose parents drink too much are not alone.
4. Children can't cause, control, or cure a parent's alcoholism.
5. There are many good ways for kids to take care of themselves.
6. It is healing to identify and express feelings.
7. It is okay to talk about parental drinking to a special group or friend.
8. Kids of alcoholics are at high risk of substance abuse themselves.
9. It is important for children to identify and use a trusted support system outside the family.
10. There are many ways of problem solving and coping with parental alcoholism.

These points serve as the foundation for most psychoecuational programs and can effect meaningful and even life-giving changes in children as young as 5, 6, and 7 years old (Robinson, 1989, as cited in O'Rourke, 1992).

Provide Emotional/Developmental Support

While counselors cannot make alcoholism in the family disappear, they can help children of alcoholics by providing emotional support. Woititz (1984, as cited in Webb, 1993) and Musello (1984, as cited in Webb, 1993) pointed out that COAs are frequently confused by what they are told and what they see. They hear double messages like "I love you-go away;" "You can't do anything right-I need you;" "Always tell the truth-I don't want to know." Double messages are not only confusing for children, but also place them in a double bind. They develop the following distorted beliefs: not to feel, not to be angry, and to be overly responsible or irresponsible. Because COAs survive by hiding their feelings as well as their parents' problems, pretending everything is normal, and trying to avoid being discovered, the needs of these children include exploring feelings, building self-esteem, developing coping skills, managing stress, and decision-making (O'Rourke, 1990, as cited in Post & Robinson, 1998).

Counselors can provide emotional support by expressing genuine interest and compassion for the child. This is especially important because COAs grow up confused about how people interact, how to recognize their own feelings, how to be aware of others' feelings, or how to discuss feelings (Feaster, 1996). Although children from alcohol-abusing homes may not readily reveal their feelings, they need opportunities to examine chemical abuse and its effect on families. Feaster (1996) believes that COAs need opportunities to talk because they may have difficulty talking due to the need to protect the substance abuser. Counselors can help children to understand that alcoholism occurs because of a problem the parents have and help them understand they are not responsible for their parents' behaviors. In addition, they may help children become aware that they are responsible for their own behavior. Giving children choices to make helps ensure their ability to manage and control their lives (Post & Robinson, 1998).

Children of alcoholics may benefit from such guidance as helping them develop autonomy, independence, social orientation, and social skills. Counselors can also help them to develop a close bond with a caregiver and enable them to negotiate successfully an abundance of emotionally hazardous experiences. Helping them to perceive their experiences constructively, even if those experiences cause pain or suffering, allow them to gain other people's positive attention. It is no surprise that they need help developing and maintaining a positive vision of life (U.S. Department of Health and Human Services, 1991).

Developmental support groups are an effective way to assist children of alcoholics. Post and Robinson (1998) suggest that counseling strategies that help children use creative expression, such as play therapy, are helpful. They also point out that as a rule, children of alcoholics do not have opportunities to play. As a result, they may have more difficulty than most children connecting with peers, so counselors can help COAs find time to play through encouraging interaction with peers. Play therapy has the therapeutic value of connecting the head with the heart through humor and fun. Forms of play therapy include dramatic play, psychodrama, board games, and noncompetitive group games. Other creative outlets include painting, clay, music, writing, puppets, collage, and woodwork. All of these ways help children express feelings of anger, sadness, embarrassment, rage, and loneliness. Play therapy allows children to be free to emerge and deal with their feelings (Glover, 1994).

DISCUSSION

Alcoholism represents a serious health problem today. The Children of Alcoholics Foundation (1984, as cited in Johnson & Leff, 1999) estimates that there are 28.6 million Americans alive today who were raised in homes where one parent was an alcoholic. The number of children younger than 18 currently living with an alcoholic parent total 11 to 17.5 million (Windle, 1997, as cited in Johnson & Leff, 1999). This problem obviously is of monumental size, but yet it is still somewhat of a neglected issue. It is sad to think that this population is not receiving the attention and services that they deserve. Children of alcoholics are victims of chance. They are at risk for a host of emotional, physical, developmental, and social problems. They are not sick themselves, but they are subject to an unhealthy environment polluted with family conflict, unstable and unpredictable conditions, inconsistent discipline and an atmosphere that promotes lack of trust and self-blame. These factors are all detrimental to a child's own functioning and development. Historically, most attempts to identify and assist COAs have been initiated after a child displays behavioral problems or a parent comes to the attention of professionals (Wilson & Blocher, 1990). In addition, because most of the research has been correlational, the obtained relations between child problems and alcoholism could be attributed to third variables and associated family processes (Sher, 1991, as cited in El-Sheikh & Cummings, 1997). Efforts need to be planned in a systematic way to address the problems as early as possible.

At a minimum, the research to date highlights the need for further investigations of multiple dimensions of emotional responding among COAs, including physiological, overt-behavioral, and verbal expression, in varying background anger contexts. Very few studies using children as subjects have systematically examined relations between parental drinking problems and child's interpersonal and emotional functioning. In addition, very few studies have examined the effects of parental drinking problems of COAs functioning through actual participant behavior and objective ratings by external observers, despite the prevalence of behavioral methods in the general interpersonal skills literature (El-Sheikh & Cummings, 1997). Price and Emshoff (1997) stress the importance of more stringent methods of program design and evaluation that are needed to bolster research efforts. These methods include better sampling procedures, random assignment of subjects of treatment types, the use of untreated control groups for comparison, appropriate sample sizes, developmentally and culturally appropriate screening and diagnostic instruments, and more precise definitions of parental alcoholism.

An overview of the research on children of alcoholics points toward the need for better, longitudinal research in this area. This makes sense because a majority of the present research on COAs only examines behavior at one point in time. Longitudinal studies would allow us to predict when early disorders and behavioral deviations would be transient or when they would be precursors to more severe types of maladaptive behavior. This type of study would also enable us to explain specific childhood outcomes. Differences in childhood outcomes could be studied simultaneously to understand whether antecedents discovered for one are specific to it or are general antecedents leading to a broad variety of outcomes (Johnson & Leff, 1999).

Proposing a solution to these problems, Emshoff and Anyan (1989, as cited in Price & Emshoff, 1997) called for the use of "action" research, a model that emphasizes an interactive relationship between research and intervention. This approach would emphasize evaluations of a subject's functioning over time. As a part of the action research model, the distribution of

evaluation results is an important step leading to improved services for COAs. Evaluation data also indicate the need for future research, thus contributing to the continual cycle between basic and applied research. This research would allow counselors to understand the lasting effects of alcoholism on children and help them to cope and handle the problems within their households.

It is also important for there to be assimilation between intervention and prevention programs. Grant (2000) concludes that:

> Because children are exposed, through no fault of their own, to alcohol abuse and dependence during their critical developmental years, they are thrust into families and environments that pose extraordinary risks to their immediate and future well-being. These factors often threaten the achievement of their fullest potential. Unless comprehensive and intensive interventions are provided to address the full range of needs of children exposed to abuse and dependence, along with the needs of their families, the potential costs to human services, health, education, social services and correctional systems will quickly become overwhelming. (p. 115)

Grant asserts that what is urgently needed is a comprehensive strategy that integrates all systems oriented toward the provision of health, social, and treatment services, designed to improve the lives of children at risk from their exposure to alcohol and dependence in the family. Such a strategy must include a broadening of an array of prevention services targeted to the needs of these children at every developmental stage, coupled with aggressive interventions to enhance their lives and protect their safety.

There is also need for counselors to improve their understanding of the unique problems and special needs of this population. Counselor's efforts to develop awareness of the problems children of alcoholics have at home and at school should be an ongoing process. Unfortunately, many people who work with COAs are not trained to recognize the subtle signs of being a COA (Price & Emshoff, 1997). Professionals as well as school personnel and others must realize that there is no single kind of alcoholic family or a single type of COA. Families and COAs are more diverse than that, and circumstances and outcomes are experienced differently by individual members (Bowen, 1966, as cited in Walker & Lee, 1998). During the school year, the counselor can continue the helping process by maintaining resources and offering them to school personnel when appropriate, ordering materials and books, and placing them in the school library. In the past, lack of information available to the professional community has often resulted in children of alcoholics being misunderstood and misdiagnosed. (Wilson & Blocher, 1990). As Naiditch & Lerner (1987, as cited in Wilson & Blocher, 1990) wrote, "We must remember that children of alcoholics are not 'sick.' They are experiencing normal reactions to what are often abnormal circumstances" (pp. 102). A greater understanding of the problems these children face as well as the outcomes and effects of enduring life with an alcoholic parent can help these children survive these abnormal circumstances. In "breaking the silence," COAs can receive the attention that they crave and help that they truly deserve.

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Quarterlife Crisis: The Unaddressed Phenomenon

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Authorities in counseling agree that life transitions present difficulties for individuals and may evolve into crises. The phenomenon caused by a life transition typically studied and understood is the midlife crisis. Although much is known about the midlife crisis, there is little research done about a new trend known as the quarterlife crisis. The purpose of this paper is to discuss the quarterlife crisis by drawing from information about the midlife crisis and quarterlife changes.

During the past half century, research has been done to understand the midlife crisis, a rite of passage that society understands and accepts for individuals around the age of 40. However, until recently, little attention has been given to the quarterlife crisis, a growing phenomenon in American society among "twentysomethings" (individuals typically between the ages of 18 and 30). Little research has been done regarding the quarterlife crisis and twentysomethings in general. Because of this and the stigma associated with seeking therapy among twentysomethings in today's society, those going through a quarterlife crisis tend to feel isolated. Slaikeu (1984) reported that "a transition or life event can precipitate a crisis if the timing of it is inconsistent with society's expectations" (as cited in Herr, 1999, p. 224). This includes transitional situations which "call for changes in self-concept, identity, and use of time that the individual may be unprepared to make or finds unusually difficult to accommodate" (Herr, 1999, p. 224); examples include not being settled in a career or not being married at a particular age. Twentysomethings who feel as though they are alone in their troubles and who do not seek help for their problems can experience stress, depression, or anxiety.

Since Alexandra Robbins and Abby Wilner (2001) published the book *Quarterlife Crisis: The Unique Challenges of Life in Your Twenties*, this phenomenon began to gain attention in the media. It became the topic of talk shows (Oprah), TV series episodes (ER), movies (Garden State), songs (John Mayer's *Why Georgia?*), and internet message boards (www.quarterlifecrisis.com). Twentysomethings going through quarterlife crises are choosing to change jobs or careers many times throughout this period in their lives and may even return to school; these trends are likely to affect the job market and the economy. Twentysomethings in the quarterlife crisis can develop psychological problems, ranging from minor to severe, which accompany an identity crisis. Herr (1999) notes that "stress is associated with life events or the accumulation of life events, and when stress rises to unhealthy levels… physical or mental disease is likely to result" (p. 224). These are serious implications for career and psychological counseling. Therefore, research needs to be done about twentysomethings regarding career change, job change, depression, anxiety, and techniques or strategies that work best when counseling people going through a quarterlife crisis.

The purpose of this article is to address the quarterlife crisis by identifying problems faced by twentysomethings and raise awareness about the prevalence of this phenomenon in our society. This article begins with an overview of the quarterlife crisis and its similarities to and

differences from the midlife crisis. Next, problems that arise due to the transition from college into the world of work are discussed. This article concludes with recommendations for counseling strategies, research, and awareness.

DEFINITION OF QUARTERLIFE CRISIS

Throughout the years, people have experienced unique challenges as a result of life transitions, some of which have been so severe that they have been referred to as crises. Elliot Jacques (1965) first coined the term "midlife crisis" in his paper *Death and the Midlife Crisis*, in which he developed the idea by analyzing the creative processes of artists and writers including Dante Alighieri (as cited in Bhatia, 2003, ¶ 1). According to Glassner (1994), Jacques and later psychologists "postulated that what provokes such a crisis is a person's realization that he or she is mortal and…the hallmark of such a crisis is an acute sense of time running out" (p. 30). In a more recent study of Americans, Wethington (2000) noted that many associated the midlife crisis with normal aging as opposed to imminent death. Middle-aged people reach a point when they start to ponder the direction of their lives and then attempt to alter it (Robbins & Wilner, 2001). Society has come to recognize this crisis in middle-aged people and accept it as a common stage of life.

Additionally, Glassner (1994) believes that members of the baby boom generation face their own type of midlife crisis which he terms the "career crash." He has concluded that baby boomers suffer from life anxiety as opposed to death anxiety because they "see themselves living productively for a good forty or fifty more years and worry they will spend much of that time either in jobs they dislike or out of work entirely" (p. 30). Instead of feeling that their lives are dull or empty, baby boomers find that their lives are overloaded and feel overworked; they despair that the situation will never improve (Glassner, 1994). As a result, Drake Beam Morin (2000) concludes that "a typical forty-year-old white-collar worker will change jobs two or three times before retirement" (as cited in Glassner, 1994, p. 16).

In contrast, the quarterlife crisis affects a younger population who are experiencing problems due to life transitions that vary greatly from the midlife transition. According to Robbins and Wilner (2001), the crisis "covers the interval that encompasses the transition from the academic world to the 'real' world…usually most intense in twentysomethings" and it "may be the single most concentrated period during which individuals relentlessly question their future and how it will follow the events of their past" (p. 2). While the midlife crisis and quarterlife crisis both stem from a major life change, the quarterlife crisis occurs because there is "none of that predictability that drives middle-aged people to do unpredictable things" (Robbins & Wilner, 2001, pp. 2 – 3). Upon graduation, the once clear-cut path becomes blurred and many twentysomethings begin to feel lost in a sea of a million possibilities. The quarterlife crisis is, in effect, a response to overwhelming instability, constant change, countless choices, and a panicked sense of vulnerability (Robbins & Wilner, 2001). Twentysomethings begin to question themselves incessantly, lose their sense of identity, or question their career choice. Some may respond to these issues by quitting their jobs, stalling career decisions, falling into a state of depression, or developing anxiety disorders.

PSYCHOLOGICAL EFFECTS OF QUARTERLIFE CRISIS

Research has shown that individuals experiencing a midlife crisis feel stress due to some midlife transition. In a research study conducted in 1997 and 1998, Wethington (2000) reports that "among respondents who have reached the age of 50, 35.2% reported that they had experienced a midlife crisis" (p. 91). She also reports that most Americans can recognize the term midlife crisis and only 9.2% could not provide some definition of the term (Wethington, 2000). Events that may be connected to midlife stress include the death of loved ones, family problems, career disappointments, or personal health crises (Chiriboga, 1989; Siegler, 1997; Sunder & Hunter, 1989; Wethington, 2000). Middle-aged people may react to this stress by engaging in sudden and drastic changes in their personal goals or lifestyles.

While the quarterlife crisis is also the result of a major life change, the effects on twentysomethings could not be more different. According to Wethington (2000),

> The term midlife crisis gives meaning to experiences that may be unusual, and may provide helpful ways to appraise and cope with events. The idea of an expectable crisis ("everyone has one") may provide comfort for those who are having a difficult time in their middle years (Rosenberg et al., 1999). The use of the term "crisis" may encourage those having a particularly difficult time to seek help and social support. (p. 102)

For this reason, middle-aged people may expect the difficulties associated with the midlife transition, recognize the onset of a midlife crisis, and seek counseling to help them through it. On the other hand, individuals experiencing difficulty in their twenties do not expect this type of a crisis and are not aware that anyone else is feeling the same as they are. Consequently, this crisis tends to hit them more powerfully because they feel that they are having a much more difficult transition period than their peers; aren't the twenties supposed to be trouble-free (Robbins & Wilner, 2001)? Because of the unexpectedness of these overwhelming feelings, twentysomethings begin to feel completely lost and helpless. According to Robbins and Wilner (2001), "just as the monotony of a lifestyle stuck in idle can drive a person to question himself intently, so, too can the uncertainty of a life thrust into chaos" (pp. 3 - 4).

Those who face a quarterlife crisis may experience many symptoms ranging from intense job dissatisfaction to depression. They report that the main symptom is an identity crisis which may emerge as a state of panic and disappointment when they realize that things (such as meaningful jobs or relationships) are missing from their lives (Robbins & Wilner, 2001). Although little research has been done regarding this age group, Robbins and Wilner (2004) have created an online website, www.quarterlifecrisis.com, devoted to researching, supporting, and providing resources for twentysomethings who have difficulties going through this time in their lives (¶ 2). By interviewing over one hundred twentysomethings, they have found that this crisis can bring up feelings of depression and anxiety linked to job-hopping, alcohol or substance abuse, or stalling their lives. The most prominent feelings are of isolation and, therefore, they do not seek counseling because of the stigma associated with it (Robbins & Wilner, 2001). Robbins and Wilner (2004) report that 62% of twentysomethings who participated in a survey reported that they have had signs of depression and 91% reported that they have signs of general anxiety post September 11, 2001. Of the people surveyed, only 7% have sought help for their problems. 28% don't have time, money, or don't know where to go for help, while 65% have not tried to seek help for their problems (Robbins & Wilner, 2004). These findings are both alarming and demonstrate the potential risks involved for twentysomethings.

TRANSITION FROM SCHOOL TO WORK

One significant similarity among everyone going through a quarterlife crisis is the transition from school to work. Twentysomethings are entering the work force at a time when society is changing due to technological advances, and they are not well-prepared to cope with these changes. They are also dealing with many life transitions at once including finding their first job, adjusting to work, selecting a life partner, learning to live with a new roommate or life partner, moving back into a family's house, and/or dealing with financial concerns (Herr, 1999). According to Heckhausen (2002), "in general, life-course transitions are highly sensitive phases for the interplay of sociostructural, institutional, and individual forces. Life-course transitions provide chances for growth and upward social mobility as well as risks for decline and downward mobility" (p. 174). Herr (1999) contends that "there are clear relationships between life events and physical and mental health" and that "sometimes transitions turn into crises" (p. 224). With many overlapping life transitions, it is apparent that there is a potential for crisis development.

While there are many life changes, the most distinct for twentysomethings is the transition from school to work. Over the past century, science and technological advances have increased rapidly, changing the face of society. The technological revolution has had an affect on our culture in terms of family, economics, life expectancy, and, most relevantly, workforce. According to Herr (1999):

> The effects of emerging technologies…have profound implications for the workforce. They are changing the jobs available, their locations, and the characteristics of jobs as well as the broader economic climate. In so doing, they are changing the contexts, content, and vocabulary with which counselors and clients must process the problems and anxieties that result from work-related questions. (p. 38)

Because of these changes, twentysomethings are facing diverse occupational issues and must deal with them in different ways than their parents did only a generation ago.

While frequently changing jobs or careers may generate anxiety among twentysomething workers, job mobility proves to be a normal trend for workers in this age group. The U.S. Department of Labor and Statistics (1993) has shown that, in their analysis of the labor market experience of individuals between 18 and 30 years old, most individuals work in 7 or more jobs during these 12 years. This report also shows that most of these individuals are employed for 9 of the 12 years and that 40% work 11 years or more during this time period (U.S. Department of Labor and Statistics, 1993). The average twentysomething who participated in Robbins and Wilner's online surveys at Quarterlifecrisis.com has only stayed at their first job for 1 yr., 9 months and reports feeling unhappy with their current job. While many twentysomethings perceive job dissatisfaction as abnormal, historically this has proven to be the standard.

COUNSELING THE INDIVIDUAL GOING THROUGH A QUARTERLIFE CRISIS

Herr (1999) describes people who experience a developmental or situational crisis as "people who typically have exceeded their levels of emotional resources or support systems to cope with a particular event or transition"(p. 226), but who are not mentally ill. Therefore, counseling models that may work are those which are used to help an individual through a

significant developmental change in their lives. Slaikeu (1984) suggests an assortment of strategies to deal with these changes including coping imagery, thought stopping, rational emotive therapy, group sharing or writing of experiences and feelings, and outside readings (as cited in Herr, 1999, p. 226). One such model, presented by Schlossberg (1991), "Your Steps in Mastering Change" includes approaching change, taking stock of the resources available to cope with the change, and taking charge (as cited in Herr, 1999). This model helps the individual deal with decision-making and change in order to increase their sense of options and control over the situation. Counselors can use this technique to assist twentysomethings to reassess their situation and to equip them with the social support and informational resources to cope with their problems.

Robbins and Wilner (2000) encourage online message boards and the formation of support groups to help individuals deal with their quarterlife crises together by chatting, networking, and participating in activities. The website they have created also provides links to websites which might help twentysomethings deal with life, work, and social difficulties that they are experiencing. For example, the CareerBuilder.com link includes online surveys, career assessments, and a job search, while the Roomate.com link includes a database of apartment or house owners looking for roommates in cities across the U. S.

Career change is a prominent issue for twentysomethings and special attention must be given to the career counseling aspect of dealing with the quarterlife crisis. Because the heart of the quarterlife crisis is identity crisis, these individuals might need to reassess their goals in terms of life, career, and relationships. They will undoubtedly need to reexamine their values and how these values are reflected in future career choices or changes that they will make (Zunker, 1999). Counselors must provide a safe environment to educate individuals regarding stress, depression, anxiety, or other symptoms before engaging in career counseling. Herr and Cramer (1996) suggest goals for counseling midlife career shifters, which may also prove beneficial for counseling quarterlife career shifters. These goals include helping individuals clarify their reasons for a career change, obtain the necessary information regarding education, envision the effects of the change, develop appropriate job-seeking skills, assess characteristics as they relate to prospective jobs, and recall their social support network (Herr & Cramer, 1996).

DISCUSSION

Because the quarterlife crisis has only gained minimal recognition in society, much more awareness needs to be raised and research needs to be done in order to help twentysomethings cope with their specific needs. Robbins and Wilner's quarterlifecrisis.com website has 3,519 members of twentysomethings registered to their online community and over 85,000 messages posted to their message boards. Most of the threads, or forums, encourage members to describe their quarterlife crises and for other members to provide support and offer suggestions for dealing with issues.

Although Robbins and Wilner have broken ground by raising awareness among twentysomethings, there is further work that needs to be done. Campuses need to raise awareness by encouraging on-campus programs for students, especially graduating students, to educate them about the phenomenon. If students better prepare themselves for the world outside college by learning about quarterlife crises, including signs, symptoms, and resources to sort out the crisis, they will be better prepared to handle these life transitions.

College career counseling centers should be responsible to educate students about the developmental difficulties faced by college graduates and suggest resources for twentysomethings to utilize. Authorities in career counseling agree that choosing a career is a lifelong process. Due to changes in technology, workers are likely to change jobs many times throughout their lifetimes. Counselors need to be aware of the life transitions that twentysomethings are confronted with and ways to cope with their problems.

After Jacques Elliot (1965) coined the term midlife crisis, many studies have been done to understand the specific problems faced by adults in midlife, what counseling methods work best to help them, and how the midlife crisis has evolved over time. Significant findings, as shown by the surveys conducted at quarterlifecrisis.com, part of groundbreaking research on twentysomethings, have shown that the quarterlife crisis is occurring in today's society. Therefore, research should be done with young adults to determine why the quarterlife crisis is emerging, what counselors can do to help, and how twentysomethings need to adapt in order to fit into the changing society. Further research is needed to determine the extent to which people in the quarterlife crisis are at risk for depression, anxiety, and other disorders. According to Robbins and Wilner (2001), there are no statistics regarding the risk of depression, suicide, and anxiety disorders among 21 to 35 year olds. However, Dupont (2000) has found that "there is a high rate of all forms of disorder in this age group, including addiction, anxiety, depression, and many other kinds of problems because of the high stress associated with the transition from being a child to being an adult" (as cited in Robbins & Wilner, 2001, p. 6).

The Chinese character for crisis is made up of two parts: danger and opportunity (Smith, 2004). Inherent in crisis is an opportunity to change, learn, and grow. With the proper resources, societal awareness, and counseling, twentysomethings living through a quarterlife crisis will learn the proper coping techniques and grow as a result of these unavoidable life transitions. On the other hand, twentysomethings are extremely vulnerable; changes need to be made to raise awareness, spark research, and educate counselors in order to avoid the dangers that can result from the quarterlife crisis.

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Partner Abuse: For Better or Worse?

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Domestic Violence represents one of the most underreported crimes in the United States and occurs regularly in every community. Although society has become more aware of the seriousness and prevalence of domestic violence, many people still do not understand the dynamics of domestic violence. This paper examines the major issues of domestic violence and presents implications for counseling practice, education, and research.

Historically in the United States, partner abuse was considered a normal feature of family life and did not call for legal or public intervention. This belief stemmed from the notion that family must be guarded from outside influences in order to create a sense of security and happiness within the home (Dobash & Dobash, 1979). A ruling from an 1874 North Carolina Supreme Court holding best exemplified this societal opinion regarding domestic by stating: "If no permanent injury has been inflicted, nor malice, cruelty nor dangerous violence shown by the husband, it is better to draw the curtain, shut out the public gaze, and leave the parties to forget and forgive" (as cited by Burgess-Proctor, 2003, p. 34).

Awareness of marital violence as a crime began in the 1970s when a statistical link between marital violence and child abuse became apparent (Borkowski, Murch & Walker, 1983). This awareness was further fueled by the growth of women's rights groups and feminist organizations. As a result of these developments, there was a dramatic increase in the abundance of literature, research, and resources available to female victims of domestic violence (Lucal, 1992). However, partner abuse continues to be one of the most underreported crimes in the United States (Foreman & Frederick, 1984) with only half of all domestic violence incidents reported to the police (U.S. Department of Justice, 2000).

Presently in the United States, domestic violence continues to represent a widespread social issue with nearly one in every three adult women experiencing at least one physical assault by her partner during her lifetime (American Psychological Association, 2004). According to several studies, these statistics could possibly be underreported since many women do not report battering until it reaches a life-threatening stage (Burgess-Proctor, 2003; Szinovacz & Egley, 1995). Finally, domestic violence is pervasive throughout every community as it cuts across all racial lines, ages, educational levels, religious backgrounds, and socioeconomic levels (Family Services Contact, 2002; Gorde, Helfrich & Finlayson, 2004).

Abuse by the hands of a trusted person, such as a husband, can be far more destructive than abuse by the hands of a stranger. This is because of the frequency that domestic violence can occur within the home, the victim's proximity to her abuser, and the numerous emotional and psychological issues felt afterward that are not usually felt when assaulted by a stranger. These emotions include confusion, love, loyalty, self-blame, guilt, and shame. Not to mention that an abused woman may feel torn between protecting herself and helping the man she loves (Gosselin, 2000).

Given the widespread occurrence of domestic violence and its destructive nature, counselors need to be aware of the dynamics within an abusive relationship and know how to handle victims needing help. Accordingly, the purpose of this paper is to discuss the terms used to describe domestic violence, reasons why men choose to abuse and the types of abuse inflicted, the progression of violence, and reasons why women choose to stay in an abusive relationship. Preferred practices of counseling are described, and implications for counselor education and research related to domestic violence are provided.

DEFINITIONS OF DOMESTIC RELATIONSHIP AND DOMESTIC VIOLENCE

Domestic violence does not have a single definition and the legal interpretation of a domestic relationship differs from state to state. Given the ambiguity of what constitutes a domestic relationship, the ability to legally label a situation as domestic violence can potentially change when you cross state lines. What is considered domestic violence in one state may be deemed as assault in another depending on factors such as the relationship between the abuser and the victim, as well as the type of harm inflicted.

Furthermore, the term domestic violence encompasses several forms of abuse and levels of severity, which allow for varied interpretations of an abusive act by both the victims involved and law enforcement. Abuse can include emotional abuse, economic abuse, sexual abuse, using children, threats, using male privilege, intimidation, isolation, and a variety of other behaviors used to maintain fear, intimidation and power (Dobash & Dobash, 1979; Rapp-Paglicci, Roberts & Wodarski, 2002; Vincent & Jouriles, 2000). These different forms of abuse can fall into one or more of the three following categories: physical abuse, sexual abuse, and psychological abuse (Foreman & Frederick, 1984).

Domestic Relationship

Although the legal definition can be different in each state, the common denominator found in each state's definition of a domestic relationship is marriage. After this, the legal interpretation can differ to in terms of choosing to include people who still are or used to be legally married. It can also potentially include persons who are not married and are currently residing together, or used to cohabitate in the previous year, or other specified period of time (New Jersey State Bar Association, 2004). The definition can also include a married or non-married male and female who biologically share a common child or if the woman is pregnant (Gosselin, 2000). More recently, several states have started to include relationships where people are having or have had a dating history or engagement (National Center for Victims of Violent Crime, 2004).

To show how the definition of domestic relationship can change from state to state, consider the differences between New Jersey and South Carolina. New Jersey's Prevention of Domestic Violence Act of 1990 states that a domestic relationship can constitute two people within one of the following types of relationships: married, non-married, currently share a child or expecting one, boyfriend, girlfriend, family member, gay or lesbian partner, roommate, caretaker, or any other adult who lives with you or used to live with you (New Jersey State Bar Association, 2004). However, this Act is also considered one of the strongest domestic violence acts in the United States.

According to South Carolina's Domestic Violence Protection Act of 2003, domestic violence can only occur between "Household Members." This term specifically means, "spouses, former spouses, parents and children, persons related by consanguinity or affinity within the second degree, persons who have a child in common, and a male and female who are cohabiting or formerly have cohabited" (South Carolina Legislature, 2004, ¶ 3). Notice the absence of protection for victims participating in a same-sex relationship, same-sex roommates, and people who are dating. In South Carolina, a domestic violence victim cannot bring charges of domestic violence against their abuser if their relationship doesn't qualify as a "Household Member."

Domestic Violence

Domestic violence consists of the willful intimidation, assault, battery, sexual assault or other abusive behavior perpetrated by one family member, household member, or intimate partner against another in order to establish power and control (Goodkind, Sullivan & Bybee, 2004; National Center for Victims of Violent Crime, 2004; Ronan, Dreer, Dollard & Ronan, 2004). Abuse occurs when one person believes he or she is entitled to control another through the use of power (Foreman & Frederick, 1984). In many instances, the term "domestic violence" can be used interchangeably with "battering."

In defining domestic violence, it's an imperative to note that domestic violence is not about fighting (Womanspace, 2004). Fighting occurs in almost all cultures, nations, communities, and families without endangering the autonomy of those involved and sometimes it helps to establish people's rights and freedoms (Stark & Flitcraft, 1996). According to Stark & Flitcraft (1996), "Battering occurs when persons have been forcibly isolated from potentially supportive kin and peer relations and become locked, like hostages, into situations in which objectification, subordination, and continued punishment are inevitable" (p.27 - 28).

Physical Abuse

According to Gosselin (2000), physical abuse is defined as the "use of force or threat of force that may result in bodily injury, physical pain, or impairment" (p. 11). The severity of physical abuse or aggressive behavior can range in consequences from bruising to murder. Specific examples of this type of abuse include: hitting, choking, biting, kicking, pinching, spitting, burning, cutting, and denying medical care (Family Services Contact, 2002; New Jersey State Bar Association, 2004; Women's Law Initiative, n.d.).

According to some studies, women seek emergency medical treatment for injuries related to domestic violence more than any other reason. To strengthen the implications of this statement, consider that adults who are not abused make only one visit for emergency medical treatment in their lifetime, but abused women average more than one type of these visits a year (Stark & Flitcraft, 1996). Regarding the types of injuries sustained by abused women and treated in the emergency room, one study found that "battered women were 13 times more likely than other women receiving emergency care to be injured in the breast, chest, and/or abdomen, and three times as likely to be injured while pregnant" (Rapp-Paglicci et al., 2002, p. 10).

Sexual Abuse

Sexual abuse occurs when the victim is forced into having sexual intercourse with the abuser or take part in any unwanted sexual activity (Wellesley Centers for Women, 2001). Sexual abuse can also occur when a person who is ordinarily able to give consent, cannot give consent and a sexual act is perpetrated against her (Gosselin, 2000). An example of this would be if a woman was intoxicated to the point of being incoherent and her partner takes advantage of her sexually. Specific examples of this type of abuse are rape, sodomy, kissing, forced nudity, treating someone in a sexually demeaning manner, etc (New Jersey State Bar Association, 2004; Women's Law Initiative, n.d.).

Marital rape is the term used to describe when a woman is forced to submit to unwanted sexual advances and intercourse perpetrated by her husband. Confusion regarding this type of rape usually occurs because the couple is married and it's assumed that both partners are consensual. However, even though a couple may be married and have had consensual sexual relations at one point in the past, this does not allow the assumption that automatic consent will be given to any future sexual acts (Wellesley Centers for Women, 2001). The prevalence of this type of rape can be seen in the study results of prominent rape researcher, Diana Russell. In a study of 900 randomly selected women, she found that while 3% were raped by a stranger, 8% had been raped by their husband (as cited in Abuse Counseling and Treatment Inc., 1995).

Psychological Abuse

Psychological or emotional abuse is the verbal and non-verbal intentional infliction of anguish, pain, or distress designed to control the victim (Foreman & Frederick, 1984; Horne, Merz & Merz, 2001). Unless the abuser openly threatens his victim, all other forms of psychological abuse are legal. Examples of this type of abuse can include the following: constant verbal abuse, harassment, excessive possessiveness, isolating the victim from friends and family, humiliation, minimize and deny that the abuse has occurred, blame the victim for the abuse, deprivation of physical and economic resources, and destruction of personal property and pets (Family Services Contact, 2002; Horne et al., 2001; New Jersey State Bar Association, 2004; Szinovacz & Egley, 1995; Women's Law Initiative, n.d).

Many researchers have found that psychological abuse is usually a precursor to physical abuse (Vincent & Jouriles, 2000). Given this, psychological abuse has the potential to be even more damaging than physical because since it can occur more frequently. Furthermore, constant verbal abuse can destroy a victim's sense of confidence, lower their self-esteem, and make a victim even more vulnerable to further abuse (Horne et al., 2001; National Center for Victims of Violent Crime, 2004). An example of how a victim's sanity can be eroded is if her partner repeatedly punches her in the stomach, denies that he hit her, and then tells her that she has a crazy imagination. Over time, she will start to doubt her sense of reality, which will lead to a loss in self-confidence and can make her more dependent on her abuser.

REASONS WHY MEN ABUSE THEIR PARTNERS

There have been numerous theories developed to explain why men choose to abuse their partners, but there is no one theory that can entirely explain this complicated phenomenon. However, many theories generally agree that men use violence because of a need to gain power

and control over their partner, and they have learned that violence is an acceptable and effective method to do it (Foreman & Frederick, 1984; Rosenbaum & Leisring, 2003).

Everyone will feel angry at some point in life, but how we choose to deal with that anger is a personal choice. We can either chose to control ourselves and deal with our anger in a constructive manner, or we can choose to use violence as an outward expression of our anger. Men who choose violence to express their anger show that they are out of control, which is ironic because that is the feeling they are trying to regain (Womanspace, 2004).

Some theories also explain that domestic violence occurs as a result of the reaction between an abuser's characteristics and the needs of their environment (Burgess-Proctor, 2003; Cano & Vivian, 2003; Dobash & Dobash, 1979; Stith, Smith, Penn, Ward & Tritt, 2003). Furthermore, when these needs become overwhelming, the abuser will display signs of deficient social skills, such as communication and problem-solving skills, when they resort to using violence to resolve conflicts in their relationship (Ronan et al., 2004).

Characteristics of an Abuser

Regarding male abusers, the term 'characteristics' refers to personality problems, childhood experiences, and interpersonal family dynamics (Gosselin, 2000; Stark & Flitcraft, 1996; Stith et al., 2003; Szinovacz & Egley, 1995). According to Rosenbaum and Leisring (2003), "Approximately 45% of male batterers have witnessed domestic violence in their family of origin" (p. 9). If a child grew up in a violent home, he was most likely nurtured in a chaotic, unstable, dangerous, and insecure environment, and he learned that violence was a normal method of effectively dealing with problems (Rosenbaum & Leisring, 2003).

An abuser might also display a lack of stress-management skills and have social-skills deficits, which can result in the abuser feeling like he has no control over his life (Cano & Vivian, 2003; Ronan et al., 2004; Vincent & Jouriles, 2000). After analyzing the results from several studies regarding the social skills of violent men, Vincent and Jouriles (2000) found the following:

> Violent men may require social skills training to generate competent (i.e. less aggressive, more constructive) responses to marital situations…these men [have shown in studies] either may not have competent responses in their behavioral repertoire or may choose aggressive/incompetent responses for other reasons. (p. 25)

Environmental Needs of an Abuser

The needs of an abuser's environment include cultural norms that support violence and sexism, as well as economic stress and poverty (Cano & Vivian, 2003). From a young age in the United States, men and women learn a variety of social norms that can put them at risk for partner abuse. The first norm that many men learn is that they should always be in control of themselves, their environment, and the people around them (Womanspace, 2004). The second norm that men can learn is that violence is an effective and acceptable method of maintaining power and control (Cano & Vivian, 2003). If the abuser can get away with his violent behavior and not face any consequences such as being arrested and/or jailed, or realize that no one cares about his actions, he may quickly learn that violence is an acceptable method.

The third norm learned by men is that women need to be taken care of, provided for, and controlled. This norm stemmed from the historical premise that women were the property of

men (Dobash & Dobash, 1979). To further perpetuate this, women are also socialized from a young age that they are expected to be good wives, mothers, and daughters, as well as take care of their family and husbands before themselves (Borkowski et. al., 1983).

PROGRESSION OF VIOLENCE

There are several theories that explain the progression of violence in a relationship and the most famous is Dr. Lenore Walker's three-part "Cycle of Violence" (Gosselin, 2000). While all theories are slightly different, they all agree that relationships do not start out being violent and that the abuse follows a relatively predictable pattern. Most theories describe violence occurring in four progressively worse stages. These stages are: Phase I, the Pre-Battering Stage; Phase II, the First Act of Physical Violence or Beginning Stage; Phase III, Moderate Abuse; Phase IV, Severe Abuse (Dobash & Dobash, 1979; Family Services Contact, 2002; Gosselin, 2000; Institute for Family Violence Studies Rural Victimization Project, 2003; National Center for Victims of Violent Crime, 2004; Rosenbaum & Leisring, 2003; Womanspace, 2004).

Phase I – Pre-Battering

This phase is the beginning of the relationship and is usually characterized with physical and emotional attraction that brings the couple together (Gosselin, 2000). In the first few weeks, months, or years of the relationship there is no physical battering. However, over time tension builds as the male partner becomes increasingly more controlling and starts to display verbally angry outbursts.

In this initial phase, the female may not yet realize that she's in a violent relationship and will try to nurture the abuser. She may also try to be compliant in order to avoid his temper and will ignore signs that there is a problem in the relationship (Womanspace, 2004). The problem is that no matter what she does to try and assuage the abuser, he will still find the most trivial issue to become angry about. In response, the woman may continue to wait out periods of tension and hope that they pass without another outburst (Institute for Family Violence Studies Rural Victimization Project, 2003).

As the pre-battering phase moves forward, the abuser will continue to be verbally abusive, start throwing and breaking objects, make threats, isolate the victim from support, abuse trust by withholding information, and seriously disrespect their partner (AARDVARC, 2004; Family Services Contact, 2002; Peace At Home, 2004; Womanspace 2004). However, once an abuser starts to hit or break objects, or make threats, the violence will almost always escalate to battering (AARDVARC.org, 2004).

Phase II - First Act of Physical Violence or Beginning Stage

The second phase begins with the first act of physical violence, which usually consists of a single strike that results in little or no injury. Common examples of violence that appear in this phase are pushing, grabbing, restraining, shaking, blocking doorways, and holding down (AARDVARC.org, 2004; Family Services Contact, 2002; Womanspace, 2004). While this initial event may be inconsequential in terms of physical injury, it is dramatic regarding the emotional responses of the abuser and his victim (Borkowski et al., 1983). In response to the

event, both partners may feel shock, guilt, disgust, disbelief, surprise, and shame. They might also try to treat the initial event as something out of the ordinary and the man will apologize for his actions.

The reactions of the man and woman are best explained by the following quote from Dobash & Dobash (1979):

> At the time the man often feels guilt, begs forgiveness, and promises that it will never happen again, and the woman is usually willing to forgive him once the initial shock, and hurt feelings have passed. The relationship is reconstituted as though the event will never happen again. This reconstitution is based upon evidence, hope, and rationalization. (p. 96)

Regarding the first act of violence in a relationship, this quote means that since there was no previous history of violence the victim has hope and belief there is no reason for the violence to repeat. The victim may try to further rationalize the attack and accept the blame for it on herself (Gosselin, 2000).

Phase III – Moderate Abuse

The third stage is initiated by a change in frequency or severity of abuse inflected on the woman. Common types of abuse seen in this stage include slapping, pinching, pulling hair, kicking, and spanking (Womanspace, 2004). The abuser might still try to apologize, but over time he no longer feels bad for his actions (Dobash & Dobash, 1979). In this stage the abuser learns that he no longer needs to apologize, give gifts, or show affection in order to make her stay with him (Institute for Family Violence Studies Rural Victimization Project, 2003). At this point, the victim might try to leave the relationship, but she will usually fail due to further psychological and physical threats from the abuser (Womanspace, 2004).

Phase IV – Severe Abuse

The final and most severe level of abuse is arrived at when the victim feels that she cannot get away because she is under constant surveillance, as well as psychological and physical attack. Common types of abuse seen at this stage include rape, choking, beating with objects such as a stick or furniture, and use of weapons (Gosselin, 2000; Dobash & Dobash, 1979; Family Services Contact, 2002; Institute for Family Violence Studies Rural Victimization Project, 2003; Womanspace, 2004). The victim may have tried to leave several times, but after failing each attempt she has learned to become helpless and withdraws completely from society (Borkowski et al., 1983). This stage may also lead to homicide as the severity and frequency of abuse becomes increasingly violent (Womanspace, 2004).

For the victim, this final stage can be filled with terror and bring about depression or posttraumatic stress syndrome (Coolidge & Anderson, 2002; Horne et al., 2001; Rosenbaum & Leisring, 2003). The victim may also consider suicide as the only way out of her situation as she becomes increasingly dependent and vulnerable to her abuser. According to Stark & Flitcraft (1996):

> 19% of all battered women have attempted suicide at least once, 38% were diagnosed as depressed or having another situational disorder, and 10% became psychotic…In other words, the battered women were psychologically normal individuals who developed a complex psychosocial profile in the context of ongoing partner assault. (p. 163)

Reasons Why Women Stay

Many people outside of the relationship may ask, “If she’s being abused mentally and physically, why doesn’t she just leave?” Furthermore, many people oversimplify the answer to this question by blaming it on the victim. Some people might also think that the victim may “want” or “enjoy” this kind of treatment, or that she has a weak strength of character (Borkowski et al., 1983). However, what many people don’t realize is that there is usually no one reason why a woman will stay and that her situation is probably very complex.

Statistics note that the average time a victim spends in an abusive relationship is between 5 – 10 years before they leave (Health24.com, 2004). According to research by Ferraro & Johnson, between 50 to 80% of abused women will remain with their abuser or return to them after leaving a shelter or separating from them (as cited in Stith et al., 2003). Some of the factors that explain these statistics and why she chooses to stay are: love for the abuser, socialization, religion, presence of children, lack of skills and resources, lack of support, low self-esteem, and fear (Abuse Counseling and Treatment Inc., 1995; Borkowski et al., 1983; Dobash & Dobash, 1979; Foreman & Frederick, 1984; Gosselin, 2000; Psychology Today, 1992).

Love for the Abuser

The first point to remember is that the woman loves her abuser and not the violence, which is why she initially entered the relationship. With this in mind, she wants her relationship to work and will wait and hope for things to improve. Her reasons for hoping are the promises that the abuser has made to stop being violent and the convincing explanations he has offered for his behavior (Womanspace, 2004). The victim may also believe that her partner is "sick" and needs her help, which she wants provide since she loves him (Abuse Counseling and Treatment Inc., 1995).

Socialization

From an early age, women in the United States are socialized into sex roles that define their place in a family. This means that woman are expected to get married and have a family, which entails that she will be entirely responsible for taking care of the domestic work, childcare, and emotional stability of the family (Dobash & Dobash, 1979).

When the emotional stability of the family is thrown off balance or if there is violence, she might feel that she has failed in her responsibility of keeping the family stable. Also, since the woman has accepted the well-being of her family as her responsibility, she might feel like a failure if she chooses to leave her husband or partner (Foreman & Frederick, 1984). Therefore, the victim may choose to stay since she believes in the possibility of making the relationship work if she tries harder and does whatever is necessary.

Religion

Religion can also play a powerful force in making a woman stay in her abusive relationship since many religions strongly discourage divorce and the breakup of the family (Womanspace, 2004). If a woman has strong religious convictions, she can potentially feel an

enormous amount of guilt if she leaves her marriage. Religious beliefs can also reinforce her commitment to her marriage by endorsing the idea that the husband is in charge of the family and the wife has an obligation to serve him (Abuse Counseling and Treatment Inc., 1995).

Children

Often times a woman will choose to stay in an abusive relationship because of a desire to keep the family together. A major motivator for this is that she may want her children to have a positive relationship with their father. What is sad about this rationale is that children have the potential of becoming victims of their father's rage either by watching him abuse their mother, or him turning on his children (Foreman & Frederick, 1984). A woman might also feel that the responsibility of being a single parent outweighs the cost of her staying in an abusive relationship (Family Services Contact, 2002).

A woman might also stay because the abuser has threatened to hurt the children or take them away from her if she leaves (Borkowski et al., 1983). Taking the children away has proved to be real threat given the statistic that in 70% of all cases involving battering, the abuser [the husband] gets custody of the children (Psychology Today, 1992).

Lack of Skills and Resources

A major obstacle preventing a woman from leaving may be that she is physically isolated from community resources, she doesn't have any money, and/or she lacks job skills. In many cases, the abuser has made the victim entirely dependent on his income, controlled all of their assets, not allowed her access to education, and/or forced her to stop working so she only takes care of him and domestic responsibilities (Florida Coalition Against Domestic Violence, n.d.; Foreman & Frederick, 1984; Gosselin, 2000). If this is the case, it can be very difficult for her to leave since she may not have access to healthcare, shelter (their home), transportation (the family car), and money to fulfill basic needs such as buying food. She may also not be able to afford legal assistance for obtaining a divorce or restraining order, or dealing with child custody issues (AARDVARC.org, 2004).

If the victim hasn't worked for a long period of time, she may not have any job skills that would enable her to find an opportunity that will pay enough for her to be able to afford housing and pay for basic necessities. On the other hand, if she has been working, her partner may have emotionally abused her so badly that she doesn't feel competent enough to successfully hold a job. Or the abuser could threaten to start bothering her at work, which could jeopardize her ability to hold the job (Womanspace, 2004).

For many women, the thought of having to move into a woman's shelter with her children, as well as facing the possibility of going on welfare, may create too great a barrier for her to leave (Abuse Counseling and Treatment Inc., 1995). Depending on each woman's situation and her barriers for obtaining resources, she may figure it's better to put up with the abuse instead of leaving

Lack of Support

Many abused women may not have much support since they have been isolated from friends and family by an abusive partner. In other cases, the victim will actively isolate herself as an attempt to hide signs of the abuse from outsiders due to shame or because family and friends have told her that the abuse would stop if she was a better partner (Foreman & Frederick,

1984). The isolation can result in her feeling that she has nowhere to go and make her even more dependent on her abuser.

Another case where a woman may not have support is if family and friends do not believe that her partner is abusing her. This can happen if the abuser is very charming, likable to outsiders, or has a respected position in the community such as mayor, a minister, or police officer (Borkowski, 1983). This scenario can further make abused woman feel as though she has nowhere to run since the abuser has convinced her support group to be on his side.

Low Self-esteem

If a woman has been emotionally and/or physically abused for any period of time, it can negatively affect her self-esteem, or the way she feels about herself (Vincent & Jouriles, 2000). When she has a low self-esteem, she might not be able to trust her thoughts and feelings, and she might feel worthless. As a result of self-doubt, she lacks the self-confidence needed to make decisions and solve problems, which can make solving small problems incredibly difficult (Stark & Flitcraft, 1996). In many cases the abuser has destroyed her confidence and made her feel that she cannot make it on her own without him (Foreman & Frederick, 1984).

Fear

Fear is a major factor for why a victim will not to leave an abusive relationship. The abuser may have threatened her welfare and she is afraid of being killed if she tries to leave. Even if she does leave, he might have convinced her that he will find her, hurt her, and never leave her alone. According to the National Coalition Against Domestic Violence (as cited in AARDVARC.org, 2004), the fear of being killed is real because women who leave their abuser have a 75% greater chance of severe injury or death than those who stay.

She might also be afraid to leave because the abuser has threatened to commit suicide or hurt her children if she leaves (Abuse Counseling and Treatment Inc., 1995; Institute for Family Violence Studies Rural Victimization Project, 2003; National Center for Victims of Violent Crime, 2004). The victim may be afraid that the legal system will not protect her if she leaves (Family Services Contact, 2002). She may also fear living alone and the prospect of trying to support herself and her children. Finally, even if she does leave, the feeling of fear may never really go away because she may never know when the next attack might come or where he might be located (Rapp-Paglicci et al., 2002).

DISCUSSION

Domestic violence against women has proven to be a significant social issue in the United States. According to a study published by Tjaden & Thoennes in 2000 (as cited in Jasinkski, 2004), almost 2 million women are physically assaulted each year and more than 50 million are assaulted in their lifetime. Men choose to assault their partners through a wide variety of methods for numerous reasons. Furthermore, partner abuse has historically not been considered a serious issue due to expectations placed on married women. In order to confront partner abuse successfully, society needs to be educated in the dynamics of domestic violence so they can better understand the serious nature of this crime.

The major therapeutic goal when counseling a female victim of domestic violence should be to encourage the growth of autonomy and empowerment within them (Family Services Contact, 2002; Stark & Flitcraft, 1996; Womanspace, 2004). Autonomy in this context refers to helping the client realize their personal freedom or self-possession, and empowerment refers to teaching her how to take the authority to make decisions for freeing herself from the situation (Womanspace, 2004). In order for a woman to successfully deal or cope with her abusive situation, she needs to have the ability to respond to it on her own volition. The counselor should support and provide her with options so she can start to realize her own decision-making confidence.

In order to promote these goals, a counselor should take the stance of supporting all of the victim's decisions and choices, no matter what they may be. Even if the client chooses to renter an abusive situation, the counselor must stay supportive and provide the client with a safe environment for self-expression so she can rebuild her decision-making confidence. Stark and Flitcraft (1996) stated the following:

> Despite the frustration of witnessing a client failing to leave a situation we believe puts her in danger, 'rescuing' such women only reinforces their sense of not being able to do so for themselves. Worse, when benign paternalism fails, therapists often behave like rejected lovers, alternately acting out in the treatment process or unwittingly identifying with the assailant's anger. (p.175).

Since the counselor's office is usually the last and only safe place for her to think and share her thoughts, a counselor could do considerable harm if he or she didn't show support to the client through respecting her situation and choices.

A second implication for counselors is to not suggest couples therapy as a viable option for treatment. In order for couples therapy to be effective, there should be some sense of equality and balance between the partners so they can safely talk about issues in a secure environment. In a violent relationship where a man is abusing his partner, there is no equality because he has chosen to abuse her through power and control. Furthermore, domestic violence is not about marital or relationship problems, but instead about the abuser's choice of violence and acting out in anger against his partner (Family Services Contact, 2002). Until the abuser learns to deal with his anger in a constructive manner, couples therapy cannot work because it is not a safe atmosphere for a woman to express herself without the fear of having her abuser "getting back at her" when they go home (Ronan et al., 2004).

A third implication for counselors is that there is no one best strategy in responding to domestic violence victims (Goodkind et al., 2004; Stith et al., 2003). Counselors need to keep in mind that each situation for every woman experiencing domestic violence is unique. The same strategy that meets the needs of one woman may have different consequences for another woman, depending on her individual situation.

Regarding counselor education, programs can better train their student to effectively deal with victims of domestic violence by providing comprehensive information regarding domestic violence. Students should be taught the dynamics of domestic violence and different types of treatment methods. These programs should also include "an analysis of the society in which wife beating occurs and the cultural beliefs and institutional practices that contribute to this pattern" so they can better understand the bigger picture of domestic violence (Dobash & Dobash, 1979, p.12).

Finally, implications for research suggest that there should be more research put forth to study the effectiveness of different types of domestic violence intervention programs. There is

currently scant research on which types of intervention programs are most effective and helpful for women in a violent relationship (Vincent & Jouriles, 1988). If there was more effort put forth in this area, victims could potentially be better assisted in our communities.

A second area requiring more research attention is changing the way that data for statistics is gathered. In most of the statistics or reports currently available, the statistics were gathered from abused women who were residing in a shelter, had been in a shelter at one point, or had some contact with law enforcement. While these are great places to find data, the problem presented here is that most of these women are usually from certain socioeconomic brackets and ethnic background (Jasinski, 2004; Stith et al., 2003). In order to better portray the prevalence of domestic abuse in the United States, studies should make more of an effort to gather data from abused women who would probably never interact with an outside agency for support (Goodkind et al., 2004).

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Relationship Between Teacher Obsessiveness and Reporting of Classroom Management Problems of Students with ADHD

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Eleven special education teachers were administered the Measurement of the Obsessive-Compulsive Personality (OCS) and the Conners' Teachers Rating Scale (CTRS-28) to investigate whether there is a relationship between the teachers' obsessive tendencies and their reporting of the severity of the problems of the students with ADHD in their classrooms. MANOVA results revealed that teacher obsessiveness had a significant impact on the CTRS-28 Inattentive-Passive scale, but no impact on the remaining CTRS-28 scales. These results suggest that teachers with obsessive tendencies are less aware of their ADHD student's problems with distractibility and disorganization.

Attention Deficit Hyperactivity Disorder (ADHD) is a disorder that begins in early childhood and is marked by abnormally high levels of problem behaviors (such as impulsivity/hyperactivity, and/or distractibility) that often results in school problems (Snowman & Biehler, 2000) and academic efficiency impairment on more than one level (DuPaul et. al., 1997). It is estimated that approximately three to five percent of school-age children have ADHD; with the males outnumbering the females by about four to one (American Psychiatric Association, 2000). Children diagnosed with ADHD are also at a high risk for difficulties with social relationships (Barkley, 1990).

Managing an ADHD student can be quite demanding and frustrating. Often, ADHD children challenge the competency of teachers through classroom difficulties such as high rates of movement, disruptions, interruptions and verbal outbursts; all of which may lead to increased levels of teacher frustration and anger (Pfiffner, 1996).

A teacher's own personality also affects his or her own classroom management strategies or techniques. Studies suggest that those teachers who impart suppleness, humor, enthusiasm and an eagerness to learn tend to obtain most favorable results with ADHD students (Hallowell & Ratey, 1994). In particular, patience is considered to be a critical factor for preventing behavioral problems and for maintaining an efficient working classroom environment (Rief, 1993).

There are numerous techniques that teachers can use to manage students with ADHD. The main key to managing ADHD students lies with persistency and consistency regarding applications of techniques (Hallowell & Ratey, 1994). Some techniques that aid in the management of ADHD students include: posting rules; repeating directions; knowing your limits; making eye contact; adding structured lessons; limiting homework assignments; monitoring behavioral progress; being unconventional; avoiding overstimulation; praising students (both verbally and nonverbally); using outlines for older students; announcing new ideas before implementing them and seeking verbal confirmation from students; using daily progress charts/reports/journals; using games as learning/educational purposes for counting/sorting/learning shapes/sizes/colors; using repetitions; avoiding a monotone voice;

encouraging physical movement; and using positive reinforcement to gain and retain attentiveness throughout the course of the school day (Hallowell & Ratey, 1994).

Numerous techniques can also be used in the classroom to increase the efficiency of school days, including seating students away from distractions; organizing the room with observable boundaries for work and play; displaying numerous visual aids for simple reminders; and displaying behavioral charts and progresses of the day/week for every student (Pfiffner, 1996). In addition, instructional strategies need to utilize effective routines with regard to schedules, teaching major academic subjects during the morning hours, altering between active and less active activities, and most importantly, taking breaks (Pfiffner, 1996). In addition, to be an effective teacher of ADHD students, one should always deliver lessons vividly, by maintaining attention and interest (Pfiffner, 1996).

Token economies are an efficient way of administering positive reinforcement to reduce unwanted behaviors/outbursts and increase desirable behaviors (Pfiffner, 1996). Some tokens may include stickers, food, small toys, computer time, or time spent with what the child likes to do the most. Even time-out can provide positive feedback by having the student realize what she or he has done is not appropriate. When using time-out, a teacher should use a consistent procedure, select an appropriate length of time; create back-up plans in case time-out fails; decide what behaviors should result in time-out; explain the process to the students; and when time-out is over, do not debate what happened (Pfiffner, 1996).

Some schools have implemented the School Environment Learning Program (SELP), a structured program that provides control over consequences (Gordon & Asher, 1994). SELP focuses on following class rules; completing schoolwork/activities; and interacting with other students in an appropriate manner (Gordon & Asher, 1994). Most importantly, the program's primary focus is attaining rewards instead of avoiding punishment (Gordon & Asher, 1994). As discussed by Snowman & Biehler (2000), avoiding frustration and boosting student's self esteem are effective ways of reducing ADHD students' management problems.

Obsessiveness and perfectionism are often used interchangeably, and refer to an important dimension of psychological functioning (Flett & Hewitt, 2002). Perfectionists tend to exhibit a need for assurance or certainty and may be preoccupied with order and routines (Dumont, 1996). Many perfectionists exhibit problems in dealing with frustration, disappointment, and stress environment (Dumont, 1996), and believe that human flaws need to be conquered and perfected (Smith, 1990). Many perfectionists tend to exhibit compulsive tendencies and repeat behaviors that are self-rewarding (Smith, 1990).

Perfectionism and obsessiveness, in relation to teaching, can pose both positive and negative effects on teachers' management styles of ADHD children. Too many obsessive tendencies can place undue expectation of compliance and increase stress within the classroom (Bieling, 2003). Perfectionists may obsess with minor details; be easily frustrated with imperfections of others and seek excessive organization, structure and order (Smith, 1990). On the other hand, teachers that are too laid back may not exhibit sufficient structure and may not set consistent riles, routines and expectations. Consequently, it seems that when it comes to educating ADHD students, the best teacher may be one that exhibits some perfectionistic tendencies – sufficient to focus enough on daily routines to develop consistent structure, expectations and consequences – but not so much that the teachers begins to expect undue compliance with such structure and routines without being able to tolerate minor deviations from compliance with such expectations.

The present study was designed to examine the relationship between teacher obsessiveness and reporting of classroom management problems of students diagnosed with ADHD. It was hypothesized that those teachers that exhibit a moderate amount of obsessiveness/perfectionism will be most able to tolerate ADHD students' classroom behaviors, while those teachers that fall along wither extreme of the obsessiveness continuum (not enough, or too much) will report most difficulties with managing ADHD students in their classrooms.

METHOD

Participants

Participants included eleven special education teachers (one male; ten females) between ages 24 and 49 (mean = 34.13) employed at a therapeutic school and preschool in urban New Jersey. The teachers had two to 20 years of experience (mean = 7.28) in the classroom. All teachers had at least one student diagnosed with ADHD in their classroom. The students were between five and 13 years of age (mean = 8.57).

Instruments

All teachers were administered the Measurement of the Obsessive-Compulsive Personality (OCS; Gibb et. al., 1983) and the Conners' Teachers Rating Scale (CTRS-28; Conners, 1989).

The OCS is a 22-item self report measure where participants respond true/false to statements that describe obsessive attitudes and behaviors. Twenty of the items are included in the overall total, and so the score ranges from 0 (not obsessive) to 20 (most obsessive). The instrument is standardized and has been found to be valid and reliable (Gibb et al., 1983).

The CTRS-28 is a 28-item measure that assesses the teachers' perception of their students' problem behaviors. The items are scored on a 4-point scale (0=not at all; 1=just a little; 2=pretty much; 3=very much) with regard to the severity of each problem behavior. The instrument renders score on four scales: Conduct Problem; Hyperactivity; Inattentive-Passive; and Hyperactivity Index. Consequently, every student receives four scores, one per each index. The CTRS has frequently been used in research as well as clinical practice. It is a standardized instrument that has been reported to be reliable and valid (Conners, 1989).

Participants also completed a demographic questionnaire that asked their age, gender, ethnicity, amount of years teaching, and amount of years teaching at the specific facility where the study was conducted.

Procedure

Following approval by the Institutional Review Board, teachers were approached about whether or not they know that they have at least one ADHD student in the classroom, and those who responded in the affirmative were asked to participate in the study. Participants completed one set of questionnaires per each ADHD child in their classroom. Upon completion, participants were debriefed. Upon collection of all materials, statistical analyses were performed to test the study's hypotheses.

RESULTS

Pearson Product-Moment Correlation Coefficients were performed to assess the relationship between the scales of the two measurement instruments (the OCS and the CTRS-28). The correlations revealed a significant negative correlation between the teachers' OCS scores and the CTRS-28 Inattentive-Passive scales scores ($r=-.395$, $p<.002$). This finding indicates that teachers who were more obsessive were less likely to notice their student's problems with distractibility and passivity. When the OCS variable was categorized (by grouping teachers into one of three groups – those whose OCS score fell below one standard deviation below the mean, those whose score fell within one standard direction around the mean, and those whose score exceeded one standard deviation above the mean), MANOVA was performed. The results revealed that teacher obsessiveness had a significant impact on the CTRS-28 Inattentive-Passive scale, ($F=2.739$, $p<.083$) but OCS had no impact on the remaining CTRS-28 scales. Consequently, the results provided a partial support for this study's hypothesis.

DISCUSSION

The present study supports previous research on perfectionism, in relation to displaying both adaptive and maladaptive aspects (Wei, et.al., 2004). Perfectionism, as in this study, can be understood as a construct with several dimensions (Flett & Hewitt, 2002). A teacher's own perfectionistic personality may help in setting achievable goals and maintain appropriate organization and order; but may also result in unrealistic expectations with regard to performance (Wei, et. Al., 2004).

Teachers with significant obsessive tendencies appear to focus more on acting out behaviors of ADHD children (for example, hyperactivity) while not noticing as many problems with distractibility. This means that obsessive teachers are more likely to attend to ADHD students acting-out behaviors and may tend to implement interventions aimed at reducing these problems, while they may spend less time addressing ADHD children's distractibility. The results of this study suggest that obsessive teachers need to be vigilant about recognizing their ADHD student's problems with distractibility.

This study presents with several important limitations. All but one teachers were females, and the sample was quite small. In addition, only one school produced the sample, and the demographics of the teachers and students were limited to mostly middle-class, non-minority individuals. Consequently, the generalizibility of these findings may be very limited. Future studies should attempt to replicate these findings with larger, more diverse samples.

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