Emotional availability (EA): the assessment of and intervention for global parent-child relational quality

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We thank the Temple Buell Foundation and the Bohemian Foundation for their support for a span of three years. We sincerely thank the study families and professionals, as well as numerous students and staff who participated in assessment and intervention.

Abstract

Caregiver-child relationships offer the first opportunity for emotional communication and the chance for a secure attachment (Biringen, 2004). When communication is emotionally connected and available, the likelihood of a secure attachment is enhanced. Such positively toned emotional communication that takes into account both interactive partners is referred to as "emotional availability" (Biringen, Robinson, & Emde, 1998).

Key-words: emotional availability (EA), caregiver-child relationships, EA Scales

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What is emotional availability (EA) more specifically?

Psychoanalytic thinkers Mahler, Pine and Bergman (1975) used the term "emotional availability" to describe a "supportive presence" as the infant explored the world. The availability of the parent without necessarily "doing" something with the child was described, in fleeting terms, as "emotional availability". The mother's supportive presence and autonomy-granting was seen to be balanced by the child's "refueling" and seeking out connection. Thus, in the earliest writings on emotional availability, a mother contribution and a child contribution were implicit, but not explained further or more specifically.

Bowlby (1969/1980) and Ainsworth (Ainsworth, Blehar, Waters, & Wall, 1978) wrote about sensitivity,

Efficiency of experiential psychotherapy in the treatment of children with attention deficit hyperactivity disorder

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Abstract

The paper presents the results of a controlled study that had the purpose to test the efficiency of a complex plan for the treatment of attention deficit hyperactivity disorder. This therapeutic plan combines metaphorical scenarios adapted for therapeutic intervention in small groups of hyperactive children with special groups of professional optimisation, organised for the teachers of these children. The subjects were 40 children diagnosed with ADHD, combined type. The psycho-diagnostic test battery used for selection included: anamnesis (Barkley, 1991), Semi-structured Clinical Interview for Children and Adolescents, ADHD Rating Scale (rated by the teacher) (adapted after Barkley, 1991), completed before treatment and after treatment and Behavioral Coding Sheet (adapted after Barkley, 1991), completed before treatment and after treatment.

One-way ANOVA showed that there is a significant difference between the four groups on each criterion ($p < .05$). Bonferoni Post-hoc multiple comparisons tests showed that this difference is due to the mean scores for the control group, significantly different from the experimental groups. This means that there is a statistically significant reduction of the intensity of the disruptive behaviour after the treatment. The participation of teachers in a professional optimization group leads to a significant behavioral progress of children in their class, which are diagnosed with Attention Deficit Hyperactivity Disorder.

The originality elements of the paper are: 1) using a modern research design by completing the clinical controlled study with qualitative analysis of the process; 2) validation of experiential expressive techniques for the therapy of ADHD children and creating new techniques; 3) validation of a training program for primary school teachers for working with ADHD children in the classroom.

Key-words: child, ADHD, experiential psychotherapy, controlled study

1. Introduction

Attention deficit hyperactivity disorder (ADHD) is one of the most common behavioral disorders of childhood and is characterized by hyperactivity, impulsivity, and inattention (American Psychiatric Association, 2000).

Children and adolescents with ADHD are at a significantly higher risk for numerous emotional and social problems than those without ADHD, including academic and occupational underachievement, violence and criminality, increased suicide and risk-taking behavior, depression, addiction, interpersonal difficulties, and family disruption (Barkley, 1998).

Identifying efficient treatments for children with conduct and emotional disorders is a present-day problem in clinical psychology and psychotherapy research.

Disruptive disorders in childhood, due to their high prevalence in population, have an important social and economic impact not only on children, but also on their families, their teachers and colleagues. This is because of the externalized character of these disorders, capable of disturbing the activity of all the actors in the children's environment. Thus, making the treatment of childhood disruptive disorders more efficient will have important social effects, effects linked to a better life-quality of the families, teachers and colleagues of these children.

The problem of the efficiency of child psychotherapy is a very actual one on international level. In a paper published by H.G. Hair in the *Journal of Child and Family Studies* he refers to a study made by Hoagwood in 2003 about all evidence-based controlled studies published regarding the results of psychotherapy. The author arrived at the fabulous number of over 1500 clinical controlled studies regarding the efficiency of child and adolescent psychotherapy and 12 important revisions of the studies between 1998 and 2002. These controlled studies had the purpose to demonstrate the efficiency of the therapeutic interventions, meaning the possibility that a therapy will produce good effects in ideal conditions (see Hair, 2005).

A strength-based approach in understanding and supporting people with intellectual disability and autism

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Abstract

Historically, autism was defined as a pattern of ***deficits*** in the area of cognitive functioning, social interaction, communication and restricted and repetitive behaviours. This approach did little for the real people living with autism, as well as for professionals because success cannot be achieved based on deficits.

The solution ironically, came from the people with autism who tried to describe their way of experiencing the world. From there, through the work of a few devoted professionals such as Martha Leary (Canada) and Anne Donnellan (USA) a new approach has risen – a neurological one, refining the observations on people's observable behaviours, proving that each twirl and whistle can be profoundly meaningful.

The current article will outline the role of neurological factors in understanding the challenges of people with autism, and it will offer to the professionals and families a sample of how a treatment plan can be developed in order to support people with autism to overcome their daily challenges, to fulfil their potential and to enhance their capacity to contribute meaningfully to the community life and society in general.

Key-words: autism, neurological factors, sensory and movement differences, accommodations, challenging behaviours, support plan, facilitated communication

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The behaviours of a person with autism often appear bizarre, unusual, difficult to understand, inappropriate and challenging to the people around them. Families and sometimes, professionals find it difficult to understand, assess the behaviour in a certain context and to support the person to face their challenges. People with autism have high risks of being ignored, isolated, labelled as retarded and stigmatised. They are often condemned to a life below their abilities, a life full of frustration lacking opportunities to learn new things and to develop skills, which is the main cause of their deterioration and deficits. In 2001, Emerson introduced the term "challenging behaviours" to recognise that some behaviours used by a person with a disability have the potential to result in serious consequences for them and those around them: ***"Culturally abnormal behaviour(s) of such intensity, frequency or duration that the physical safety of the person and others is likely to be placed in serious jeopardy, or behaviour which is likely to serious limit use of, or result in the person being denied access to ordinary community facilities (Emerson, E., 2001).*** In this regard, the term "challenging behaviour" is used in this document to denote behaviours identified as a challenge for individuals, families, carers and those providing support and not as a "problem" with the person or an illness or a diagnosis.

In the last years, there is a core body of research introducing a new way of looking at autism and its challenges. This new approach does not look at autism as being a pattern of deficits; it rather recognises that people with autism are ***different***. This is a ***neurological perspective*** that has as main hypothesis the fact that people with autism have a very different way of receiving information from the environment or from the body, of processing this information and a specific manner of elaborating a response. As a result, the researchers no longer call these aspects "deficits", but rather ***"sensory and movement differences".*** This perspective opens new dimensions in treatment and support, because it implies that not all the people are the same, which means that we acknowledge the right of each person to be herself/himself, it means to respect the unicity of each person and to support each human being to develop her/his potential through appropriate methods and adjustments, rather than forcing people to fall in a certain category that we call "normality". These specific strategies that a person discovers herself to adapt to the environment or with the help of a professional, are called ***"accommodations"***. ***Accommodations are defined as personalized strategies that assist one in temporarily overcoming the difference in movement and sensory processing, which are problematic to an individual***

The medical-legal expertise in the case of a minor's emotional and sexual abuse

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Abstract

The purpose of this paper is to emphasize the specifics of the legal medicine expertise in a case of a sexual and emotional abuse of a five year old child. The objectives are: 1. regarding the abused minor: to highlight the signs of emotional and sexual abuse and behavior disorders; 2. regarding the parents: to highlight normal or deviant sexual behavior, psychological disorders, and the attitude towards the minor. In order to achieve these objectives we used the following methods: the study of the files, interview with every member of the family, psychiatric evaluation (past and present conditions), and psychological assessment. For the parents' evaluation the following were used: EMBU, Scale of Self Esteem, NEO PI-R, Rosenzweig, the Tree Test, the Rorschach Test, and the structural interview. For the psychological evaluation of the child the Family Test and the House Test were used. The conclusions are the following: the minor has shown an emotional abuse due to the conflicting atmosphere between the parents; clear signs of the child's sexual abuse could not be identified, just behavior disorders, meaning a hyper-sexualizing of the behavior not suitable to the minor's age. The parents do not show any specific psychiatric disorder symptoms, so they are responsible for their deeds. This case shows the difficulties that specialists have to face when attempting to clearly identify a sexual abuse of a minor.

Key-words*:* sexual and emotional abuse, expertise, psychological evaluation, psychiatric evaluation

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Introduction

Friedrich (1991) divides the behavioral indicators of the abused persons in two categories: sexual indicators, generally with high probability and non-sexual behavioral indicators, considered to have, in general, a low probability.

1. Sexual indicators (for children under 10 years): precocious sexual knowledge; drawing of sexual organs; sexual aggression of smaller children (representing an identification with the aggressor); making sexual invitations or gestures with sexual connotations towards the adults (suggesting that the child expects and accepts sexual activity as a way to relate to the adult); involvement in sexual interactions with animals or toys; excessive masturbation (several times a day, without stopping when someone sees him etc.).

2. Indicators of non-sexual behavior

The reason for which non-sexual behavioral indicators are considered to have a low probability is that these symptoms may be due to other types of trauma (substance abuse, emotional maltreatment, death of a close person etc.).

The non-sexual behavioral indicators for children under 10 years are: sleep disorders, enuresis, regressive behavior (the need to take a transitional object to school), self-destructive behavior, impulsivity, concentrating difficulties, the refusal to remain alone, the fear of a certain person (possibly the abuser) or of a certain type of person; cruelty against animals (in boys); pseudo-maturity within the family.

The combined presence of the sexual and non-sexual indicators is a factor that suggests the likelihood of a sexual abuse.

The reason of the expertise

The subject, aged 33, is accused of emotional and sexual molestation of his own child, who is currently aged 5, a reason for which the psychiatric expertise of the three family members was requested.

The objectives of the expertise

a. Regarding the minor: identifying the signs of a possible emotional or sexual abuse, identifying the

Pathological gambling: impulsiveness, coping strategies and psychopathological symptoms

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Abstract

Literature registered many psychological conceptualizations aiming to explain how pathological gambling can be considered a disease and on what mechanisms it is based.

The primary aim of the study was to evaluate the presence of disorders regarding the psychological structure and functioning of the subjects diagnosed with Pathological Gambling (PG). The presence of different categories of disorders has been evaluated: affective disorders, personality disorders, substance addiction, obsessive – compulsive disorder. We also assess the expression of impulsiveness behaviors and the coping strategies. Twenty-seven subjects were recruited from the Clinical Service for PG "GAME OVER", Italy.

Both the methods, and the main results obtained will be presented, followed by the discussion of the data obtained in relation to those existing in literature.

Key-words**:** pathological gambling, disorders, clinical evaluation, psychopathological symptoms

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I. Introduction

For many years gambling has been a scarcely studied phenomenon, and nevertheless, of low interest for psychologists. The first signs of interest in this phenomenon showed by psychologists and physicians appear since Kraepelin, who talks about "the gambling mania". In 1980 gambling is included by the American Psychiatric Association in DSM-III, this event signaling its recognition as a true mental illness.

As a consequence of its intense expansion as a social phenomenon, gambling gained a growing interest in researchers and institutions over the last years.

Such an activity has been deeply rooted in human nature, ever since the origins of civilization, as a form of social interaction. In the media era we live in, the new technologies have created new games on one hand, and an easier accessibility to them on the other hand. Our age is not only that of new lotteries, but especially the age of video poker, which simulate poker in absence of opponents. As Croce asserted (2001), the video poker caused the multiplication of the addiction cases, converting a "disease", initially limited to smaller group of people, into a mass phenomenon.

There are still many uncertainties related to the classification of the pathological game, mostly due to its links to other disorders. Thus various work hypotheses developed regarding the structure and pathological functioning of the subjects diagnosed with PG: affective disorders, including depression and anxiety, substance addiction, personality disorders (like Obsessive–Compulsive, Antisocial, Avoidant, Borderline, Schizoid), Obsessive-Compulsive Spectrum Disorders, Impulse Control Disorders. The definition proposed by the DSM – IV-TR (2000) places pathological gambling among the "Impulse Control Disorders Not Otherwise Specified".

The study originated in a Clinical Service for the treatment of Pathological Gambling (PG), having therefore as primary aim the evaluation of the psychological state of people who have requested treatment for their gambling problems. With regard to the high frequency of other disorders (in Axis I and II) reported in literature on these subjects, it was considered appropriate to conduct a comprehensive assessment in order to plan a proper and specific treatment program that takes into account not only the behavior of gambling

The self image of the homeless adults

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Abstract

This issue is meant to offer a ray of light on the way homeless adults perceive themselves and on the way this aspect influences their behavior into the world.

It is well known that when speaking of self image we refer to aspects reflected by the answers to: Who am I? Who do the others think I am? How do I (get) to know myself? How do I accept my identity? These are some questions people permanently try, in a conscious or less conscious manner, to answer all their life. And why is that? It is because our self perception is a very important aspect of our psychic life.

Key-words: homeless adults, identity, self image

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Each of us may say something about oneself, may characterize oneself, yet there are cases when the self perception does not fit into reality, to the others' opinion or to the ideal personality model we tend to. This aspect becomes very important for the condition of socially vulnerable persons – especially homeless persons – who feel that they are labeled just because they no longer have a home. Actually, in this case, a negative self image starts from inside.

The self image represents a global evaluation of the own person, which is not inborn but is created by means of learning, by means of the experiences one may have, of the actions one achieves or takes part to. The orientation for self evaluation is learnt by means of the socialization process when the person becomes aware of its own value by relating to the others. The attitude of the parents, teachers, colleagues, bothers, friends, contributes to creating the self image of each of us, to setting a social status, a certain level of aspirations that would imprint, starting from childhood, on all our actions and behaviors.

We may say that the personal image is the base of our whole personality. Related to it, our experiences tend to become reality and strengthen our own image determining as such a vicious circle. All our actions and feelings are in accordance with our own image. We shall behave exactly the way we think we are. We can not do otherwise, no matter how hard our will proves to be. The one considering oneself to be a "loser" shall behave accordingly, failing no matter how hard he would try to meet success and no matter how many chances would interfere. The one considering oneself to be "unlucky", shall do everything to prove he is a victim of "bad luck".

The self image is defined by the way we perceive our own physical, emotional, cognitive, social and spiritual characteristics that would shape and strengthen the dimensions of our ego. According to our perception at a certain moment of our development, on what we would like to be or what we might want to become, we may distinguish more states of our ego: the present ego, the ideal ego and the future ego.

As far as people living on streets are concerned, we may identify a series of aspects that might characterize the self image, as it is perceived by the respective persons. Based on the observation files and meeting protocols registered in the psychological office Samusocial in Romania (SSR) I made a synthesis of the main psychosocial behavior aspects related to the self image of the homeless adults.

In case of these beneficiaries *the self image* refers to the way they perceive and describe when talking of themselves. I considered two alternatives of self appraisal: *a good self image* when the person speaks of itself in positive terms and *a deteriorated self image* when the person speaks of itself in negative, depreciatory terms.

Responsibility assigning refers to the tendency noticed in a person's speech of considering that the current situation is the effect of one's own actions or it is the result of others' action (close relatives, family, partner, neighbors, institutions etc.). I have noticed two such tendencies: *assigning the responsibility to one/ or more persons around* and *self assigning*. This aspect is important for the psychological assistance process

Mechanisms involved in group or individual unification psychotherapy with persons with depressive disorder

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Abstract

This article presents the results of a unification psychotherapy program for subjects with depressive disorder, with special considerations regarding the psychological mechanisms involved. The research was conducted with three groups of subjects with ages between 34 and 38 years: one receiving individual psychotherapy, one participating in group psychotherapy, and a control one. Depressive symptoms, self-esteem, interpersonal problems and global functioning were assessed. Statistical data revealed a general mechanism involved in unification psychotherapy for depression, and mechanisms which are specific to the type of its administration (individually or in group).

Key-words: psychotherapy, depression, mechanisms, self-esteem, interpersonal problems

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Introduction

One of the latest trends in psychotherapy is to study the process that makes it work, given the long history of studies on its efficiency (Lebow, 2006).

The therapeutic process can be seen from two perspectives: one regarding the mediating variables and one focused on exchanges that take place between the client and the psychotherapist. The first perspective is a large one and has as main objective to identify the mediating and the moderating variables of the outcome of psychotherapy. The moderating variable is the one whose values previous to psychotherapy influence its effects (e.g. gender, optimism or self-esteem). The mediating variable is the one whose variance through the psychotherapy explains the variation in the global result for all the subjects, no matter their characteristics prior to therapy (e.g. the perceptual processing). There are variables that can be considered both a moderator and a mediator (the level of optimism at the beginning of therapy may be the moderating variable and its variation through therapy, the mediating variable).

There are both types of studies conducted on subjects with depression in addition to those validating various forms of psychotherapy.

The mediators or moderators are identified by statistic procedures (Johansson and Høglend, 2007) adapted to the type of study. In comparative studies the Baron and Kenny (1986) mediation model can be used, and in controlled clinical studies the Kraemer et al. model (2002, in cit.op.). But the most important request is that the variable be explained by theory and have theoretic relevance (Honos-Webb, 2005, Johansson and Høglend, 2007).

Researchers discovered some of these variables in psychotherapy for depression: the therapeutic reactance as a predictor of future therapy outcomes for chronic depression (Bruce et al., 2003), the ability to master relationship conflicts, especially assertiveness and the ability to question the other's reaction (Grenyer, 2002), sudden gains between therapy sessions (Hardy et al., 2005), working alliance, emotional arousal and perceptual processing (Missirlian et al., 2005).

Approximately 160 clinical trials or comparative studies have been mentioned, demonstrating the efficiency of different forms of psychotherapy for depression and 40 meta-analyses (Cuijpers et. al., 2008). They revealed some interesting differences not taken into consideration enough in everyday practice:

- interventions centered on problem solving were more efficient,
- interventions realized by students had smaller effects than those run by specialists or health professionals,
- efficiency varies with the subjects involved,
- there is no relation between the effects and subjects' condition and the beginning of treatment,
- individuals that receive psychotherapy following periodic screening have more modest gains compared to those who answer themselves to community announcements,
- there is an influence depending on the type of control group used,
- there is no other significant relationship between characteristics of the target population and size effect (ibidem).

A literature review of the use of Eye Movement Desensitization and Reprocessing (EMDR) in adults diagnosed with post traumatic stress disorder

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Abstract

Posttraumatic stress disorder (PTSD) is a pernicious mental health problem that causes severe occupational and social impairments. Epidemiologic studies show that about 56% of the population will be exposed to a traumatic event and about 8-12% will meet the criteria for PTSD during their lifetime. Given the chronicity and the high rates of PTSD in today's society, it is imperative to determine the most efficacious intervention that has the potential to reduce symptomatology. This literature review indicates that EMDR is a therapy that can be implemented with sustained benefits.

Keywords: Eye Movement Desensitization and Reprocessing (EMDR), Post-Traumatic Stress Disorder (PTSD), trauma, Cognitive Behavioral Therapy (CBT), Trauma Focused Cognitive Behavioral Therapy (TFCBT)

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Background and Significance

56 percent of the U.S. population will be exposed to one or more significant traumatic events and eight to 12 percent will meet the Diagnostic and Statistical Manual of Mental Disorder (DSM) criteria for PTSD (Post Traumatic Stress Disorder) during their lifetimes with numbers of the afflicted increasing rapidly (Department of Veteran Affairs, 2009). Yet successful treatment of PTSD remains limited. One promising, yet minimally utilized treatment is Eye Movement Desensitization and Reprocessing (EMDR). However a question which needs to be addressed is: Is EMDR an effective and evidence-based treatment for PTSD?

The correlation between trauma and psychiatric symptoms has been documented for more than two hundred years. Early psychoanalysts, such Freud, noted a link between neurosis and trauma, but true clinical interest increased after each of the two World Wars. PTSD was referred to as "battle fatigue", "shell shock" or "soldier's heart" (Saddock & Saddock, 2005). The diagnostic approach to PTSD continues to be refined even with the soon-to-be-published DSM V. Ever-increasing exposure of individuals to trauma will surely increase the incidence of PTSD around the world. With fewer psychiatric practitioners and decreased access to care, it will be important to employ therapies for PTSD which are effective and efficient (APA Compendium, 2006).

What is EMDR?

The technique of EMDR was first developed by Francine Shapiro, PhD in 1989. EMDR is a psychotherapeutic intervention in which a specific type of eye movement is induced by the therapist. As the therapist induces this eye movement, they concurrently elicit conscious recall of the traumatic event(s) through techniques such as exposure therapy, image habituation training, applied muscle relaxation, biofeedback, assisted relaxation and active listening or re-exposure to traumatic events through various means. Eye movement is induced through a variety of techniques such as hand tapping, the use of focused light or auditory stimuli.