FOCAL POINT

YOUTH, YOUNG ADULTS, & MENTAL HEALTH

SUMMER 2011

V. 25

HEALTHY RELATIONSHIPS

FOCAL POINT IS PRODUCED BY THE PATHWAYS RESEARCH AND TRAINING CENTER (RTC) AT PORTLAND STATE UNIVERSITY IN PORTLAND, OREGON

Summer 2011
Vol. 25

Introduction: Healthy Relationships
L. Kris Gowen 3

Getting Along: Youth and Family Views of Healthy Relationships in the Transition Years
Pauline Jivanjee & Jean M. Kruzich 5

The Importance of Therapeutic Alliance for Transition-Aged Youth
Brittany Jordan-Arthur, Gabriela Romero, & Marc Karver 8

Three Views of Evolving Relationships in the Transition Years: A Mother and Two Siblings
Corinne Spiegel, Jasmine Spiegel, & Joel Spiegel 11

A Story of Connecting
Lynn Twigg 13

How Mental Health Challenges Impact the Sexual and Relational Health of Young Adults
L. Kris Gowen 15

Data Trends: Associations Between Childhood Maltreatment and Young Adult Romantic Relationships: A Focus on Gender Differences
Celina Kishna & L. Kris Gowen 19

Building Healthy Relationships with Your Medication and Medication Provider
Beckie Child 21

Key Helping Relationships Among Young Adults with Mood Disorders
Michelle Munson 25

Data Trends: Being Treated Differently: Stigma Experiences of Adolescents with Mental Health Disorders
Aakrati Mathur 28

Building an Online Community
Wesley Kittel 30

SUMMER 2011 *FOCAL POINT* STAFF:

Editor: L. Kris Gowen, gowen@pdx.edu
Assistant Editor: Nicole Aue, aue@pdx.edu
Layout/Design: Nicole Aue, aue@pdx.edu

WE INVITE OUR AUDIENCE TO SUBMIT LETTERS AND COMMENTS:

L. Kris Gowen, Editor: gowen@pdx.edu
Publications Coordinator: rtcpubs@pdx.edu

Focal Point is a publication of the Research and Training Center for Pathways to Positive Futures. This publication was developed with funding from the National Institute on Disability and Rehabilitation Research, United States Department of Education, and the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (NIDRR grant H133B090019). The content of this publication does not necessarily reflect the views of the funding agencies.

www.pathwaysrtc.pdx.edu

INTRODUCTION

HEALTHY RELATIONSHIPS

The desire for connection is strong for most people, but many may not realize how necessary it is in order to live a healthy life. In the 1940s, psychologist Rene Spitz observed the development of infants in two institutions—one a nursery in which the infants were raised by their mothers, and the other an orphanage in which infants were raised by overworked caregivers, each responsible for approximately ten three-month olds. The babies in both settings were adequately fed and bathed, and received medical care—the only thing different was the amount of emotional connection they experienced. After a year, Spitz found that the normative development of the infants raised in the orphanage steadily deteriorated, while those in the nursery thrived. After two years, the observations were worse; 37% of those in the orphanage died—those that managed to survive never learned to walk, speak, or feed themselves. This tragedy, while extreme, illustrates how human connection is not only desired, but is necessary for survival: "The high mortality is but the most extreme consequence of the general decline, both physical and psychological, which is shown by children completely starved of emotional interchange" (p. 149). This need to have relationships with others, of course, does not end in childhood, but continues as we get older. Relationships play an especially important role in youths' lives, as relationships with peers and partners become more essential and family relationships begin to reflect more balanced and equal interactions.

But in order for human contact to be beneficial, it needs to be healthy. While the characteristics of healthy relationships vary depending on the persons involved, the nature of the relationship (i.e., parent-child, best friends), and factors such as age, there are some commonalities. A healthy relationship between two people provides them with the opportunity to grow, share themselves, and form a bond that enhances the self and the other. Individuals in a healthy relationship exhibit trust, respect, and care for themselves and each other—and they listen to each other and work to make the relationship survive. This issue of *Focal Point* is about Healthy Relationships and their effects on young adults with mental health conditions. While most of the articles focus on the positive aspects of relationships, others highlight more negative experiences and their impacts.

Many different types of interpersonal relationships are featured. The family is often seen as the origin of a person's relationship experiences; interactions within the family are seen as the precursors to other relationship success. Corinne Spiegel and her children share their experiences with living with a child with serious emotional difficulties, and Lynn Twigg tells her story of reconnecting with her biological family—for better and for worse—after years in the foster care system. Pauline Jivanjee and Jean Kruzich sum-

> "A healthy relationship between two people provides them with the opportunity to grow, share themselves, and form a bond that enhances the self and the other."

marize their research about the importance of parent-child relationships during young adulthood, a time often associated with increased independence.

However, young adults need more types of supportive relationships than just those within the family. The importance of a strong therapeutic relationship is articulated by researchers Brittany Jordan-Arthur, Gabriela Romero, and Marc Karver. Michelle Munson writes about how natural mentors—whether they be family members, friends, or other trusted adults—offer advice and connection. But sometimes those closest to us do not always provide the support needed; a summary of Tally Moses' research of how youth experience stigmatization within the family, among peers, and at school demonstrates how different relationships can affect youth in negative ways.

As children grow into young adults, romantic and sexual attachments become more important. Yet these types of relationships can be difficult to talk about, especially with young adults (never mind with young adults who have mental health challenges). Too often, adult supports want to ignore the reality that these seemingly vulnerable youth are engaging in intimate relationships which, when at their best, are some of the most wonderful experiences a person can have, but at their worst can have serious adverse effects on a person's physical and emotional health. To that end, we offer two articles about intimate relationships: one that addresses how the sexual health needs of young adults with mental health conditions are different from those of young adults in general, and another on how early experiences with trauma—often found in young adults with mental health conditions—influence romantic relationships.

Two other articles consider how relationships with inanimate objects should be considered as well as those between people. An article by Beckie Child addresses the importance of having a healthy relationship with one's medications and the people behind the prescriptions. Wesley Kittel describes how the internet has helped people form connections and supports as he tells the story of building an online community for young adults with mental health conditions.

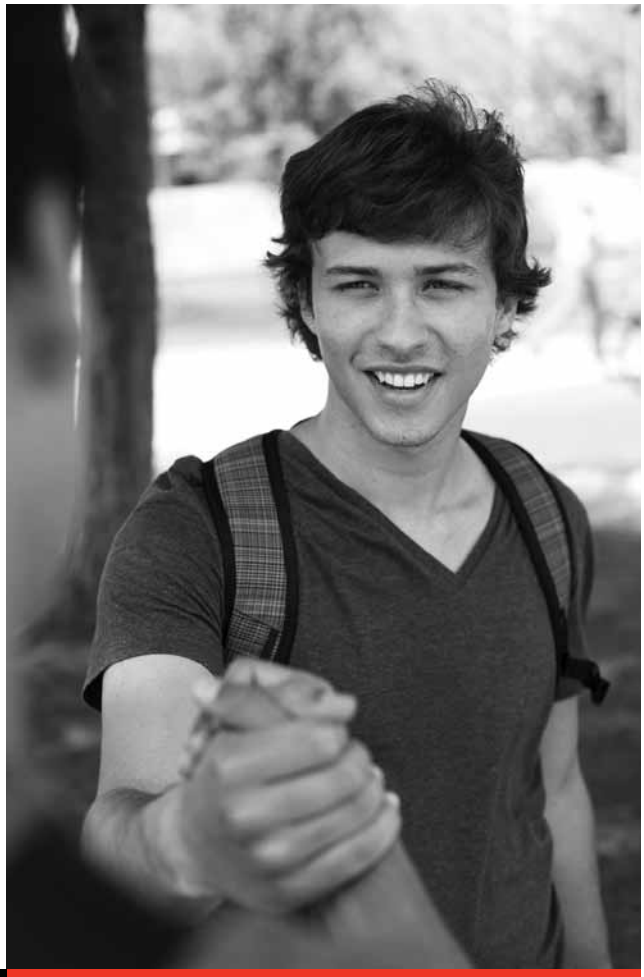
We hope that this issue of Focal Point encourages you to take a broad look at the meaning of "healthy relationships" and how all of us can provide supports for young people as they negotiate interactions with the many people that cross their paths daily, picking and choosing who they let into that inner circle of support that they—like all humans—need not just to have a fulfilling life, but literally for survival.

REFERENCES

1. Spitz, R. (1949). The role of ecological factors in emotional development in infancy. *Child Development, 20,* 145-155.

AUTHOR

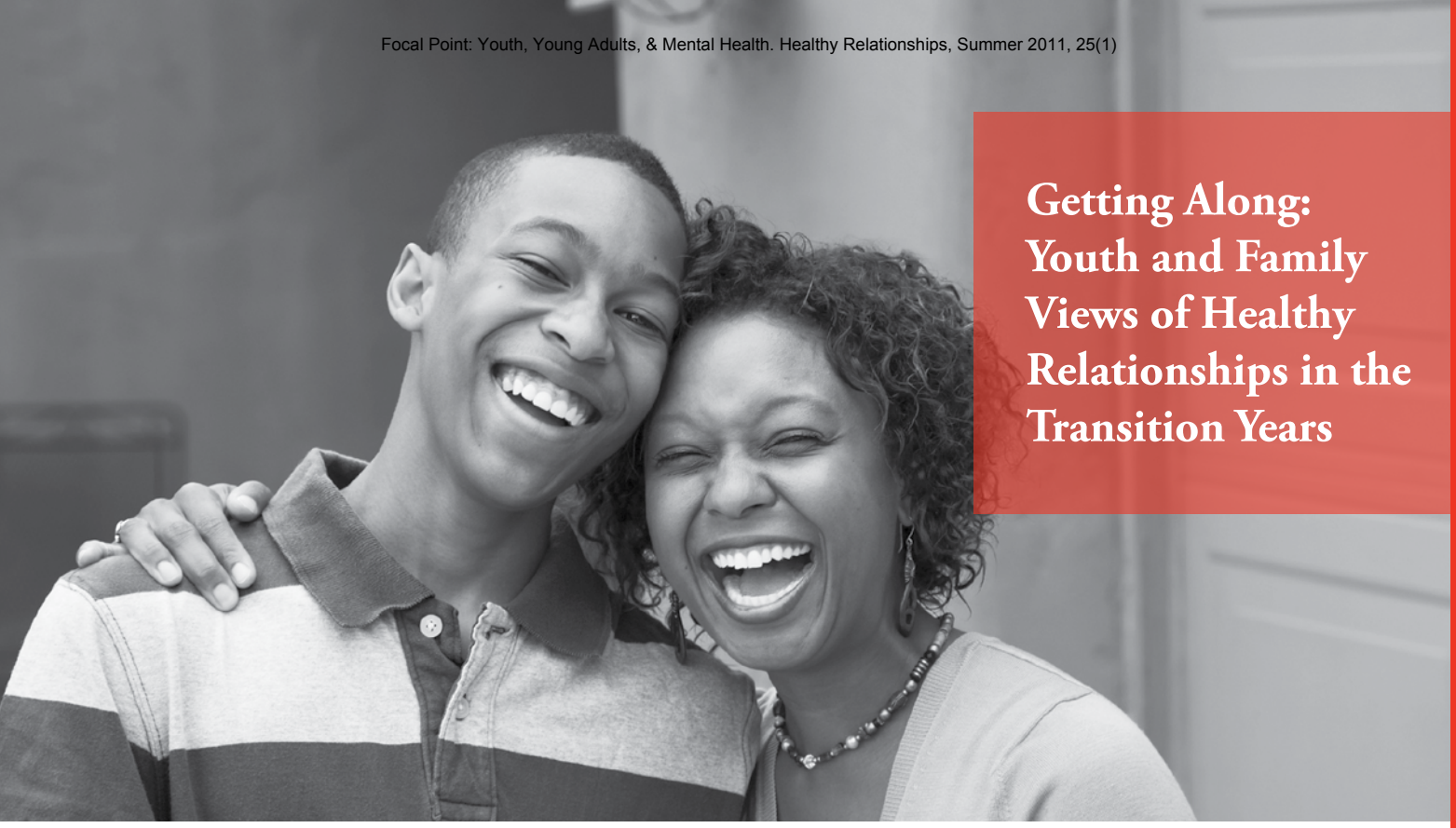
L. Kris Gowen is Research Associate and Editor of *Focal Point* at Pathways to Positive Futures.



CONNECT WITH THE PORTLAND RTC ON THE WEB:

www.pathwaysrtc.pdx.edu

Regional Research Institute for Human Services, Portland State University. This article and others can be found at www.pathwaysrtc.pdx.edu. For permission to reproduce articles at no charge, please contact the publications coordinator at 503.725.4175; fax 503.725.4180 or email rtcpubs@pdx.edu



Getting Along: Youth and Family Views of Healthy Relationships in the Transition Years

As young people navigate the transition years from 14 to 30, healthy relationships in families shift gradually. Parent-child relationships in which parents are responsible for their children's well-being and make decisions on their behalf evolve into adult-adult relationships. While these relationships continue to include love and caring, emerging adults achieve varied levels of autonomy and independence from parents, and peers and intimate relationships become increasingly important. For young people with serious mental health conditions, parent-child conflict, parents' concerns about their young adult's mental health symptoms, and youth perceptions of parent interference may challenge healthy relationships between parents and their children as young adults.

Developmental theorists have provided frameworks for understanding healthy relationships during the transition years. Parent-child relationships inevitably shift in adolescence and emerging adulthood as young people clarify their own values and ideals; develop their identity; maintain and develop relationships with peers, role models, and romantic partners; explore and pursue educational and career options; and gradually achieve increased independence from the family in their financial and living situation.[1] These activities occur within the context of family transitions that include young people moving in and out of the family home, development of adult-adult relationships, and parents refocusing on their own relationship, careers, and aging parents.[2,3]

When a child has a serious mental health condition, parent perceptions of the causes of mental illness and subsequent responses such as sadness, self-blame, guilt, worry, pessimism, and expression of stigmatizing attitudes affect parents' attitudes and their evolving relationships with their children in the transition years.[4,5] From the perspective of young people, these responses may manifest as over-protection, mistrust, and over-vigilance, although over half of the young people in a recent study said that they were not treated differently by their family because of their mental illness.[5]

UNDERSTANDING YOUTH AND FAMILY VIEWS OF FAMILY RELATIONSHIPS

To gain understanding of the impact of a serious mental health condition during the transition years, a team of researchers and trained youth and family research assistants who had participated in mental health services facilitated 20 focus groups throughout the Seattle, Washington and Portland, Oregon metropolitan areas. Participants consisted of 36 young men and 23 young women aged 15-28 with mental health conditions and 42 family members (most of whom were mothers). As part of the discussion of barriers and supports to a successful life in the community, participants talked at length about the importance of healthy supportive relationships with family and friends.

YOUTH VIEWS OF RELATIONSHIPS WITH THEIR FAMILIES IN THE TRANSITION YEARS

While some of the young people in our focus groups were estranged from their parents, most participants talked enthusiastically about how important it was for them to have parents that tried to understand and support them,

Regional Research Institute for Human Services, Portland State University. This article and others can be found at www.pathwaysrtc.pdx.edu. For permission to reproduce articles at no charge, please contact the publications coordinator at 503.725.4175; fax 503.725.4180 or email rtcpubs@pdx.edu

and that stood by them even through tough times. One young woman commented that it was helpful to have:

> *"parents who finally got what was going on. I think I am lucky in a lot of ways because my parents do understand. They don't have it first-hand but they understand that life isn't the same for me as it is for them."*

Some focus group participants had been involved in mental health services for many years but when asked where they received the most support, they tended to be most thankful for family and friends' support over time:

> *"I would say friends and family members [provide me with the most support], because family members, they know what you've been through. They see it for themselves, so that is somebody you can talk to who knows what you have been through and probably [has] been through it with you."*

> *"The best support you can have is your circle of friends and your family. There's people that do care about you and there is no doubt and they're free and they're always there… They do have a vested interest in your life, in your happiness, that feels really good. Having that—you can't put a price on it."*

Some participants had been through many challenges such as being kicked out of school and involvement with juvenile justice, and therefore particularly appreciated support from family, as noted by one young woman: *"I know that is why I've been able to deal with the stuff I've dealt with—I've gotten close to my mom and friends."* While commenting on the benefit of a supportive family, participants retained a desire to achieve independence and thrived where families allowed them to grow up: *"It's nice that I have, really, a safety net to fall back on with my family, but at the same time I am able to make decisions for myself."*

FAMILY MEMBERS' VIEWS OF RELATIONSHIPS WITH THEIR CHILDREN: TRANSITION YEARS

Recognizing the mental health challenges faced by their children, family members who participated in the focus groups understood that their children were following different paths to adulthood than other young people, as illustrated by a parent's comment: *"I have learned to stop comparing [my son] to other people. I look at his successes as they are."* These parents realized that their children might need to depend on them more and for longer periods than typically developing young people. Because of their sensitivity to warning signs of emotional difficulties, some of these parents reported worrying about their child and consequently being vigilant to their child's demeanor, while avoiding sharing their perceptions. For example, a mother described her tendency to observe her son's behaviors in order to anticipate difficulties:

> **"It's nice that I have, really, a safety net to fall back on with my family, but at the same time I am able to make decisions for myself."**

> **"I think I am lucky in a lot of ways because my parents do understand. They don't have it first-hand but they understand that life isn't the same for me as it is for them."**

> *"No matter what kind of kid you have, you always are going to be thinking and worrying about your kid… especially if you have got a kid who has gone through the kind of stuff that ours has, that those little insights, those little looks, those little habits, those little behaviors that are… a clue to potential problems."*

Many family member participants had children whose mental health difficulties started when they were very young, and over time they learned to be effective advocates for their young children. However, as their children transitioned to adulthood, parents discovered that to promote healthy relationships with their adult children, they needed to step back and let their children speak for themselves. An adjustment to this stage of life means young people having more independence and parents taking a back seat:

> *"Loving doesn't mean doing. I think mothers always think if you are loving, that you are doing something for them. It can be more of a passive, 'I'm here and I love you,' without burning yourself out."*

These parents also understood that their children wanted to make their own decisions and be independent. To address the tension in their relationships, some parents tried to achieve a balance between being supportive and taking over. One mother described her strategy for assisting her son with a college application:

> *"[He's a] proud kind of kid who didn't want to depend*

Regional Research Institute for Human Services, Portland State University. This article and others can be found at www.pathwaysrtc.pdx.edu. For permission to reproduce articles at no charge, please contact the publications coordinator at 503.725.4175; fax 503.725.4180 or email rtcpubs@pdx.edu

on his parents at all… I would just say, 'Let me be your secretary. That is all I'm going to do for you. I am just going to do the labor.' In other words, when I was filling out the forms that were hard for him to do…I would say, 'Hey, most families do this…' That allowed him to maintain his dignity which was really important to him."

Parent participants offered advice to other parents about maintaining casual but supportive adult-to-adult relationships. One mother whose son had schizophrenia encouraged other parents to find interests in common with their children, so that the focus of conversations would not always be on their illness and treatment. Parents recognized the importance of their children developing peer relationships and reported encouraging peer relationships by, *"always letting him know that he has a choice. It is really okay to go and be with your buddies instead of come here."*

DISCUSSION AND IMPLICATIONS

While healthy family relationships in the transition years assume increasing independence of young people, where there is a serious mental health condition, the picture of healthy relationships looks different. Young people in this study were grateful for the support their families continued to give them and their perseverance through difficult times. Family members indicated that they continued to be concerned about their children's well-being and they had developed strategies to encourage their children to pursue their goals while being supportive cheerleaders and playing useful roles in the background.

> **"I know that is why I've been able to deal with the stuff I've dealt with—I've gotten close to my mom and friends."**

Young people with mental health conditions want their parents and friends to understand how their mental health conditions affect them, to be willing to talk through problems without interfering, and to provide care, support, and a safe zone when they are dealing with challenges. At the same time, young people want to experience independence, freedom to make decisions, and opportunities to be adults, free of parental interference. While worrying about their young adult children's well-being, parents appreciate their children's desire to grow up and they seek roles to support and encourage them, and to create opportunities for forming and strengthening relationships, particularly with peers and mentors. Service providers can facilitate healthy relationships between young people with mental health conditions and their families and friends by asking young people what types of support they need, whom they perceive as supports, and how they would prefer to enhance their relationships with supportive people.

REFERENCES

1. Arnett, J. J. (2000). Emerging adulthood: A theory of development from the late teens through the twenties. *American Psychologist, 55,* 469-480.
2. Blacker, L. (2005). The launching phase of the life cycle. In B. Carter & M. McGoldrick (Eds.), *The expanded family life cycle: Individual, family, and social perspectives* (3rd ed., pp. 287-306). New York: Pearson Educational Publishing.
3. Preto, N. G. (2005). Transformation of the family system during adolescence. In B. Carter & M. McGoldrick (Eds), *The expanded family life cycle: Individual, family, and social perspectives, (3rd ed., pp.* 274-286). New York: Pearson Educational Publishing.
4. Moses, T. (2009). Parents' conceptualization of adolescents' mental health problems: Who adopts a psychiatric perspective and does it make a difference? *Community Mental Health Journal, 47*(1), 67-81.
5. Moses, T. (2010). Being treated differently: Stigma experiences with family, peers, and school staff among adolescents with mental health disorders. *Social Science and Medicine, 70,* 985-993.

AUTHORS

Pauline Jivanjee is a member of the Pathways Transition Training Collaborative and a faculty member at Portland State University School of Social Work.

Jean M. Kruzich is an associate professor at the University of Washington School of Social Work.

THE IMPORTANCE OF THERAPEUTIC ALLIANCE FOR TRANSITION-AGED YOUTH

Transitioning youth with mental illness are among the most difficult populations to maintain in treatment, as the transition stage of development is often characterized by further deterioration of mental health and functional outcomes.[1] Strong relationships with support systems and mental health service providers are important for a healthy transition to adulthood. During this critical developmental period, the therapeutic relationship can help youth navigate the challenges that come with the transition to adulthood and be a model for other healthy relationships in a youth's life.

Adolescence is a critical period to engage youth in treatment as many young people continue to face the mental health challenges they experienced in childhood, while additional disorders commonly conceptualized as adult disorders emerge. Almost 25% of youth have met criteria for a mental health disorder with severe impairment at some point in their lifetime.[2] Yet youth with mental illness experience a serious decline in access to treatment and often drop out of treatment.[3] Initial encounters with mental health services and providers therefore can have important implications for future service utilization.

THE IMPORTANCE OF THERAPEUTIC ALLIANCE

Building a strong therapeutic alliance is considered a best practice for improving treatment outcomes and engaging and maintaining youth in mental health treatment.[4] Based on our experience and research, the therapeutic alliance is a multi-faceted construct, comprised of three elements of connection: emotional-affective; cognitive; and behavioral.[5] The emotional-affective connection is the "relational bond" that forms between client and service provider. Cognitive connection refers to the way treatment is conceptualized by the client, such as agreement on goals and planned tasks, as well as being optimistic and motivated about the therapeutic process or viewing the service provider as credible. Lastly, the client's participation in treatment, collaboration on tasks, and openness in speaking with the service provider, is part of the behavioral connection.

Although all three components are important for a strong alliance between service provider and client, the emotional-affective connection is crucial for initial establishment of alliance.[5] The emotional-affective connection is particularly important when transitioning youth first enter treatment. Initially, adolescents and transitioning youth, consistent with developmental expectations, enter treatment feeling skeptical towards trusting therapists as these professionals are seen as similar to other adult authority figures who may impede youth progress toward autonomy.[6] If the emotional-affective connection is not established initially, then trust and comfort are negatively impacted and treatment cessation is more likely.[5] Additionally, clinicians must establish credibility by giving a good rationale for treatment in order for youth to have sufficient motivation to remain engaged in treatment.[5]

BARRIERS TO THERAPEUTIC ALLIANCE

Many factors can jeopardize formation of the therapeutic alliance. One major threat to therapeutic alliance is the absence of a developmentally sensitive approach. Transition to adulthood presents a host of new challenges as greater independence is established and youth go to college or attend other post-secondary training, obtain employment, become financially independent, learn to budget and pay for expenses, and maintain a home. In addition to typical developmental challenges, transitioning youth with mental illness encounter additional obstacles such as lack of educational attainment, poverty, lack of family support, and homelessness.[3,7] Therapeutic alliance suffers if the service provider is not mindful of, or diminishes or ignores, the changes and outside pressures that occur during transition to adulthood for youth.[5]

Cognitive changes during this developmental stage present unique threats to the therapeutic alliance. During this period of cognitive development, young clients often ask many questions regarding the therapeutic process. Service providers report perceiving questions from adolescent clients as challenging their expertise, but providers should be mindful that requests for additional explanations should be expected and seen as interest and developmentally appropriate attempts to exercise autonomy, not disrespect.[5]

Regional Research Institute for Human Services, Portland State University. This article and others can be found at www.pathwaysrtc.pdx.edu. For permission to reproduce articles at no charge, please contact the publications coordinator at 503.725.4175; fax 503.725.4180 or email rtcpubs@pdx.edu

As minors, youth often do not enter treatment of their own volition and may therefore lack an understanding of the reason for, or importance of, treatment.[8] This lack of "buy-in" may result in increased resistance to treatment and eventual dropout;[9] addressing questions from youth and providing developmentally appropriate responses may help engage youth in treatment.

BUILDING A STRONG THERAPEUTIC ALLIANCE

A service provider can apply many strategies to foster a strong, developmentally appropriate therapeutic alliance with transitioning youth. It is important for the service provider to be mindful that increased role exploration is normal for transitioning youth.[10] If a youth's need for identity exploration is validated by the service provider, the therapeutic relationship can be enhanced and the youth's work in therapy can be viewed as a continuation of identity discovery.[5] For example, a therapist can help a young adult balance her role of being a "good" daughter with spending more time with her friends, while also determining what sorts of long-term goals she may have for her career. Additionally, a stronger youth-service provider therapeutic relationship can be established if the youth feels validated throughout treatment.[11]

During this developmental stage, youth express an increased desire for autonomy. For the developing youth, acquiescing to treatment may be seen as a threat to independence.[5,9] However, the client's initial negative perception of therapy can be overcome by collaborating with the youth to increase openness to treatment.[5] As previously discussed, service providers should view client questions as an opportunity to engage the youth in treatment and not as a challenge of their abilities.[5] It is important for the service provider to stress that treatment is a tool to empower the youth, rather than a way to diminish autonomy. Being sensitive to and addressing the biological and cognitive changes experienced by transitioning youth will also strengthen the therapeutic relationship. Discussing changes the youth is experiencing and how they relate to mental health and treatment goals may assist the youth in their treatment and permit the youth to feel more comfortable and open with the clinician—provided the client is ready to discuss these changes.[5]

Provider attributes associated with positive alliance include being flexible, confident, warm, interested, empathetic, experienced, honest, respectful, and trustworthy.[12] Therapeutic techniques such as exploration, reflection, notation of past therapy successes, accurate interpretation, affirmation, understanding, expression of affect, and attending to clients' experience have been found to lead to positive alliance.[13] Service providers can establish alliance by taking steps to collaborate with youth on identifying treatment goals.[14] The use of humor in treatment is especially useful when working with youth; simply getting clients to laugh may dramatically improve client-service provider relationships, since many youth associate a sense of humor with genuineness and trust-worthiness.[9]

Ackerman and Hilsenroth found that service provider qualities such as being rigid, uncertain, overly critical, exploitive, distant, tense, aloof and distracted are hazardous to therapeutic alliance. Service provider techniques associated with ineffective treatment and lower alliance include: over or under structuring therapy; being overly managing; using silence inappropriately; and belittling the client.[15] Service provider behaviors such as overemphasis of information from past sessions, criticism, failure to acknowledge youths' emotions, and misunderstanding of the client, also result in poor alliance.[13] Additionally, pushing the client to talk and diminishing the client by over-asserting credentials or superiority during treatment also negatively impact alliance.[14,9] Mutual respect between the service provider and transitioning youth will alleviate the youth's perceived threat of diminished authority and encourage the youth to respond with greater ease.[9]

Family involvement can help (rather than hinder) the

therapist-youth alliance if there is adequate balance between the youth's need for autonomy and family treatment participation.[5] Family members can be potential allies in treatment; treatment retention is higher for adolescents if the parent feels that treatment is valuable and that the youth is improving.[16]

Since cultural competence may have a great impact on therapeutic alliance, it is important for service providers to be sensitive to issues such as stigma, as well as culturally preferred interpersonal styles, values, and beliefs. Service providers should be cognizant of stigma associated with mental health treatment and its influence on a client's view of the presenting problem and treatment process. Stigma can be diminished by providing culturally-adapted education about mental health treatment that can increase client understanding of therapy, resulting in lower probability of treatment cessation.[17] Taking time to learn about client cultural background and communication style has been shown to have positive outcomes, with service providers feeling more therapeutically confident afterwards.

CONCLUSION

By being sensitive to issues and challenges of youth in transition and considering the recommendations outlined above, service providers may build strong therapeutic relationships with transitioning youth with mental illness. A strong therapeutic relationship is critical for engaging and retaining youth in mental health services that are vital for treatment and functional outcomes. Providing transitioning youth with a positive treatment experience during this critical period of development may lead to improved treatment outcomes for this at-risk population.

REFERENCES

1. Robbins, M. S., Turner, C. W., Alexander, J. F., & Perez, G. A. (2003). Alliance and dropout in family therapy for adolescents with behavior problems: Individual and systemic effects. *Journal of Family Psychology, 17*(4), 534-544.
2. Merikangas, K. R., He, J.-P., Brody, D., Fisher, P. W., Bourdon, K., & Koretz, D. S. (2010). Prevalence and treatment of mental disorders among US children in the 2001-2004 NHANES. *Pediatrics, 125*(1), 75-81.
3. Davies, M., & Vander Stoep, A. (1997). The transition to adulthood for youth who have serious emotional disturbance: Developmental transition and young adult outcomes. *Journal of Mental Health Administration, 24*(4), 400-427.
4. Shirk, S., & Karver, M. S. (2011a). Alliance in child and adolescent psychotherapy. In *National registry of evidence-based programs and practices.* Retrieved from http://www.nrepp.samhsa.gov/
5. Castro-Blanco, D., & Karver, M. S. (2010). *Elusive alliance: Treatment engagement strategies with high-risk adolescents*. Washington, DC: American Psychological Association.
6. Digiuseppe, R., Linscott, J., & Jilton, R. (1996). Developing the therapeutic alliance in child-adolescent psychotherapy. *Applied & Preventive Psychology, 5*(2), 85-100.
7. Zigmond, N. (2006). Twenty-four months after high school: Paths taken by youth diagnosed with severe emotional and behavioral disorders. *Journal of Emotional and Behavioral Disorders, 14*(2), 99-107.
8. Shirk, S. R., & Karver, M. S. (2003). Prediction of treatment outcome from relationship variables in child and adolescent therapy: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 71*(3), 452-464.
9. Hanna, F. J., & Hunt, W. P. (1999). Techniques for psychotherapy with defiant, aggressive adolescents. *Psychotherapy: Theory, Research, Practice, Training, 36*(1), 56-68.
10. Cohen, J. C. (1968). Erikson, Piaget and child development. *PsycCRITIQUES, 13*(5).
11. Karver, M. S., & Caporino, N. (2010). The use of empirically supported strategies for building a therapeutic relationship with an adolescent with oppositional-defiant disorder. *Cognitive and Behavioral Practice, 17*(2), 222-232.
12. Shirk, S., & Karver, M. S. (2011b). The alliance in child and adolescent psychotherapy. In J. Norcross (Ed.), *Psychotherapy relationships that work: Evidence-based practices* (2nd ed.) New York: Oxford University Press.
13. Karver, M. S., Shirk, S., Handelsman, J. B., Fields, S., Crisp, H., Gudmundsen, G., & McMakin, D. (2008). Relationship processes in youth psychotherapy: Measuring alliance, alliance-building behaviors, and client involvement. *Journal of Emotional and Behavioral Disorders, 16*(1), 15-28.
14. Creed, T. A., & Kendall, P. C. (2005). Therapist alliance-building behavior within a cognitive-behavioral treatment for anxiety in youth. *Journal of Consulting and Clinical Psychology, 73*(3), 498-505.
15. Ackerman, S. & Hilsenroth, M. (2001). A review of therapist characteristics and techniques negatively impacting the therapeutic alliance. *Psychotherapy: Theory, Research, Practice, Training, 38*(2).
16. Diamond, G. M., Diamond, G. S., & Liddle, H. A. (2000). The therapist-parent alliance in family-based therapy for adolescents. *Journal of Clinical Psychology, 56*(8), 1037-1050.
17. Hwang, W.-C. (2006). The psychotherapy adaptation and modification framework: Application to Asian Americans. *American Psychologist, 61*(7), 702-715.

AUTHORS

Brittany Jordan-Arthur is a Clinical Psychology Doctoral Student at the University of South Florida.

Gabriela Romero is an undergraduate student at the University of South Florida.

Marc Karver is an Associate Professor at the University of South Florida studying treatment processes and the prevention of youth suicide.

Regional Research Institute for Human Services, Portland State University. This article and others can be found at www.pathwaysrtc.pdx.edu. For permission to reproduce articles at no charge, please contact the publications coordinator at 503.725.4175; fax 503.725.4180 or email rtcpubs@pdx.edu

3 Views of Evolving Relationships in the Transition Years:

A Mother and 2 Siblings

A MOTHER'S PERSPECTIVE

Raising four children is a challenge for all parents, but when one child has significant mental health issues, it is even more complicated. Our goal has always been keeping our family just that: a family. For Nathan, our son with autism spectrum disorder, severe anxiety, impulsivity, obsessive compulsive disorder, pervasive developmental disabilities, and "episodic rage disorder," life is often overpowering. We work hard to maintain his natural supports, including connections with siblings and extended family.

We never know what sends Nathan into a frenzy or rage, and find ourselves working hard to avert anything unexpected. We are determined to make sure that he and his siblings have a normalized relationship. Fortunately, our children have always gotten along well and accepted Nathan despite his challenging and even dangerous behaviors.

As a teen, Nathan experienced extraordinary difficulties, from academic struggles to isolation from former friends, and outrageous eruptions of anger. He refused to go anywhere where there were crowds, even to restaurants or movies. He became increasingly violent at home, punching holes in walls, kicking tables, and tossing dishes at the slightest provocation. At school, he knocked over signs and even kicked others. Nathan's anger and inability to calmly voice what he was feeling caused him to act out in ways that were not safe for him or for others. We went to top-notch doctors, but his mental health diagnoses and co-morbid developmental disabilities made treatment exceptionally difficult. Still, his siblings accepted him and tried to coax him to accompany them when they went out with friends. Occasionally, Nathan would go with them, but often they came home early because Nathan's anxiety level would change for the worse.

Nathan could be charming and thoughtful, even tender towards pets and younger kids. That, however, could change in a flash. When Nathan was placed in a day treatment program, his siblings willingly joined him at family therapy sessions, anxious to help as they could. When Nathan was placed in a residential treatment program out of state, it was sad yet comforting for his siblings. Our household was calm and quieter then, but as one of our kids pointed out, "it's just not the same without him." During a school break, we took the whole family to visit Nathan, and they were clearly happy to be together. My husband and I visited Nathan once a month, spending weekends with him so we could maintain normal family connections, even though it meant the other kids had to have someone stay with them at home. It was disruptive to family routine, but everyone accepted it.

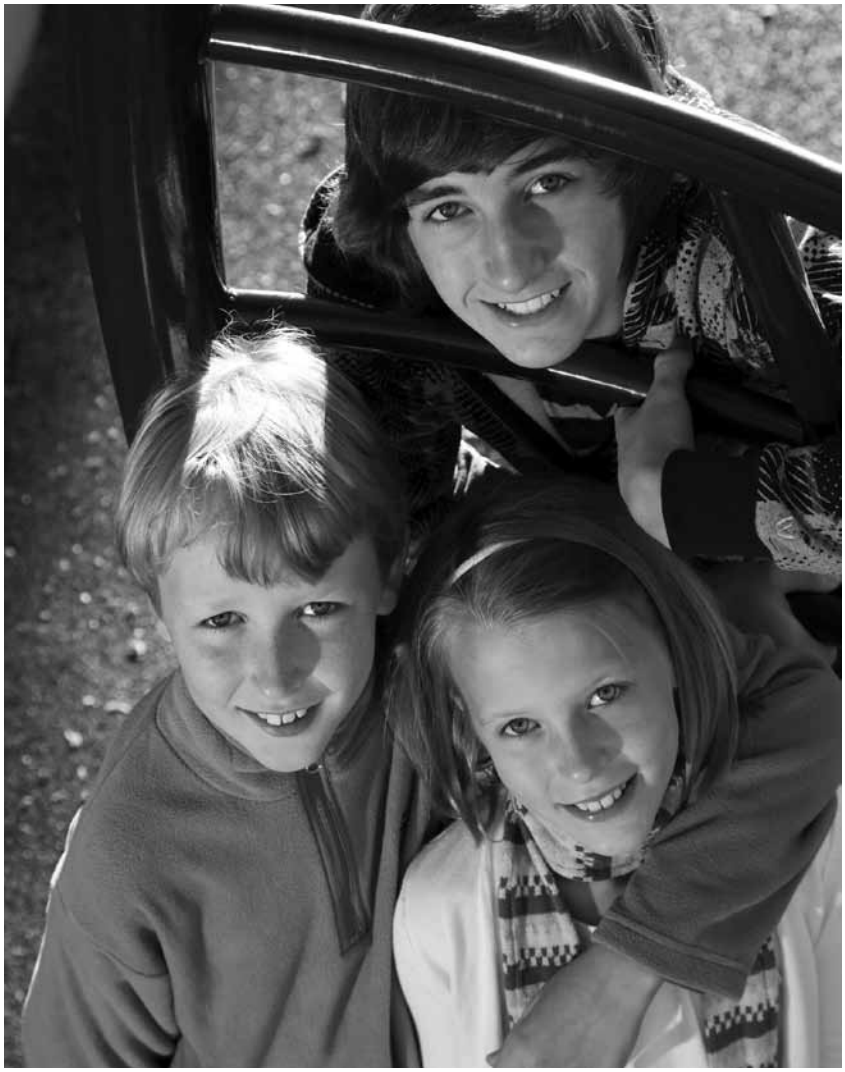
When Nathan's erratic behaviors resumed shortly after coming home, he was placed in a group home where he found success in a structured environment. He graduated from high school with a modified diploma, in great part because of his developing talent as a glass artist. However, his efforts at employment, even with a job coach, were disastrous. He refused to wear the uniform required and made co-workers, especially women, uncomfortable by staring at them. He upset his siblings by making fun of them, but they seemed to recognize that as part of his mental illness and were able to accept him despite his negative comments.

At 19, Nathan moved into an apartment complex for people with mental illness. However, he was quite vulnerable to others. Within months, he was befriended by people who convinced him they should move in with him. They convinced him to go away with them, stole his checkbook, and fraudulently spent tens of thousands of dollars before we even knew it. We filed a missing person report; his brothers called anyone who might know where he was, and drove around looking for him. After locating him, it took six separate psychiatric hospitalizations before Nathan was placed in a group home, where he is stable and enjoying life and the occasional visits with his siblings.

A SISTER'S PERSPECTIVE

When my brother Nathan became a teenager, our previously close relationship began to change, and he seemed angry at me for reasons that made no sense at all. Though his development stalled, his temper and frustration grew. He was increasingly inappropriate in public places and his mood could shift from happy-go-lucky to violent rage at the drop of a dime. I wanted to hang out with my brother, but he was unkind and unwilling to spend time with me. My parents explained his behavior to me as best they could, and I recognized he was not like my other brothers. It was hard explaining Nathan to my friends, and though I had people over to our house occasionally, I preferred spending time elsewhere. It was just easier to meet friends anywhere else than being at home where Nathan would bother us.

As a family, we met with therapists and doctors to help Nathan, but the process was difficult for everyone. Some of the therapists were terrible, yet we all went to family sessions anyway hoping it might help. Nathan seemed to be angrier with every passing day and we never knew why. My parents were struggling to figure out how to keep my brother afloat in a world that was not designed to help him at all, and they had to go through some experiences that are unfathomable to most parents. They sent him to other schools and lockdown facilities, and even relinquished his care into the hands of the state when it seemed like it was their only option to get him the treatment he needed. Despite all of that, I never felt like I missed out on my childhood. In fact, I would argue I am a better person today because of it. It was never easy having an older brother with mental illness, but I sincerely doubt that any of us would be as patient, caring, strong and resilient as we are today without my uniquely difficult older brother.



A BROTHER'S PERSPECTIVE

I was an independent teenager and had my own social and sports-related activities, so I was not at home with Nathan as much as when we were children. It was difficult for my friends to understand him. Introducing Nathan wasn't anything like "Hi, this is my brother and he has learning disabilities and mental illness." I just said, "This is my brother." But his anger and lack of control were embarrassing. He was a handful, and very difficult to be around very long, so staying away from home was best for me.

Being close in age, I tried to help him, but he is too headstrong to effectively influence. He is probably in the best situation of his life right now. But I do feel that at some point someone is going to have to take over my mother's role as guardian, and it might as well be me. While I don't have much regular contact with Nathan now, I could if it were necessary.

AUTHORS

Corinne Spiegel is Disabilities Program Manger for Jewish Family and Child Service.

Jasmine Spiegel is a college student and is employed part-time.

Joel Spiegel is a college student and is employed part-time.

Regional Research Institute for Human Services, Portland State University. This article and others can be found at www.pathwaysrtc.pdx.edu. For permission to reproduce articles at no charge, please contact the publications coordinator at 503.725.4175; fax 503.725.4180 or email rtcpubs@pdx.edu

A Story Of Connecting

It doesn't matter who you are or where you come from in life—we all have connections to our biological parents that can never be broken.

For some of us, it is simply being born to a parent that we never meet, although that parent may be psychologically present forever. For others, a biological parent is there for a lifetime. For many of us, our stories lie somewhere in between on a continuum of connectedness to one's biological parents. My story is one of those that lies somewhere in the middle. My mother abandoned me and my sister, Renee, when I was 6 months old and Renee was 3 years old. We lived with our father and step-mother until we were 12 and 15 years old. After years of abuse and neglect, my sister and I entered the foster care system. We aged out of the system without a family when we each turned 18. We struggled to maintain our own connection, but have successfully done so. We are now 28 and 31 years old and although we have been scarred by many things that happened to us before and after entering foster care, we are growing into strong and accomplished women who many would be proud to claim as daughters.

Although I had no memory of my mother, I had an image of her in my mind and I knew she was out there somewhere. Part of me wished she would find us one day and come back into our lives to save us from our suffering, while every day that she didn't I became angrier with her for not doing so. Both my sister and I had a desire to reconnect with our biological families after we left foster care. Renee wanted to find our mother and I did not—I wanted to reconnect with my aunt. Perhaps my sister had more empathy for our mother, as Renee lost custody of her own two children at a very young age. I however, had none. I could not comprehend how a mother could do such a thing to her children. We suffered immensely from not having a good parent in our lives, and government agencies make poor substitutes for parents.

I got my own apartment at 16.5 years of age and was able to start college at 18 despite having dropped out of high school in the beginning of my sophomore year. While in college, I tracked down my paternal aunt, and at 19 I took a 900-mile bus ride to reconnect with her. My aunt and I spent years building a relationship across so much distance and it took many difficult conversations about my past before we could finally move forward with what has recently become a very strong relationship.

I remember checking my email during my third semester of college and seeing an email from my father's new girlfriend. My aunt had given my father my email address since I had not yet told her the truth about why he had lost his children, and that I did not want to have contact with him. Although I was quite shaken up from the message, I responded and was offered financial support from this woman who called herself my step-mom, but was the same age as my sister. Despite the things my father had put my sister and I through I agreed to email him, partly because I desperately needed the financial help and also to tell him I was doing well despite what he had put me through. I told him about my 3.9 GPA and my 3 years of living on my own when most people I knew still lived with their parents. His response was that he hadn't taught me to be very humble. I quickly closed the door of communication and have only spoken to him once since then. That one time was in order to try to find my other siblings.

I had never stopped wondering about them, though I had given up on fruitless internet searches with only the first and last name of my mother to search by. With nowhere else to turn, I emailed my father and asked him for more information about my mother. He gave me her adoptive parents' last address and phone number and as

it turned out they still lived there and had the same phone number after 26 years. They gave me the number they had for my mother and I brought it to my sister Renee. On Christmas Eve 2008 my sister and I called our mother together. It was such a joyous occasion with smiles and tears, shock and excitement. I forgot all about my anger and was so happy I had found my mother. She was happy we had found her too and she flew 900 miles with my half-brother to visit us. What an exciting time—my first day of graduate school was so hectic because I had my newfound mother and brother at my apartment and couldn't focus at all. Renee and I went to visit our mother that spring and got to meet our step-father and half-sister. They had written "welcome home Renee and Lynn" on the glass door for when we arrived.

After what I would call the honeymoon period of reconnecting was over, many questions remained that had to be answered before I could move forward. My mother's story just didn't add up; her tale was one of outside forces taking her children from her and an inability to find us despite concerted efforts. There was no tale of mistakes or an apology for the horror stories that we shared with her of our lives. I requested a records review from the child welfare

agency we were placed through and found out that they had found my mother when I was 12 and told her where we were—yet she failed to contact us back then. In my eyes, that meant she had abandoned us a second time and I was once again angry, this time more than ever before. And now there was a face and voice behind the anger and betrayal I felt. I decided to give my mother a chance to own up to her mistakes and lies, and apologize. Once again, she would not do so and instead treated me like a trouble maker, one who wouldn't just "stop living in the past and enjoy the years ahead as a family." My feelings were invalidated, and I took a long vacation from my newfound family so my life wouldn't completely fall apart. Now having an opposite experience of reconnecting to compare to the one I had with my aunt, I had a profound realization of how much my aunt loved me and what a great person she is. She listened to the hard things I had to say about my past and her brother, and she empathized with me and walked beside me through those difficult steps toward the wonderful relationship we now have.

Let's fast forward two years and four months from when I found my mother to today. I do not speak to my mother anymore and do not have much of a relationship with my newfound siblings either. My sister tries to reach out to our mother but my mother doesn't have time for her. Both of our lives were derailed by reconnecting with our mother. I almost dropped out of graduate school and almost lost my job and apartment—and my sister did lose her job and apartment to move close to our mother. We had lost our identities when we went into foster care and never had help finding them there. We then tried to find our identities on our own and were shocked to find that learning about our history and getting to know our mother and siblings made it even harder to determine who we are. This is not to say that finding our mother was a negative experience—neither of us would go back and undo it. We have learned where we come from and where our lives would be had we grown up with our mother. Frankly, we are both glad we didn't because she would never have been able to make us into the women we are today. We would be stuck living in poverty in a rural town with no opportunities for our future. We may have struggled to incorporate this information into our identities, but at least we have it now. The void has been filled and we are finally settling into knowing who we are and where we come from, and do not have to wonder about what might have been.

Looking back on the road I have walked to get to where I am today, I have much advice to give to people working with young people in the foster care system who have been disconnected from their families. First, no matter what challenges a young person's biological parents may have, that relationship must be valued and respected for the lifelong psychological and/or physical connection that it is. It should be no one's decision but the young person's whether a parent will be in his or her life. If there is disagreement, the young person will carry out their wishes as soon as they are able, with or without the consent of supportive adults. Second, it is much better for young people to have help with the difficult work of building their identity through establishing who their family is and what that means for their life. Do not make them do it alone when they may not have any support. Third, the best thing you can do to help a young person reconnect is help them manage their feelings of confusion, anger, betrayal, and grief. Help them manage their hopes and expectations and be there to support them if they are let down. It is also important to teach them how to set healthy boundaries in their relationships with their parents and everyone else in their lives. I know adults in my sister's and my lives may not have wanted to "rock the boat" or upset us by telling us they had found my mother when I was 12. I'm sure they thought they were doing what was best for us. I wish they had known that we needed the boat to be rocked while we had support in our lives instead of having to do it alone as adults. Young people need to build their identity and reconnect with their families before they leave foster care, not a decade later.

AUTHOR

Lynn Twigg is a 28-year-old foster care alumna.

Regional Research Institute for Human Services, Portland State University. This article and others can be found at www.pathwaysrtc.pdx.edu. For permission to reproduce articles at no charge, please contact the publications coordinator at 503.725.4175; fax 503.725.4180 or email rtcpubs@pdx.edu

HOW MENTAL HEALTH CHALLENGES IMPACT THE SEXUAL AND RELATIONAL HEALTH OF YOUNG ADULTS

Sexual behavior is a normative aspect of young adulthood—90% of young adults have had vaginal intercourse and/or oral sex before the age of 30.[1] Similarly, engaging in romantic and/or intimate relationships is seen as an essential developmental task of young adulthood. However, little is known about the sexual and romantic relationships of young adults with serious mental health conditions (SMHC), despite the fact that there is evidence that this population is disproportionately affected by poor sexual health. This article will outline what is known about the sexual and romantic relationships of young adults with SMHC and highlight the importance of engaging in conversations about sexual and romantic relationships with young adults experiencing mental health challenges.

SEXUAL HEALTH CHALLENGES OF YOUNG ADULTS IN THE GENERAL POPULATION

While sexual experience among young adults is clearly normative, young adults face high rates of negative sexual health outcomes. Every year, of the 19 million reported new cases of sexually transmitted infections (STIs), half occur in 15-24 year-olds.[2] Over half (55%) of unplanned pregnancies occur among women aged 20-29.[3]

There are a number of factors that contribute to poor sexual health including greater quantity of sexual partners, low condom use, and lack of access to health care—all of which are experienced at high rates by young adults in the general population. Males ages 20 to 24 have an average of 4 lifetime sexual partners, and 30% report having seven or more sexual partners. Females in this age range report 3 lifetime sexual partners, and 21% report having seven or more sexual partners.[4] Percentages of 18-29 year-olds who report using a condom at last intercourse range from 19-53%; variation depends on gender and relationship status. For example, condom use is higher for those in casual relationships when compared to those in a committed relationship.[5] Overall, condom use remains low.

Young adults are the least likely age group to have health insurance in the United States. They report either missing or delaying care and failing to fill prescriptions due to their lack of coverage.[6] The lack of access to health care can prevent young adults from obtaining a variety of sexual health services, such as STI testing and treatment, birth control and family planning, and prenatal care. Additionally, many youth and young adults rely on publicly funded sources of care to maintain their sexual and reproductive health. The overall increases in the need for these services and cuts to public funding often stretch the capacity of these clinics to provide adequate and timely care.

THE SEXUAL HEALTH OF YOUNG ADULTS WITH SMHC

Very little is known about the sexual health of young adults with SMHC; what little research there is shows that rates of risky sexual behavior and negative sexual outcomes

in young adults with SMHC are especially high. In a representative sample of middle and high school students, depressive symptoms in males were associated with not using a condom during last sex; in females these symptoms were associated with having an STI.[7] Among a group of 21-year-olds, those diagnosed with a serious mental illness were more likely to report having sex without a condom and a lifetime history of STIs when compared to those without mental illness; these associations were not dependent on gender or socioeconomic background.[8] Young adults with a mental health diagnosis and a substance use disorder were more likely to have unprotected sex and history of STIs.[8] In a community sample of late adolescent women, higher rates of unwanted pregnancy were associated with higher scores on a measure of bipolar disorder.[9] Although this limited research provides some evidence that young adults with serious mental health conditions also exhibit poor sexual health and risky sexual behaviors and may be at greater risk for a negative sexual outcome than young adults in the general population, a major limitation to this research is that it is correlational. Therefore, it remains unclear as to whether mental health status causes risky sexual behavior, risky sexual behavior has a negative impact on mental health, or some other factor(s) impacts both.

Relationship Between Mental Health and Risky Sexual Behavior

Given the association between SMHC and risky sexual behavior, it is important to understand why these two characteristics might be related. Several factors may play a role in this phenomenon such as childhood trauma, stigmatization, and the characteristics of the mental illness.

It is possible that young persons with SMHC have been exposed to traumatic and/or abusive experiences in early childhood that may affect both mental and sexual health. It is well documented that a history of child abuse—especially sexual abuse—is associated with poorer mental and sexual health in adolescents and adults (see Maniglio, 2009 for a review and Kishna's article in this issue).[10]

Internal and external stigmatization of mental health conditions may also provide barriers to healthy romantic relationships and associated sexual behaviors. Low self-esteem and high internal stigmatization in young adults with mental health conditions can lead to expectations of rejection and subsequent loss of confidence to fully participate in a romantic relationship. This perceived undesirability may result in a failure to advocate for safer sex practices, resulting from fear of disapproval or loss of a partner. Internal stigmatization may cause a person to "settle" for a partner that may not respect his or her sexual limits. For example, one study found that 20% of women with a serious mental illness had sex with people they didn't like.[11]

Some mental health conditions, such as borderline personality disorder (BPD), are associated with impulsivity, poor decision-making, and unstable, intense interpersonal relationships. These symptoms can directly impact sexual behaviors and/or partner choice.[9,12] For example, impulsivity in sexual decision making could reduce rates of contraceptive use or safer sex planning. Insecure but intense relationships could cause a person with BPD to rush into a sexual relationship with someone for fear of losing her or him.

Factors Influencing Sexual Intimacy

Mental illness in young adults is not only associated with patterns of risky sexual behaviors, but also with other sexual difficulties related to intimacy and performance. Certain mental health conditions, such as anorexia nervosa and borderline personality disorder, are more likely to be associated with difficulties in romantic relationships and sexual intimacy. For example, women with anorexia nervosa have reported less closeness and comfort in their romantic relationships; these challenges in forming satisfactory relationships were associated with symptoms of depression, anxiety, fear of abandonment, and public self-consciousness.[13] Young adults diagnosed with borderline disorders report high levels of avoidance of sex (41%) and being symptomatic after sex (34%), with females more likely than males to report higher rates of sexual relationship difficulties.[12]

While treating the symptoms of one's mental health condition remains a priority for patient, family, and provider, many medications used to treat depression or psychosis are associated with sexual side effects. These include decreased sexual desire and decreased ability to perform sexually and/or orgasm. Such side effects are common: A review of the effects of anti-depressants shows that over half of persons taking these medications experience a decrease in sexual desire and/or performance.[14] Similarly, over half of men and a third of women experienced diminished sexual desire due to medication treatments for schizophrenia; a quarter of male respondents also reported erectile dysfunction.[15] Such side effects may have a negative impact on the romantic relationships of young adults.

Regional Research Institute for Human Services, Portland State University. This article and others can be found at www.pathwaysrtc.pdx.edu. For permission to reproduce articles at no charge, please contact the publications coordinator at 503.725.4175; fax 503.725.4180 or email rtcpubs@pdx.edu

Mental Illness as a Barrier to Romantic Relationships

Most sexual interactions occur within the context of a romantic relationship, yet there are particular challenges to forming and maintaining an intimate relationship when a young adult has a mental health condition. Redmond and her colleagues provide the most in-depth research on this issue. Their in-depth interviews with eight young adults with psychosis revealed that several of these youth believed that "romantic relationships and psychosis don't mix" (p. 159).[16] This caused them to either downplay their symptoms to avoid discussing their mental health with a partner, or dismiss entering into intimate relationships altogether to avoid disclosure. This fear of disclosure also caused young adults to delay dating experiences, and thus made finding a partner their age willing to progress in a relationship difficult. Another factor that delayed the progress of intimate relationships was the mental health condition itself; participants stated that while they did want to pursue and/or maintain romantic relationships, they only were able to do so when they were managing their symptoms well. While they were having difficulty managing their mental health, the added stressor of a relationship was reported to be too much to handle.

Issue of Silence

Despite the documented importance of sexual and romantic relationships in young adults, there is little evidence that those with mental health conditions have a supportive environment in which to discuss and express their sexuality and desire for intimacy. One study found that only 30% of women with a serious mental illness believed their mental health providers encouraged them to discuss sexual relationships, and that friends and family were similarly unsupportive in addressing this issue. In fact, over a quarter of these women were told they should not be having sex.[11] This same study also found that about one-third of the women were not free to have sex where they resided.

Additionally, romantic relationships can represent "normality" for young persons with SMHC, but are also perceived as "risky" because of the barriers created by internal and external stigmatization.[16] In addition, while the impact of sexual side effects of some medications on adherence to mental health treatment is unknown, open discussions of these side effects by practitioners may create a safe space for clients to discuss other treatment options, or sexual and/or romantic relationships in their lives. Young adults could benefit from encouragement to talk about relationships and get additional support to pursue intimate ones.

Even if mental health professionals were open to discussing sexuality with their clients, there is evidence that they do not receive proper training. A study of staff at a residential treatment setting revealed that while the staff were confronted with many sexual issues at work from adolescent patients (e.g., residents "acting out," history of sex abuse, lack of knowledge about sex), there was little support for them to help residents address these issues. The vast majority of professionals (90%) reported interest in receiving additional training on sexual issues and how to handle them,[17] yet a review of the top 20 social work graduate programs reveals that the 13 that do offer a course in Human Sexuality offer it as an elective only.[18]

BEGINNING THE CONVERSATION

This article highlights the importance of discussing both sexual and romantic relationships with young adults with SMHC by documenting their sexual health risk factors and challenges in forming and maintaining romantic relationships. It is essential that more research is done to better understand how to support the sexual and romantic expressions within this population—and that the necessary training for professionals follows this research.

Mental health plays a significant role in how young adults construct their intimate relationships. Given the potentially critical effects of choices and experiences in the romantic domain during this developmental period,[9] it is important to consider mental health when supporting young adults in developing healthy and fulfilling intimate relationships. Young adults with SMHC need to be told they are worthy of having a partner who cares about them; they are also worth advocating for when it comes to safer sex practices.

REFERENCES

1. Herbenick, D., Reece, M., Schick, V., Sanders, S. A., Dodge, B., & Fortenberry, J. D. (2010). Sexual behavior in the United States: Results from a national probability sample of men and women ages 14–94. *The Journal of Sexual Medicine, 7*(Suppl. 5), 255-265.
2. Weinstock, H., Berman, S., & Cates, W., Jr. (2004). Sexually transmitted diseases among American youth: Incidence and prevalence estimates, 2000. *Perspectives on Sexual and Reproductive Health, 36*(1), 6–10.
3. Finer, L. B. & Henshaw, S. K. (2006). Disparities in rates of unintended pregnancy in the United States, 1994 and 2001. *Perspectives on Sexual and Reproductive Health, 38*(2), 90-96.
4. Mosher, W., Chandra, A., & Jones, J. (2005). Sexual behavior and selected health measures: 2002. *Advance Data,* 362.
5. Reece, M., Herbenick, D., Schick, V., Sanders, S. A., Dodge, B., & Fortenberry, J. D. (2010). Condom use rates in a national probability sample of males and females ages 14 to 94 in the United States. *The Journal of Sexual Medicine, 7*(Suppl. 5), 266-276.
6. Callahan, S. T., & Cooper, W. O. (2005). Uninsurance and health care access among young adults in the United States. *Pediatrics, 116,* 88-95.
7. Shrier, L. A., Harris, S. K., Sternberg, M., & Beardslee, W. R. (2001). Associations of depression, self-esteem, and substance use with sexual risk among adolescents. *Preventive Medicine, 33,* 179-189.
8. Ramrakha, S., Caspi, A., Dickson, N., Moffitt, T. E., & Paul, C. (2000). Psychiatric disorders and risky sexual behaviour in young adulthood: Cross sectional study in birth cohort. *British Medical Journal, 321,* 263-266.
9. Daley, S. E., Burge, D., & Hammen, C. (2000). Borderline

2011 STAFF OF THE RESEARCH AND TRAINING CENTER FOR PATHWAYS TO POSITIVE FUTURES

Regional Research Institute
School of Social Work
Portland State University
PO Box 751
Portland, OR 97207-0751
Voice: 503.725.4040
Fax: 503.725.4180

Janet S. Walker and Nancy M. Koroloff, Co-Directors
L. Kris Gowen, Dissemination Manager
Donna Fleming, Center Coordinator
Nicole Aue, Publications and Multimedia Manager
Sarah Peterson, Project Support

www.pathwaysrtc.pdx.edu

PROJECTS AND STAFF:

CAREER VISIONS tests an approach to career planning and employment for young adults, ages 21-25, who are receiving SSE or extended special education services.

Jo-Ann Sowers, Principal Investigator; Jared Tormohlen, Project Manager; Jessica Schmidt and Rhenne Miles, Graduate Research Assistants; Natalie Wood, Research Intern.

BETTER FUTURES tests a comprehensive intervention to assist young people in foster care with serious mental health conditions to prepare to participate in post-secondary education.

Sarah Geenan and Laurie Powers, Co-Principal Investigators; Pauline Jivanjee, Project Advisor; Lee Ann Phillips, Project Manager; Amy Salazar, Graduate Research Assistant; Adrienne Croskey and Zoe Brown, Student Research Assistants; Lindsay Coffey, Research Intern.

ACHIEVE MY PLAN studies the efficacy of an intervention to increase young people's participation and engagement in their mental health treatment planning teams, and to build organizational capacity to support youth engagement.

Janet S. Walker and Laurie Powers, Co-Principal Investigators; Celeste Moser, Project Coordinator; Daniel Donohue, Student Research Assistant; Jen Allen, Coaching Consultant; Katrina Friedrich, Celina Kishna, and Andrea Ngo, Research Interns.

TRANSITION POLICY CONSORTIUM will develop an inventory that assesses the level of community support for transition services with a specific emphasis on measuring collaboration and continuity of care between the child and adult mental health systems.

Nancy Koroloff and Janet Walker: Co-Principal Investigators; Barbara Friesen, Project Advisor; Aakrati Mathur, Graduate Research Assistant.

FINDING OUR WAY furthers the development of a culturally specific self-assessment tool for American Indian/Alaskan Native young people. Developed for youth ages 13-19, the tool will be modified to include issues relevant to transition.

Barbara Friesen and Terry Cross, Co-Principal Investigators; L. Kris Gowen and Pauline Jivanjee, Researchers; Abby Bandurraga, Graduate Research Assistant.

EHEALTH LITERACY is a developmental project that will contribute to a knowledge base about the ways youth and young adults use the internet to find information about mental health care, conditions, symptoms, or medications. The information will be used to develop and test an eHealth literacy curriculum.

L. Kris Gowen, Principal Investigator; Matthew Deschaine, Graduate Research Assistant.

RECOVERY OUTCOMES is a secondary analysis of large national data sets. This project will analyze data from the System of Care National Evaluation related to young people's recovery outcomes.

Eileen Brennan, Principal Investigator; Peggy Nygren, Graduate Research Collaborator; Robert L. Stephens, Project Consultant.

MEDIATORS OF STIGMATIZATION analyzed data from nationally representative samples of youth and young adults, and used this information to identify potentially effective anti-stigmatization strategies.

Janet Walker, Principal Investigator.

TRANSITION TRAINING COLLABORATIVE will develop graduate and undergraduate course modules appropriate for individuals who plan to work with transition-aged youth, as well as modules for in-service delivery.

Eileen Brennan and Pauline Jivanjee, Co-Principal Investigators; Eliz Roser, Graduate Research Assistant.

personality disorder symptoms as predictors of 4-year romantic relationship dysfunction in young women addressing issues of specificity. *Journal of Abnormal Psychology, 109,* 451-460.

10. Maniglio, R. (2009). The impact of child sexual abuse on health: A systematic review of reviews. *Clinical Psychology Review, 29,* 647-657.
11. Collins, P. Y., Elkington, K. S., von Unger, H., Sweetland, A., Wright, E. R., & Zybert, P. A. (2008). Relationship of stigma to HIV risk among women with mental illness. *American Journal of Orthopsychiatry, 78,* 498-506.
12. Zanarini, M. C., Parachini, E. A., Frankenburg, F. R., Holman, J. B., Hennen, J., Reich, D. B., & Silk, K. R. (2003). Sexual relationship difficulties among borderline patients and Axis II comparison subjects. *The Journal of Nervous and Mental Disease, 191,* 479-482.
13. Evans, L., & Wertheim, E. H. (1998). Intimacy patterns and relationship satisfaction of women with eating problems and the mediating effects of depression, trait anxiety, and social anxiety. *Journal of Psychosomatic Research, 44,* 355-365.
14. Ferguson, J. M. (2001). The effects of antidepressants on sexual functioning in depressed patients: A review. *The Journal of Clinical Psychiatry, 62*(Suppl. 3), 22-34.
15. Hummer, M., Kemmler, G., Kurz, M., Kurzthaler, I., Oberbauer, H., & Fleischhacker, W. W. (1999). Sexual disturbances during Clozapine and Haloperidol treatment for schizophrenia. *American Journal of Psychiatry, 156,* 631-633.
16. Redmond, C., Larkin, M., & Harrop, C. (2010). The personal meaning of romantic relationships for young people with psychosis. *Clinical Child Psychology and Psychiatry, 15,* 151-170.
17. Zeanah, P. D., & Hamilton, M. L. (1998). Staff perceptions of sexuality-related problems and behaviors of psychiatrically hospitalized children and adolescents. *Child Psychiatry and Human Development, 29,* 49-64.
18. Gowen, L. K., & Deschaine, M. (2011). *Human sexuality pre-service training in social work.* Unpublished Manuscript, School of Social Work, Portland State University, Portland, OR.

AUTHOR

L. Kris Gowen is Research Associate and Editor of *Focal Point* at Pathways to Positive Futures.

Regional Research Institute for Human Services, Portland State University. This article and others can be found at www.pathwaysrtc.pdx.edu. For permission to reproduce articles at no charge, please contact the publications coordinator at 503.725.4175; fax 503.725.4180 or email rtcpubs@pdx.edu

DATA TRENDS

ASSOCIATIONS BETWEEN CHILDHOOD MALTREATMENT AND YOUNG ADULT ROMANTIC RELATIONSHIPS:

A FOCUS ON GENDER DIFFERENCES

SOURCES

1. Milletich, R. J., Kelley, M. L., Doane, A. N., & Pearson, M. R. (2010). Exposure to interparental violence and childhood physical and emotional abuse as related to physical aggression in undergraduate relationships. *Journal of Family Violence, 25,* 627-637.

2. Paradis, A., & Boucher, S. (2010). Research on interpersonal problems and codependency: Child maltreatment history and interpersonal problems in adult couple relations. *Journal of Aggression, Maltreatment & Trauma, 19,* 138-158.

Two recent studies investigated the associations between experiencing maltreatment in childhood and dating aggression and interpersonal problems in young adult romantic relationships, with a focus on gender differences.

METHODS

Study 1: In order to examine the effects that interparental violence and childhood physical and emotional abuse have on physical aggression in undergraduate dating relationships, Milletich and colleagues used a sample of 658 participants between the ages of 18 and 30 recruited from a south-eastern Virginia university; 27% were male and 72% were female. Participants had never been married, were mostly heterosexual and had experienced one or more dating relationships. Data were collected via self-report surveys. Independent measures included retrospective assessments of exposure to violence during childhood, both in terms of witnessing interparental violence and experiencing abuse. Dependent measures assessed participant dating aggression.

Study 2: Paradis and Boucher investigated the associations between childhood maltreatment and interpersonal problems in a sample of 1728 French Canadian University students. Most participants were Caucasian (92%) and female (81%); the average age of the males was 27 years (SD = 8.0), and 24 years (SD = 6.2) for the females. Few (7%) were married, and an additional 38% lived with a romantic partner. Seventy-five percent of all participants had been in their current relationship at least six months. Data were collected via self-report surveys. Independent measures included retrospective assessments of experiencing neglect and physical, emotional, and sexual abuse during childhood. Dependent variables were measured by the 64-item Inventory of Interpersonal Problems for Couples (IIP-C). Results from this study used the following four subscales of relationship patterns derived from the IIP-C: cold/distant (e.g., "It is hard for me to feel close to my partner"), self-sacrificing (e.g., "I try to please my partner too much"), domineering/controlling (e.g., "I am too aggressive toward my partner"), and nonassertive (e.g., "It is hard for me to tell my partner to stop bothering me") (p. 146).

For females, more physical abuse experience was associated with a threefold increased likelihood of perpetrating physical aggression towards their dating partners. In contrast, males who reported childhood physical abuse and witnessed interparental violence were 3.5 times less likely than their female counterparts to report perpetration of dating violence.

RESULTS

Study 1: Milletech and colleagues found that reports of engaging in one or more physical aggression acts towards their partners were given by 16% of males and 40% of females. In the last year, 31% of men and 25% of women reported that they had been victimized by their romantic partners. Zero-inflated Poisson (ZIP) regressions were used to identify gender differences in the associations between childhood exposure to violence and dating aggression. For every one-unit increase in reported exposure to mother-to-father violence, females reported a one-unit increase in engaging in physical aggression toward their dating partners. Similarly, for every one-unit increase in reported exposure to father-to-mother violence, males reported a one-unit increase in physical aggression toward their dating partners. For females, more physical abuse experience was associated with a threefold increased likelihood of perpetrating physical aggression towards their dating partners. In contrast, males who reported childhood physical abuse and witnessed interparental violence were 3.5 times less likely than their female counterparts to report perpetration of dating violence. However, higher reported levels of childhood emotional abuse in males were associated a twofold increase in dating violence perpetration.

Study 2: In Paradis and Boucher's sample, 20% of males and 23% of females had experienced at least one type of childhood trauma. Chi-squared analyses and t tests were used to assess the differences between males and females on the rates of different types of childhood trauma. Males reported more physical aggression than females, while females had increased reports of child sexual abuse. Two-way analyses of variance indicate that participants who experienced childhood physical abuse, emotional abuse, physical neglect, and emotional neglect were more likely to report more interpersonal problems than those who did not experience childhood maltreatment. Stepwise regressions were used to examine gender differences in the associations between experiences with child maltreatment and later interpersonal difficulties. For males, physical abuse significantly predicted the likelihood of being domineering, distant, and self-sacrificing. Also for males, emotional neglect was significantly associated with being distant and nonassertive. For females, emotional neglect was significantly associated with being distant, nonassertive, and self-sacrificing, whereas emotional abuse significantly predicted the likelihood of being domineering and distant.

CONCLUSION

These two studies contribute to our understanding of the associations between child maltreatment and later romantic relationships in two important ways. First, these studies indicate that different types of exposure to violence (e.g., witnessing interparental violence, physical abuse, and emotional abuse), are associated with different types of interpersonal problems later in life. Additionally, there are gender differences between the associations of these different types of childhood traumas and young adult romantic relationships. For example, Milletech and colleagues found that for females, childhood experiences with physical abuse were predictive of perpetrating dating violence, whereas emotional abuse predicted perpetration for males. Paradis and Boucher found slightly different patterns in how childhood maltreatment was associated with the interpersonal difficulties of young adults.

Limitations to these studies include that both samples were comprised of college students and relied on self-report measures. Additionally, childhood maltreatment was measured retrospectively, and thus vulnerable to inaccurate recollections. Nevertheless, these studies do offer findings that emphasize the importance of not only considering the impact a person's childhood maltreatment may have on later romantic relationships, but also that these early experiences may influence young men and women differently. Understanding these patterns is essential to better provide tailored support for young adults as they enter into intimate relationships.

AUTHORS

Celina Kishna is an undergraduate psychology student and a research intern for the *Achieve My Plan* study at Portland State University.

L. Kris Gowen is Research Associate and Editor of *Focal Point* at Pathways to Positive Futures.

Regional Research Institute for Human Services, Portland State University. This article and others can be found at www.pathwaysrtc.pdx.edu. For permission to reproduce articles at no charge, please contact the publications coordinator at 503.725.4175; fax 503.725.4180 or email rtcpubs@pdx.edu

BUILDING HEALTHY RELATIONSHIPS WITH YOUR MEDICATION AND MEDICATION PROVIDER

Psychiatric medication is one of many wellness tools used to help people living with mental health challenges manage their symptoms. Yet advertisements seem to over-promise on the effectiveness of medication, providing messages that medication will solve all of one's problems, or that one will miraculously recover from mental illness in 30 seconds. It's important to remember that medication is not a cure—it is a tool. While I know people for whom medication made a substantial difference, recovery remains a day-by-day journey.

The truth is that we still don't know very much about what makes some psychiatric medication work for people when it does work and what contributes to it not working in other circumstances. For example, preliminary evidence indicates that psychotropic medication may affect people differently based on their ethnicity, but few studies have aimed to understand this phenomenon.[1] Because we know so little about how psychotropic medications work, people often complain of feeling like a guinea pig when they try different medications and/or dosages of medications.

Deciding whether or not to try medication is not easy for most people. Many factors are involved in this decision. Whatever you choose, remember that this decision is not a moral one. It is a matter of deciding which tool is the best for your situation. There are several steps involved in determining whether a medication is helping or not. Here are several strategies that can help people feel more in control of their lives and choices about medication.

CONSIDER PERSONAL MEDICINE AS A WELLNESS TOOL

Not every problem requires medication. Ask your provider if there are non-medication strategies for the symptoms and problems you're experiencing. Many people living with mental health issues use *personal medicine*—personal wellness strategies and activities that enhance well-being. Pat Deegan, a psychologist/researcher who has recovered from schizophrenia, says that personal medicine is "self-initiated, non-pharmaceutical self-care activities that aim to decrease symptoms, avoid undesirable outcomes like hospitalization, and improve mood, thoughts and behaviors and our overall sense of well-being."[2] Many people use exercise and yoga as part of their personal medicine. Others use meditation, spirituality, and diet.

Another form of personal medicine is Mary Ellen Copeland's Wellness Recovery Action Plan (W.R.A.P.).[3] W.R.A.P., an emerging evidence-based practice, helps people identify their strengths and capacities and build their personal wellness toolbox for when life is difficult.[4] I know many people have used their W.R.A.P. to identify ways to reduce their medication as they've strengthened other tools.

TALKING TO YOUR HEALTHCARE PROVIDER ABOUT MEDICATIONS

If you do decide that medication is the right tool for you, it is important to realize that several types of health care providers (HCPs) prescribe psychiatric medication. Their

WHAT TO BRING WHEN YOU MEET WITH YOUR HCP

Goals and agenda for what you want to get out of your appointment.

A person that you trust—Many of us can be quite anxious when we meet with our healthcare providers and aren't able to do our best listening. Having a trusted person with us listening can be helpful.

Paper and pen to take notes or to doodle on (this can help reduce anxiety).

Questions you may have about recovery, treatment diagnosis, medications, etc.; for a list of possible questions, see http://www.peerlink.us/Downloads/SampleQuestions.pdf.

A list of your other medications—Make sure you ask about how your psychiatric medication(s) interacts with other medication you take. Another person to ask about medication interactions is your pharmacist.

knowledge about psychiatric medication and recovery can vary tremendously. But no matter who you are dealing with, HCPs who prescribe medication are required to inform you about the benefits and risks, possible adverse events, and any alternative treatments. Providers should also give you an opportunity to ask questions about any treatment(s) being offered. This is called informed consent. If your provider doesn't tell you how long she or he expects you to be on the medication, don't hesitate to ask. Ask about the risks associated with long-term use of all medications. Several of the newer antipsychotic medications have side effects which can cause other serious health conditions, such as diabetes.

It's important to have a positive relationship with your HCP. Shared decision-making (see sidebar) is an approach that can help reduce the power imbalance between your HCP and you and assist you in becoming a more active participant in your treatment.[5] HCPs should respect your decisions and boundaries even if they disagree with them. Negotiating these areas of disagreement can be challenging; if a HCP treats you disrespectfully, it's okay to discuss how you feel. You also can change providers if you don't feel comfortable with your current one.

Share Goals Not Just Symptoms

Most people discuss their symptoms with their HCP. While this is certainly important, also discussing how symptoms interfere with what is most important to you (whether it's being a good employee, a good parent, or something else) will help your HCP make better decisions about what s/he offers to prescribe you. Sometimes, discussing what's important to you can be difficult. For example, antidepressants are well known for their negative sexual side effects, and telling your HCP that it's important to have a fulfilling sex life may be particularly embarrassing. Some ways to discuss difficult, but important, concerns include writing a letter to your provider, staring at a particular spot on the wall while you talk, leaving a voice mail message, or sending your provider an email. Practice what you would say in front of a mirror and/or ask a trusted friend to help you practice what you would say. Another option is to consult with your provider to see whether a "medication holiday" is a safe option for special occasions.[6]

GETTING ALONG WITH YOUR MEDICATION(S)

Starting a New Medication

If you or your HCP suggests that you start a new medication, negotiate with your provider how long the medication trial will be. A good length for medication trials is 60-90 days. Many psychiatric medications take several weeks to get the full effect. If the problem that you and/or your provider was hoping to treat has not improved significantly within your medication trial, it is time to try something different (such as a personal medicine strategy or different medication).

If you know that your body is highly sensitive to medications, don't be afraid to ask your HCP to go slower than usual when building up the dosage. Even if your body is not sensitive to medications, it is generally a good idea to start slowly and gradually increase the dosage if needed.

Several psychiatric medications have unpleasant side effects for the first week or so, but frequently go away once

HCPs should respect your decisions and boundaries even if they disagree with them.

Regional Research Institute for Human Services, Portland State University. This article and others can be found at www.pathwaysrtc.pdx.edu. For permission to reproduce articles at no charge, please contact the publications coordinator at 503.725.4175; fax 503.725.4180 or email rtcpubs@pdx.edu

If the problem that you and/or your provider was hoping to treat has not improved significantly within your medication trial, it is time to try something different.

your body gets used to them. For some people, sticking it out for a week is OK; for others, the side effects are intolerable for even a short time. You have to decide what you can live with and for how long—but make sure to ask your provider which side effects are "urgent" and require immediate medical attention.

Lastly, inform a trusted friend or family member that you are starting a new medication. They can note if a new medication is causing problems that typically aren't expected, or that you might not notice.

Changing or Adding Medications

If you are changing medications, don't be afraid to ask your HCP to reduce your old medication dosage slowly, especially if you have been using that medication for a long time. If you need to make multiple medication changes, ask your provider to only change one medication at a time. If something doesn't work, then it will be easier to identify which medication is causing which problem.

Psychiatric medications can be finicky at times and their effectiveness can decrease. Sometimes this can mean adding an additional medication, which HCPs call *augmenting*. If your HCP is recommending more than two medications to treat one problem or condition, particularly if the medications are in the same class (e.g., two antipsychotic medications), ask your provider about his or her reasoning for prescribing both medications. You may also consider getting a second opinion. Medicaid and Medicare are required to pay for second opinions. Some people may feel uncomfortable asking for a second opinion because they feel as though they are challenging their HCP's authority. Doctors and nurse practitioners are human beings who sometimes make mistakes, or who may have narrow perspectives. That is partly why provision of second opinions is required.

Some terms to be aware of that HCPs use are *monotherapy*, *combination therapy* and *polypharmacy*. Monotherapy is the use of one drug to treat a single condition. Combination therapy is the use of multiple drugs to treat one condition. The practice of prescribing multiple medications, particularly more than one in the same class of medications is called polypharmacy (e.g., olanzapine and ziprasidone). Polypharmacy can increase the risk of bad outcomes from the medication. If you have concerns, ask your provider if you are being treated with polypharmacy.

Deciding to Stop Taking Medications

Sometimes, people living with mental health challenges decide to stop taking psychiatric medication. This decision can be a conscious and well thought-out one. Other times, the decision is due to intolerable or dangerous side effects. Many people have difficulty taking their medication as prescribed.

Occasionally, the decision to stop taking medications may be an impulsive one, with little thought to possible consequences. People who use medication can find themselves at odds with their HCP when their concerns about medications are not heard. The resulting frustration can cause complete rejection of the therapeutic relationship and medication. While this reaction is understandable, it's important to find areas of agreement between the HCP and the person taking the medication.

Before you stop taking your medication, consider the following:

- What symptoms is the medication supposed to treat?
- What is your plan to deal with those symptoms if you stop the medication?
- Have you developed skills to help you with those symptoms?

For example, if you have a problem with anxiety, what skills or techniques have you learned to help you when the anxiety reaches an intolerable level? Do you use meditation, yoga or breathing exercises to help you? This is also a good time to use your W.R.A.P. plan if you have one.

Regardless of the reason a person decides to stop taking medications, stopping psychiatric medications suddenly can cause people to become very ill—even to the point of death. In many cases, when withdrawing from psychiatric medications, individuals experience withdrawal symptoms that often look like psychiatric symptoms (e.g., psychosis, suicidality, unusual thinking patterns, etc.), which can make it appear as though the medication is needed again. If possible, people should work with their HCPs to gradually reduce the amount of medication they take. For additional support, you may wish to inform a trusted friend or family member that you have decided to stop your medication.

CONCLUSION

Many people have been told by a HCP that they have a serious mental illness and will be on medication for the rest

People who use medication can find themselves at odds with their HCP when their concerns about medications are not heard.

of their lives. The unfortunate consequence of this statement is that it can strip people of their life goals. If this has happened to you, please reconnect with your hopes and dreams. As you start following them, your life will improve, and you will have to think about the role medication plays in your life. The decision to use or not use medication is a deeply personal one and depends on many factors. I hope this article provides some strategies and ideas that will make it easier for you to make an informed decision about the use of medication in your life. Remember—people can and do recover from mental illness.

REFERENCES

1. Chaudry, I. B., Neelam, K., Duddu, V., & Husain, N. (2008). Ethnicity and psychopharmacology. *Journal of Psychopharmacology, 22*(6), 673-680.
2. Deegan, P. E. (2005). The importance of personal medicine: A qualitative study of resilience in people with psychiatric disabilities. *Scandinavian Journal of Public Health, 33*(Suppl. 66), 29-35.
3. Cook, J. (2009). *WRAP evidence base*. Retrieved February 21, 2011 from http://mentalhealthrecovery.com/art_selfmanagement.php.
4. Cook, J. A., Copeland, M. E., Hamilton, M. M., Jonikas, J. A., Razzano, L. A., Floyd, C. B., et al. (2009). Initial outcomes of a mental illness self-management program based on wellness recovery action planning. *Psychiatric Services, 60*(2), 246-249.
5. Drake, R. E., Deegan, P. E., & Rapp, C. (2010). The promise of shared decision making in mental health. *Psychiatric Rehabilitation Journal, 34*(1), 7-13. doi:10.2975/34.1.2010.7.13
6. Rothschild, A. J. (1995). Selective serotonin reuptake inhibitor-induced sexual dysfunction: Efficacy of a drug holiday. *American Journal of Psychiatry, 152*(10), 1514-1516.

AUTHOR

Beckie Child is a doctoral student in Social Work and Social Research at Portland State University and the Executive Director of Mental Health America of Oregon and the SAMHSA funded Peerlink National Technical Assistance Center. She can be reached at beckie.child@gmail.com.

PLEASE UPDATE YOUR CONTACT INFORMATION WITH THE RTC!

Help us keep our mailing list up to date by letting us know about any changes. You can also add your email to the *rtcUpdates* email list to receive information on the latest developments in research and programs pertaining to the mental health of youth and young adults.

To make updates, email your contact information to the publications coordinator at rtcpubs@pdx.edu or leave a message at 503.725.4175.

You may also contact the publications coordinator for permission to reproduce articles at no charge.

The Research and Training Center makes its products accessible to diverse audiences. If you need a publication or product in an alternate format, please contact the publications coordinator.

For more information, please see our website:

www.pathwaysrtc.pdx.edu

Regional Research Institute for Human Services, Portland State University. This article and others can be found at www.pathwaysrtc.pdx.edu. For permission to reproduce articles at no charge, please contact the publications coordinator at 503.725.4175; fax 503.725.4180 or email rtcpubs@pdx.edu

Key Helping Relationships Among Young Adults with Mood Disorders

Having a caring, close relationship with an adult has been found to be a protective factor for those who face adversity, including mental health difficulties and childhood trauma.[1] Recent research has explored supportive relationships between adolescents and mentors, including formal mentors assigned through a program, and natural mentors that emerge within the community. The presence of a mentor has been found to be related to positive life outcomes for young people.[2,3] More specifically, with regard to youth with mental health difficulties, research uncovered that relationships were one of the five principles identified to help students have success in early adulthood.[4] Also, a study of 25-year-olds who were hospitalized in adolescence reported that a small group of "resilient" participants viewed relationships as key resources in their lives as young adults (See Gralinski-Baker, Houser, Billings, and Allen, 2005 for a review).[5]

THE "GOT MOODS" PROJECT

The "got moods" project was designed, in part, to further explore the relational lives of former systems-experienced young adults, all of whom were currently struggling with mood and emotional difficulties. The main focus was to examine the presence and qualities of the supportive relationships between young adults and one "key helper." A key helper in this study was defined as, "an adult that has been particularly helpful, or supportive, in dealing with your mood and emotional problems." The participants nominated the adults whom they perceived to be most helpful with regard to their mental health difficulties.

In-depth face-to-face interviews were conducted with 66 young adults who were struggling with mood and emotional difficulties. The youth were recruited from a variety of agencies and institutions (e.g., community colleges, social service agencies, and mental health agencies) and the broader community (e.g., local eateries) in one Midwestern state. Participants were recruited from youth who:

1. were between the ages of 18 and 30;
2. were currently struggling with mood and emotional difficulties;
3. were living in the community;
4. had been diagnosed with a mood disorder during childhood;
5. had utilized Medicaid mental health services during childhood; and
6. had utilized at least one additional child-serving system of care (i.e., foster care, juvenile justice, public welfare).

Data reported in this article focuses on those between the ages of 18 and 25 that completed the qualitative sec-

tion of the study on supportive relationships with key helpers (n=59). Participants were 68% female and 66% Black, African American, or Bi-/Multi-Racial (self-identified). The mean age of participants was 21.

Trained data analysts conducted qualitative line-by-line coding, chose segments of data that they perceived as meaningful to the research questions, and assigned them codes (e.g., "reminds me to take medications"). Then, analysts came together to compare and contrast groups of codes and themes that emerged in the data. This article presents a preliminary sample of the themes that emerged in the "got moods" key helping relationships project. Percentages of quantitative items were also examined.

WHO ARE THE KEY HELPERS?

Seventy-eight percent of the participants reported a key helper in their lives. Key helpers were predominately family members and professionals. Almost half of the relationships were reported to have lasted over ten years. Interestingly, many of those with a key helper reported that they knew or perceived that their key helper also lived with mood and emotional difficulties.

How Do Key Helpers Help?

Young adults value constancy, mutuality, honesty, modeling, and encouragement in key helping relationships, among other qualities. Aspects of constancy discussed included "consistency" and "availability":

> That's why I always tell them consistency is key. I have to have somebody I can see at least once a week because, if not, you know a lot can happen in seven days, and if I don't have anybody to talk to, then that emotion stays bottled up inside. [Key Helper: Caseworker]

> *I mean she'll call me, ask me how I'm feeling, 'cause she knows that I deal with a lot of issues and she knows that I can fall off the wagon at the drop of a dime. I mean she was there when I tried to commit suicide. She was there when they pumped my stomach. She was there when I was in a psych ward. She was there. The best decision [my mother] could've ever made was putting that woman into my life because without that woman in my life I would've never had any kind of stability.... There was never a time that I didn't know where she was. There was never a time that I couldn't get a hold of her. [Key Helper: Godmother]*

Mutuality emerged as particularly significant for young adults, with regard to respect, trust, understanding, sharing and making a mutual impact or influence. With regard to mutual understanding of depression, one participant reports:

> *We'll be talking about being depressed and I'll be like, 'Yeah, and you know how when you just want to shut yourself away and just not talk to anybody,' and she's like 'Yeah, I know what that's like.' We have similar experiences. [Key Helper: Friend]*

It was important to many participants that key helpers understood, first hand through their own lived experiences, mood and emotional difficulties. Another aspect of mutuality that was valued was mutual sharing:

> *She shares some of her own personal experiences, and not just things that are like, 'Well you know, this happened to me and I overcame it by doing this,' but she'll share, like…'The baby did this and I was scared out of my mind,' and like real experiences that aren't just, you know, happy ending stories. They're like, you know, real life, 'Other people feel this way' stories. [Key Helper: Counselor]*

The above example highlights the importance of authenticity and the sharing of "real experiences," as opposed to sharing what the participant insinuates are less helpful, inauthentic, canned messages about how to overcome obstacles.

I can just let her know whenever I am cycling or going through something and she'll leave me alone.... and just make sure I'm able to stay calm.

Young adults talked about a variety of ways that their key helper facilitated their growth, for example, by helping them become more "themselves":

> *I love to write and I don't show anybody what I write, and [he] has seen what I've written, and he got me to the point where he says 'You write really good poetry. You need to show it.' He got me to the point where I was comfortable with putting it up and posting it on MySpace for other people to read. [Key Helper: Friend]*

> *She molds me into this strong person, this wonderful woman that I am, 'cause I change a lot, just from her being in my presence, just me being a woman. She really transformed me into being… a woman. [Key Helper: Professional]*

These examples show how key adults are helping young people living with mood and emotional difficulties develop and move toward adulthood. Key helpers also facilitate growth by helping participants move beyond symptoms. The example below illustrates how a key helper supported a young man by both modeling, ("shown me") and teaching ("explained this to me").

> *She helped me so much with the mood disorder and the medication, it makes me feel that I can function better as an individual in society, that I can be more independent and take care of my own means… she's shown me this and explained this to me and that's why I'm able to do it so well. [Key Helper: Professional]*

Relationships with key helpers provide a lot of different

Regional Research Institute for Human Services, Portland State University. This article and others can be found at www.pathwaysrtc.pdx.edu. For permission to reproduce articles at no charge, please contact the publications coordinator at 503.725.4175; fax 503.725.4180 or email rtcpubs@pdx.edu

types of social support, including general emotional, informational, and tangible support, along with social support directly related to managing mental health recovery and wellness.

For example, one participant described how her key helper was able to provide support when she was experiencing symptoms:

> *I can just let her know whenever I am cycling or going through something and she'll either leave me alone, or like most of the time tell everybody else to leave me alone and just make sure I'm able to stay calm. [Key Helper: Grandmother]*

Key helpers provided information support to these participants through advice related to mental health recovery and wellness, such as going to counseling or taking medication:

> *She told me that I should consider seeking help, counselor or psychiatrist to talk to. She said that she knows it might be some things that I can't talk to her about that maybe I would feel comfortable talking with someone else about. [Key Helper: Mother]*

> *When I don't want to take my medicine and I feel depressed, she say 'Well I know you don't like taking pills, but those pills is there to help you, and you know you feel much better when you take them, so just go on and take them. You'll feel a lot better.' [Key Helper: Mother]*

Tangible support related to mental health was provided in many ways; for example, helping to access services and "making sure" things get done:

> *It was my godmom who took me to counseling and who was actually providing the ride there and back and talking to the counselor and finding out what's going on and being involved in that kind of aspect and making sure I took medication. [Key Helper: Godmother]*

IMPLICATIONS

Preliminary findings from "got moods" provide a starting point for building knowledge about the supportive relationships between young adults formerly involved with public systems of care who live with mood and emotional difficulties and those they perceive provide them key help and support during the developmental transition to adulthood. The voices of youth and young adults can assist professionals in further research, program development and evaluation, and advocacy/policy initiatives.

Next steps with these data are to further examine themes related to relationship qualities and types of support related to mental health wellness and recovery, while also examining the association between supportive relationships and various young adult outcomes. These data can inform the development of measures to assess key helping relationships. Also, as professionals design programs for youth and young adults in transition, it would be prudent to examine the qualities that young adults indicate are particularly important to them, such as the quality of mutuality.

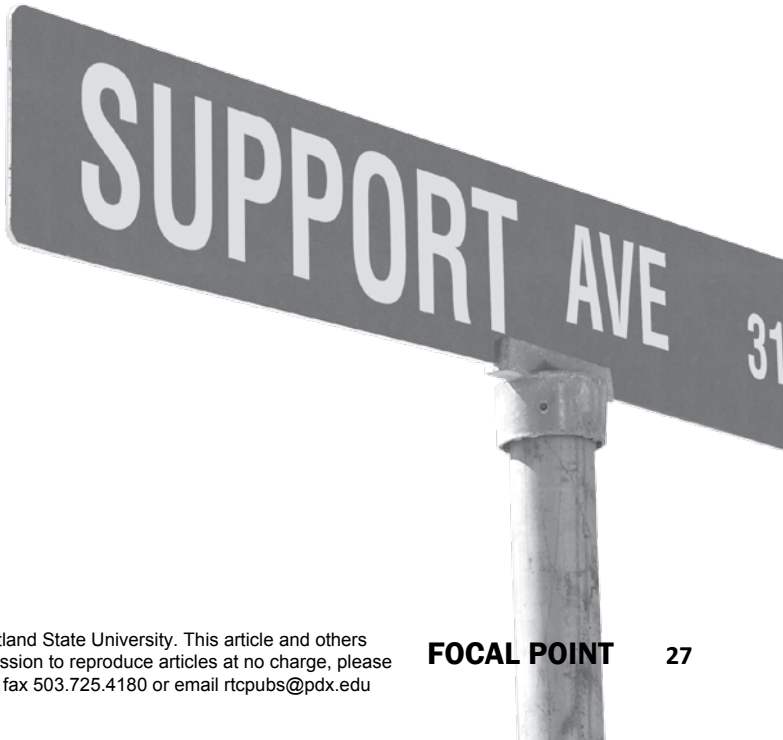
If you would like to learn more about the "got moods" study please contact Dr. Michelle R. Munson at michelle.munson@nyu.edu.

REFERENCES

1. Kaufman, J., Yang, B., Douglas-Palumberi, H., Houshyar, S., Lipschitz, D., Krystal, J., et al. (2004). Social supports and serotonin transporter gene moderate depression in maltreated children. *Proceedings of the National Academy of Sciences, 101*(49), 17316-17321.
2. DuBois, D. L., & Karcher, M. J. (2005). *Handbook of youth mentoring.* Thousand Oaks, CA: Sage Publications, Inc.
3. Munson, M. R., & McMillen, J. C. (2009). Natural mentoring and psychosocial outcomes among older youth transitioning from foster care. *Children and Youth Services Review, 31*(1), 104-111.
4. Wagner, M., & Davis, M. (2006). How are we preparing students with emotional disturbances for the transition to young adulthood: Findings from the National Longitudinal Transition Study-2. *Journal of Emotional and Behavioral Disorders, 14*, 86-98, doi: 10.1177/10634266060140020501
5. Gralinski-Baker, J. H., Houser, S. T., Billings, R. L., & Allen, J. P. (2005). Risks along the road to adulthood: Challenges faced by youth with serious mental disorders. In D. W. Osgood, E. M. Foster, C. Flanagan, & G. R. Ruth (Eds.), *On your own without a net: The transition to adulthood for vulnerable populations.* Chicago, IL: The University of Chicago Press.

AUTHOR

Michelle Munson is an Associate Professor at the Silver School of Social Work at New York University.



DATA TRENDS

BEING TREATED DIFFERENTLY:

STIGMA EXPERIENCES OF ADOLESCENTS WITH MENTAL HEALTH DISORDERS

SOURCE

Moses, T. (2010). Being treated differently: Stigma experiences with family, peers and school staff among adolescents with mental health disorders. *Social Sceince and Medicine,* 985-993.

This study sought to better understand stigma as experienced by youth with mental health problems. More specifically, the goal of this research was to examine youth perceptions of being treated 'differently' by family members, peers, and school staff because of mental health problems.

Close to half (46%) of participants reported negative treatment by family members manifested as distrust, avoidance or exclusion from family events, unfair blame, poking fun/teasing (especially by siblings), and low expectations.

METHOD

Data were collected through 60- to 90-minute semi-structured interviews with 56 volunteer adolescents (12-18 years old). Youth participants were involved in a mental health wraparound program based in a mid-sized Midwestern American city and diagnosed with one or more mental health disorders. Each interview covered a series of questions and rating scales related to mental health challenges. This study analyzed youths' responses to three interview questions: (1) How do you feel other people in your life who know that you are getting treatment for emotional or behavior issues treat you? (2) Do you feel family/peers or school treat you differently? (3) Do you feel that others treat you differently in comparison to a) your siblings (in the family), b) other kids? (p. 987). Additional demographic and clinical data were collected through agency records.

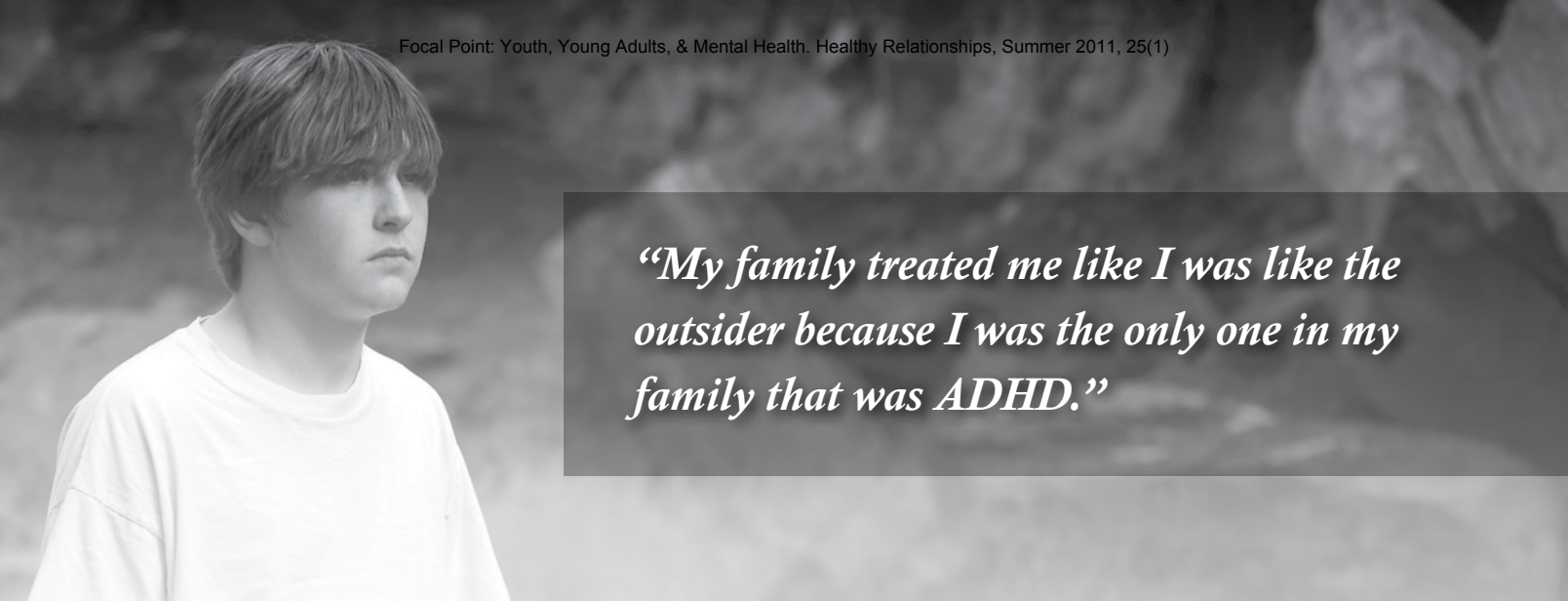
Data analysis began with classifying responses into three interpersonal domain categories: family, peers, and school. Extent of stigma experienced was numerically coded into three point scales (0=none, 1=some, 2= substantial amount) for family and peer domains and a two-point scale (0= no stigma and/or positive treatment, 1= negative treatment) for school. Bivariate analyses were used to explore the associations between stigma domains and youths' demographic and clinical characteristics.

RESULTS

Overall, inter-correlations among domains showed that participants who reported higher stigma in any of the three domains were more likely to report higher stigma in other domains too.

Stigma Experiences Within Family: Close to half (46%) of participants reported negative treatment by family members manifested as distrust, avoidance or exclusion from family events, unfair blame, poking fun/teasing (especially by siblings), and low expectations. Few participants (13%) who reported negative treatment experienced substantial stigma from immediate and extended family: "My family treated me like I was like the outsider because I was the only one in my family

Regional Research Institute for Human Services, Portland State University. This article and others can be found at www.pathwaysrtc.pdx.edu. For permission to reproduce articles at no charge, please contact the publications coordinator at 503.725.4175; fax 503.725.4180 or email rtcpubs@pdx.edu



"My family treated me like I was like the outsider because I was the only one in my family that was ADHD."

that was ADHD…They would say that like I was always like crazy" (p. 988). There were no statistically significant differences in levels of familial stigma experiences by demographic or clinical characteristics.

Stigma Experiences from Peers: Two-thirds of respondents reported experiencing at least some stigma from peers. For example, one youth said: "They [peers] act like they are embarrassed to be around me or something" (p. 989). Of those who experienced negative treatment by their peers, 18% reported feeling stronger stigma—being alienated or socially isolated: "They just ignore me….I'm in the outcast [group]. And there is hardly anyone in there, so people treat me differently" (p. 990). Bivariate data analyses revealed that females and ethnic minorities reported experiencing significantly less peer stigma than their male and white counterparts. There were no statistically significant differences in levels of peer stigma experiences by clinical characteristics.

Stigma Experiences at School: Over half (57%) of participants stated they were treated differently by teachers and school staff. One-third of those (35%) reported being treated differently in the negative sense. For example, one youth stated: "At times they [teachers] treat me differently because they don't think I can do good, they could take it easy on me because I—they don't think I can do hard [or] normal work like other kids, which is not true because I can" (p. 990). However, 22% of participants felt they were treated differently at school, but in a positive sense. One youth said during the interview, "Everybody's so proud and wants me to do so good" (p. 990). Bivariate analyses revealed that participants who experienced negative differential treatment were more likely to be incarcerated and participants reporting positive differential treatment were more likely to be in out-of home status. There were no statistically significant differences in levels of school stigma experiences by demographic characteristics.

DISCUSSION AND IMPLICATIONS

This article investigated the subjective experiences of stigma among youth with mental health disorders. What makes this study unique is that it compares and differentiates stigma experiences within family, peer, and school settings. Key findings include that while slightly less than half of participants reported experiencing stigma within their families, stigma is experienced most often from peers. Participants reported being treated differently in school as well, but often in a positive manner.

Participants who experienced stigma within one domain (i.e., family, peers, school) were more likely to report experiencing stigma in other domains. The author postulates that this could be due to greater "stigma consciousness" or "stigma sensitivity" (991) of certain participants, though it is also possible that certain individuals are more likely to experience stigma due to certain factors not assessed in this study. Analyses conducted in this study suggest that demographic or clinical characteristics are not consistent factors in predicting stigma across domains. More research is needed to determine which youth may be more vulnerable to experiencing stigma across social domains.

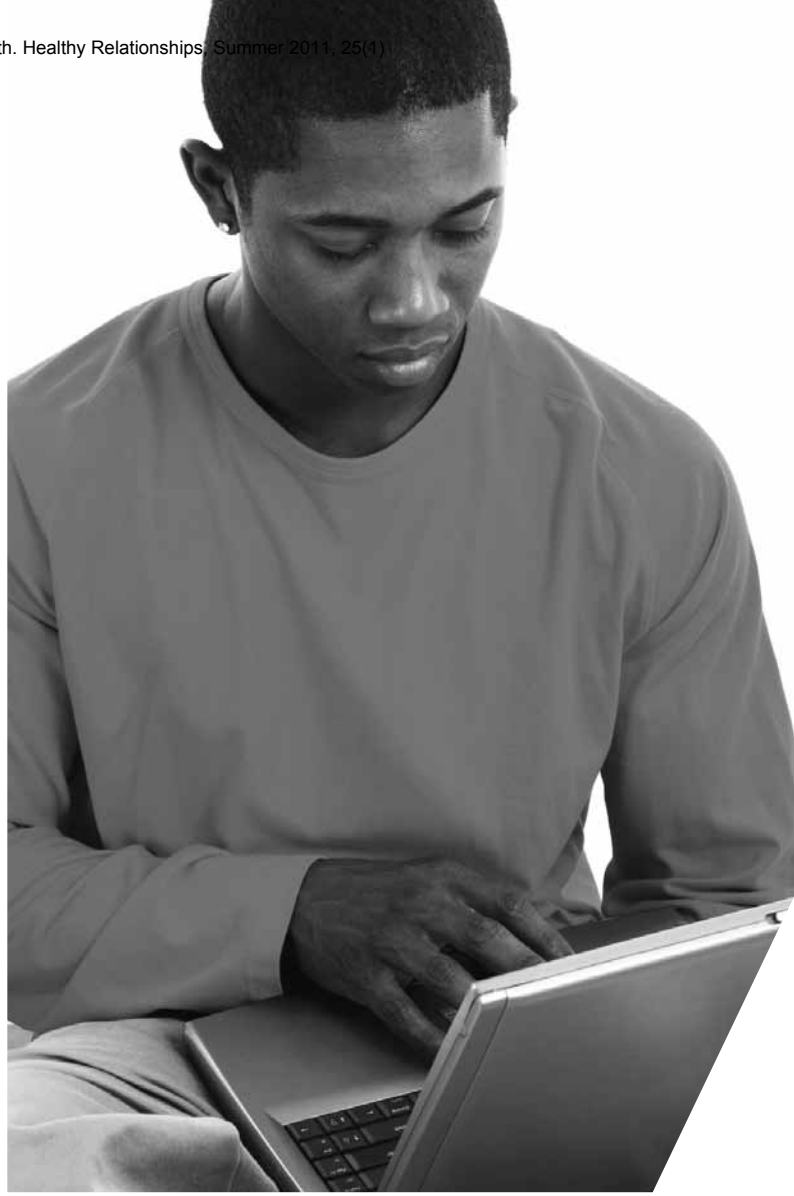
Females and ethnic minorities reported experiencing significantly less peer stigma than their male and white counterparts.

Results from this study can help practitioners appreciate that youth may experience stigma within a particular social domain, but not another. Additionally, findings indicate that youth can experience either positive or negative differential treatment in school. Therefore, it is important for adults to ask youth about both their sources of discrimination and supports in different social venues.

AUTHOR

Aakrati Mathur is a Research Assistant and doctoral student at PSU studying the social and behavioral components of health among young patients with HIV and Cancer.

BUILDING AN ONLINE COMMUNITY



March 2010: A new site is launched. It is like no other site that has ever existed. More than a year of planning and research goes into this site before it is made available to the public. It is a site made by and for young adults living with mental health conditions. The site is StrengthofUs.org.

StrengthofUs.org is the brain child of the National Alliance on Mental Illness (NAMI). NAMI is the largest grassroots mental health advocacy organization dedicated to improving the lives of individuals and families affected by mental illness. In order to gather data about what young adults living with mental health conditions would want in a website that was meant for them, NAMI sent out a survey to 16-to-25-year-olds that asked them about their online habits and activities and what resources they would want to see in a web community designed for people like them. From this survey, NAMI formed a phone-based Expert Advisory Group to discuss the creation of the future website. The Group was made up of survey respondents NAMI handpicked based on their detailed and thoughtful responses to the questions posed. I, Wesley Kittel, was one of those picked. There were at least five of us from around the country, and I was happy to represent my home state of Nevada. Dana Markey, NAMI program manager, organized the whole project.

The first phone call was all about the website. We were emailed questions in advance about what we would like the website to be like. The questions asked us to think about what content to feature, what the site should look like—we even had to come up with the name of the website. Dana ran all of the Expert Advisory Group's monthly conference calls. If members couldn't make a particular call, they could read the meeting minutes, which were emailed to all members. Any questions members had could be answered via email.

One of the hardest things the Expert Advisory Group had to figure out was what to name the site. I took it upon myself to come up with as many names as I could think of. One of the finalists was, "Out of Many, One." But there, among the list of at least fifty possible names, would be the name that would stick: StrengthofUs.org. It was perfect; the group loved it and, most importantly, there was no site with that name in existence already so we could register the domain name as our own.

After the StrengthofUs.org name became official, the NAMI team began building the website—putting the ideas of the Expert Advisory Group into action. There is a fictitious person who is everyone's friend (similar to how MySpace founder "Tom" friends all members on that social networking site). This character's name is Chuck and his email is handled by NAMI staff. People can email Chuck if they have questions or concerns about the site or life in general. There is a space called The Wire, where people can write 140-character messages back and forth to each other, much like Twitter. We created a social networking site where members can create profiles, manage their own privacy settings, upload files (pictures, video, audio recordings), add friends, write blogs, join or start groups—very much like what you would expect from any social networking site. The Expert Advisory Group was called in to become Beta Testers for the site, to be followed by a larger group of other Beta Testers identified from participants of the original survey. The site was in Beta from January 2010 to March 2010, and then it was launched for the general public.

From the beginning of the site launch, I took ownership of the site. When I say, "I took ownership," I don't mean that I literally became the site owner or Webmaster. What I mean is that I treated it like my own. I poured myself into it from the very beginning. To me, it was my baby. I poured myself into answering the NAMI survey when it had come out a year before. I poured myself into being an active

Regional Research Institute for Human Services, Portland State University. This article and others can be found at www.pathwaysrtc.pdx.edu. For permission to reproduce articles at no charge, please contact the publications coordinator at 503.725.4175; fax 503.725.4180 or email rtcpubs@pdx.edu

member of the Expert Advisory Group. I was a thorough and active Beta Tester and I was going to pour myself into helping grow the site as best as I could. To me, the site was a dream come true. Becoming mentally ill at age 18 was hard for me. I didn't want people to go through what I went through. I wanted young adults just starting college to learn from my mistakes and realize that they are not alone. For many young people, the signs and symptoms of mental illness start to show around age 18 through the early 20's—the same age many of us enter college. If I could be the person to help someone gain strength and make it through the transition from high school to college successfully, I would be proud of myself.

I started out by writing blog posts about myself and my experience with mental illness. I continue to write as many blog posts as I can about topics that I think could be helpful to transitioning youth, such as: starting a mental health journal, getting enough sleep in college, using a phone alarm as a reminder for taking medicine, etc. I treat The Wire as my own personal Twitter account where I can be myself and not worry about the impressions of others. I try to foster a community of mutual respect and encouragement of one another. The site is called StrengthofUs.org for a reason—we are all trying to gain strength from each other to heal from mental illness and continue with our lives. We write encouraging notes, comments, and emails to each other and we respect each other. We withhold judgment and try to be as polite and respectful to each other as we can. Sounds like the opposite of most websites, right? There are members who are gay, lesbian, Christian, atheist, pagan, Jewish—there is a space for everybody. There is an LGBT Support Group, a Pagan Group, a Christian Group, and there are many other groups for various interests such as Weight Management, Car Enthusiasts, Video Gaming and much more. There are groups for the various mental health conditions: Schizophrenia, Schizoaffective Disorder, Bipolar, ADHD, OCD and many others. If a member feels that there is not a group for him or her, he or she can create a new group!

The most popular sections of the website used by registered members are The Wire, Blogs, Think Positive (a section where Chuck has a weekly prompt to help users think positively), and Vent This (a section of the site where members can vent whatever frustrations they are having and get encouragement from other users). The Resources section, however, is the part of StregthofUs.org that is accessed most often, probably because you do not need to be a member of the web community to get to this section.

THE SITE IS CALLED STRENGTHOFUS.ORG FOR A REASON—WE ARE ALL TRYING TO GAIN STRENGTH FROM EACH OTHER TO HEAL FROM MENTAL ILLNESS AND CONTINUE WITH OUR LIVES. WE WITHHOLD JUDGMENT AND TRY TO BE AS POLITE AND RESPECTFUL TO EACH OTHER AS WE CAN. SOUNDS LIKE THE OPPOSITE OF MOST WEBSITES, RIGHT?

Fostering a web community is like fostering any other kind of community. It takes time, effort, and care from committed members. Of the Expert Advisory Group, only I and one other member are still active on the StrengthofUs.org site. We love helping the StrengthofUs.org family because in many cases, we've been there ourselves. We've been hospitalized, we've experienced crisis, and we've recovered or are still recovering. I envision StrengthofUs.org as being a long-lasting community where members enrich and encourage one another. They share personal stories and ideas that make a difference in the recovery of young adults with mental illness. It starts with one person who says "There's got to be a better way." The person finds the better way and shares with others his or her experience, so that others can benefit from it and become stronger than they were before. That is what StrengthofUs.org is all about. For more information, please visit www.strengthofus.org.

WWW.

STRENGTHOFUS.ORG

AUTHOR

Wesley Kittel is a Senior at the University of Nevada Las Vegas studying Special Education.

PORTLAND STATE UNIVERSITY
Research & Training Center
Regional Research Institute for Human Services
Index #230010
PO Box 751
Portland, Oregon 97207-0751

RETURN SERVICE REQUESTED

Non-Profit Org.
U.S. Postage
PAID
Portland, OR
Permit No. 770

PUBLICATIONS

Back issues of *Focal Point*, as well as many other publications by the Portland Research and Training Centers, are available for free download from our web site: www.pathwaysrtc.pdx.edu (Click on the "Publications" tab and follow the instructions.) Check for journal articles at your local library.

www.pathwaysrtc.pdx.edu/publications.php

Contact the Publications Coordinator at below phone or email for general information about publications or to request publications in an alternative format.

Publications Coordinator:

Phone: 503.725.4175
Fax: 503.725.4180
Email: rtcpubs@pdx.edu

SOME RECENT PUBLICATIONS:

JOURNAL ARTICLES

DEFINING YOUTH SUCCESS USING CULTURALLY APPROPRIATE COMMUNITY-BASED PARTICIPATORY RESEARCH. 2011. *Best Practices in Mental Health, 7*(1), 94-114.

SUPPORTS FOR YOUNG PEOPLE WITH MENTAL HEALTH CONDITIONS AND THEIR FAMILIES IN THE TRANSITION YEARS: YOUTH AND FAMILY VOICES. 2011. *Best Practices in Mental Health, 7*(1), 115-133.

FACT SHEET

EVALUATING WHETHER OR NOT TO TRUST MENTAL HEALTH INFORMATION ON THE INTERNET. 2011.

FOCAL POINT

TRANSITIONS TO ADULTHOOD. 2010, 24, Summer.

YOUTH EMPOWERMENT AND PARTICIPATION IN MENTAL HEALTH CARE. 2009, 23(2), Summer.

STIGMATIZATION. 2009, 23(1), Winter.

REPORT

PAVING THE WAY: MEETING TRANSITION NEEDS OF YOUNG PEOPLE WITH DEVELOPMENTAL DISABILITIES AND SERIOUS MENTAL HEALTH CONDITIONS. 2010.