Program Faculty

• Dr. Andrea Bergman
• Dr. Elissa Brown
• Dr. Elizabeth Brondolo
• Dr. William Chaplin
• Dr. Raymond DiGiuseppe
• Dr. Beverly Greene
• Dr. Rafael Javier
• Dr. Wilson McDermut
• Dr. Jeffrey Nevid (Clinical Director)
• Dr. Alice Pope
Ph.D. Program in Clinical Psychology

The doctoral program in clinical psychology offers two tracks of study:

• General course of study in clinical psychology
• Subspecialty track in clinical child psychology
Doctoral Training in Clinical Psychology

• Anchored in Scientist/Practitioner Model

• Emphasis on evidence-based assessment and treatment

• Primary practicum training site: St. John’s University Center for Psychological Services

• Network with a wide range of clinical externship sites throughout metropolitan New York area

• Highly favorable clinical internship placement rate

• Core faculty: renowned scholars with active roles in clinical training
Preparing Tomorrow’s Leaders in Clinical Psychology

Dr. Schnur is currently an Assistant Professor in the Department of Oncological Sciences at Mount Sinai Medical Center and Co-Director of the Integrative Behavioral Medicine Program. She believes that the education she received from St. John’s College of Liberal Arts and Sciences gave her the skills necessary for her current position of improving the quality of life for individuals suffering from cancer and its treatment: “My favorite thing about being a student at St. John’s was the top-notch, in-depth clinical supervision I received. I currently conduct research on psychotherapeutic interventions for cancer patients. My clinical training has given me the skills I need to help women cope with the stressful and often frightening experience of cancer,” says Dr. Schnur.
Dr. Philip Szeszko  
North Shore – LIJ Medical Center  
Ph.D., Clinical Psychology, St. John’s University

• Associate Investigator, Department of Psychiatry Research, Zucker Hillside Hospital and Associate Investigator, Center for Psychiatric Neuroscience, The Feinstein Institute for Medical Research

• Associate Professor, Molecular Medicine & Psychiatry, Hofstra North Shore-LIJ School of Medicine

• Dr. Szeszko’s research focuses on the use of magnetic resonance imaging and diffusion tensor imaging to characterize brain structural abnormalities including schizophrenia and obsessive-compulsive disorder and how these abnormalities are associated with functional indices

Reversed Cerebellar Asymmetry in Men with First-Episode Schizophrenia

Philip R. Szeszko, Faith Gunning-Dixon, Manzar Ashar, Peter J. Snyder, Jeffrey A. Liberman, and Robert M. Bilder

Background: Abnormalities in cerebellar structure and function have been implicated in the pathophysiology of schizophrenia. In this study, we investigated whether patients experiencing first-episode schizophrenia differed from healthy comparison subjects in regional cerebellar volumes or cerebellar asymmetry.

Methods: Volumes of four cerebellar regions (right, left, anterior, posterior) were measured from contiguous coronal magnetic resonance (MR) images in 49 (17 men, 32 women) patients experiencing first-episode schizophrenia and in 49 (27 men, 22 women) healthy comparison subjects. Patients were rated on the Scale for the Assessment of Negative Symptoms and the Schedule for Affective and Schizophrenia—Psychosis—Disorganization before the initiation of antipsychotic medication and at the time of the MR imaging scan.

Results: Patients and healthy comparison subjects did not differ in regional cerebellar volumes, but male patients demonstrated significantly reduced anterior and posterior asymmetry compared with healthy male subjects. Among male patients, greater reversals in a composite measure of cerebellar asymmetry (i.e., temporally correlated significantly, with increased negative symptoms before the initiation of antipsychotic medication.

Conclusions: These findings implicate an abnormal neurodevelopmental process involving the maturation of the cerebellum in schizophrenia and are consistent with prior studies implicating abnormal asymmetry in schizophrenia at the neuroanatomical level. Biol Psychiatry 2003;53:450–459 © 2003 Society of Biological Psychiatry

Key Words: Magnetic resonance imaging, cerebellum, asymmetry, first-episode schizophrenia, negative symptoms

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“What I like most about St. John's University is the positive and helpful attitude among its students and faculty,” says Alison Tebbett, Ph.D. expected 2014. Alison chose to pursue her graduate degree at St. John's because of the esteemed faculty and small class sizes that facilitate professor-student interactions.

Currently completing fellowship in Child and Adolescent Psychology at North Shore-LIJ.

As a doctoral candidate in clinical psychology specializing in child psychology, Alison gained experience working in the PARTNERS Program. This program offers evidence-based mental health services to children and adolescents who have experienced stressful or traumatic events, “We offer children alternative ways to cope with the thoughts and feelings related to traumatic events and give caregivers different methods of increasing their ability to gain their children’s cooperation.”
Entrance Requirements

• Possess a baccalaureate degree

• Satisfy the department that his or her undergraduate preparation indicates a high potential for successful advanced study in psychology

• Submit transcripts of undergraduate and any prior graduate work

• Have completed a minimum of 24 undergraduate credits in psychology, including courses in Introductory Psychology, Statistics, and a laboratory course

• Submit three to five letters of recommendation, one of which must be from an individual who will address the matter of the applicant's research potential

• Submit two papers from psychology courses: one a laboratory paper and one a term paper

• Provide a clearly written statement of educational and professional goals

• Submit acceptable scores from the Graduate Record Examinations (general and subject)

• Complete an interview process with the departmental admissions committee
General Requirements

• Four years of coursework, including continuous clinical practica at our psychological services center

• A one-year internship in an approved setting

• Successful completion of master’s thesis and doctoral dissertation
General Goal

To prepare broadly trained, competent, psychological professionals proficient in a variety of evidence-based psychodiagnostic, intervention, and research competencies.
Specific Objectives

• To prepare students to function in the diverse professional, academic, and research roles performed by clinical psychologists.

• To assist students in developing their ability to understand and interpret the research of others as well as to design and execute relevant research of their own.
Why did you choose St. John’s?

“I chose St. John’s for the clinical experience offered from day one of the program, the broad training across the spectrum of theoretical orientations and the diversity of the population we worked with” – Nira Golombeck

“St. John’s program was my first choice because it emphasizes both orientations: psychodynamic and cognitive behavioral. The big difference is the Center for Psychological Services.” – Beth Chen

“The reputation was the first reason but I also liked the dual emphasis on cognitive behavioral therapy and psychodynamic therapy. The ability to complete the program in a timely manner attracted me as did the stories of recent graduates’ successes.” – Joseph E. Gottesman

“Because I worked for two years before applying, I was aware that employers were thrilled to have St. John’s students working with them. The program has an excellent reputation and is known for producing very solid clinicians.” – Michele Morganstern
St. John’s University Center for Psychological Services

• Primary training site for Clinical Psychology and School Psychology programs

• Comprehensive psychological services center serving the general community
Services Provided

• Psychological services are provided to children, adolescents, adults, couples, and families experiencing emotional, behavioral, or adjustment difficulties. Services include:
  • Consultation
  • Assessment
  • Individual therapy
  • Group therapy
  • Family and marital therapy

• Cost for Services:
  For those interested in any of the above services, fees are arranged on a sliding scale basis, which is determined according to one’s income level. As part of a Vincentian University, the Center for Psychological Services is committed to making these services available to those most in need.

• Specialized Services:
  • The Child HELP Partnership, directed by Dr. Elissa Brown, is located at the Center and offers free services for children and families experiencing trauma and abuse. This clinical research program uses state-of-the-art, empirically-based CBT approaches.
  • The Center’s Military Services Initiative offers free services to military personnel and their families and includes the use of virtual reality technology to enhance the exposure-based treatment of PTSD.
Sampling of Recent Clinical Psychology Externship Sites

- Albert Einstein College of Medicine
- Albert Ellis Institute
- Bellevue Medical Center
- Bronx Children’s Psychiatric Center
- Child Mind Institute
- Coler-Goldwater Specialty Hospital
- Columbia University Medical Center
- Creedmoor Psychiatric Center
- Department of Veterans Affairs
- Elmhurst Hospital Mental Health Services
- Hackensack University Medical Center
- Jamaica Hospital Medical Center
- Kings County Hospital Center
- Long Island Jewish Medical Center, Zucker Hillside
- Long Island Jewish Medical Center, Cohen Children’s Hospital
- Lutheran Health Care
- Manhattan Psychiatric Center
- MercyFirst
- Montefiore Medical Center
- Mount Sinai Medical Center
- Nassau University Medical Center
- National Institute for the Psychotherapies
- New York Presbyterian Hospital/Weill Cornell
- NYU Child Study Center
- NYU Counseling Center
- NYU Trauma and Resilience Center
- Queens Children’s Psychiatric Center
- Queens Hospital Center
- Roberto Clemente Center
- Sagamore Children's Psychiatric Center
- South Beach Psychiatric Center
- St. Barnabas Hospital
- St. Luke’s-Roosevelt Hospitals
- St. Mary’s Hospital for Children
- SUNY Downstate Medical Center
Clinical Psychology Internship Sites 2008-2014

- Association for the Help of Retarded Children, Department for Family & Clinical Services
- Bellevue Hospital Center
- Beth Israel Medical Center
- Children’s Village
- Columbia University Medical Center
- Creedmoor Psychiatric Center
- Dartmouth Medical School
- Department of the Army
- Devereux Foundation
- Eastern Virginia Medical School
- Friends Hospital
- Green Chimneys Children’s Services
- Hudson River Psychiatric Center
- Indiana University School of Medicine
- Interfaith Medical Center
- Jacobi Medical Center
- Jersey Shore University Medical Center
- Jewish Board of Family & Children’s Services
- Lincoln Medical Center
- Maimonides Medical Center
- Manhattan Psychiatric Center
- MercyFirst
- Middlesex Hospital
- Montefiore Medical Center
- Mount Sinai Services, Elmhurst Hospital
- Nassau University Medical Center
- North Bronx HealthCare Network
- North Shore-LIJ Medical Center/Zucker Hillside
- Patton State Hospital (CA)
- Pennsylvania Hospital
- Pilgrim Psychiatric Center
- Queen’s Children’s Psychiatric Center
- The School at Columbia University
- Stony Brook University
- SUNY Upstate Medical Center
- Terry Children’s Psychiatric Center
- Ulster County Mental Health Department
- UMDNJ – Robert Wood Johnson Medical Center
- University of Colorado Health Sciences Center
- University of Tennessee Consortium Internship
- VA Hudson Valley Healthcare System
- VA Medical Center
- VA Northern CA Health Care System
- Village for Families & Children
- Yale University Psychiatry
- Yale University School of Medicine – Yale Child Study Center
Core Faculty
Elissa Brown
Professor of Psychology

• Ph.D., 1996, University at Albany, SUNY, Clinical Psychology

• Research interests:
  • Developing, testing, and disseminating therapies for children who have experienced traumatic events, such as 9/11 and child abuse

• Courses taught:
  • Behavior Therapy
  • Trauma-Specific Assessment and Intervention Practicum
School Entry After a Community-Wide Trauma: Challenges and Lessons Learned from September 11th, 2001

Elissa J. Brown1,2,3 and Amy L. Bobrow

The purpose of this paper is to describe the implementation of a school-based trauma-specific mental health program in New York City following the terrorist attacks on September 11, 2001. This program aimed to serve children most at risk for developing mental health problems as a result of physical proximity (e.g., evacuation from schools surrounding the World Trade Centers) to the trauma. As we present the components of the program, we will review the literature that guided our decision making. The ongoing struggle between searching for answers from established science and immediate needs in a crisis is highlighted. Lastly, a discussion of the lessons learned and recommended next steps is presented.

KEY WORDS: trauma; terrorism; intervention; school-based; September 11; mental health.

UNDERSTANDING THE TRAUMA

The attack on the World Trade Center (WTC) on September 11th, 2001 was a traumatic event of unprecedented magnitude. The event killed thousands of individuals, destroyed numerous New York City structures, displaced downtown businesses, and caused a climate of fear and uncertainty in the New York City area during the ensuing weeks. Many children were in close proximity to the WTC at the time of the attacks. An estimated 8,500 students were evacuated from New York City schools, experiencing dislocation, traveling to unknown destinations, and delaying reunion with their families. Some of these children were unable to return to their schools for weeks; others continued to attend school at alternative locations for several months due to air quality concerns. Some of these children witnessed the horrifying events of planes flying into buildings, bodies falling, and buildings collapsing. Many children were exposed to intense media coverage of these attacks and the ensuing terrorist threats including Anthrax. Given the large number of New York City children exposed to these traumatic events and the research indicating that traumatized children are at a heightened risk for developing psychiatric disorders, the child survivors of September 11th presented a public mental health concern, if not an outright crisis.

SCHOOL-BASED MENTAL HEALTH PROGRAMS

Literature Support for School-Based Mental Health Programs

Only a small portion of the many youth with emotional and behavioral problems is treated in traditional mental health settings (Zahn-Carsen & Daskalakis, 1997). There are many barriers to implementation of these traditional settings, including transportation concerns (Evans, Altenderfer, Minneci, & Adle, 1996), lengthy wait lists, and high no-show and drop out rates. In contrast, nontraditional settings, including schools, are more easily accessible and associated with high rates of utilization, perhaps due to reduced stigma, increased opportunity for prevention, and reduced cost (Weist, 1999). In a review of studies, 1

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Matching Interventions to Children’s Mental Health Needs: Feasibility and Acceptability of a Pilot School-Based Trauma Intervention Program

Elissa J. Brown
St. John’s University
Jennifer McQuaid
St. Luke’s Child and Family Institute
Lana Farina
Jewish Board of Family and Children’s Services
Rehana Ali and Amy Winnick-Gelles
Boys’ and Girls’ Harbor

Abstract

The primary goal was to develop and implement a school-based, trauma-specific intervention program for inner-city children exposed to the World Trade Center attacks on September 11th, 2001. The feasibility and acceptability of the program, and its research component, were examined. The efficacy of the program was evaluated in a pilot study. Sixty-three children were assessed using measures of posttraumatic stress disorder (PTSD), generalized anxiety, depression, and externalizing symptoms, and provided a 10-session, skill-based classroom intervention. Following the classroom intervention, children were re-assessed and those who continued to meet criteria for PTSD were offered an individualized intervention. The assessment was repeated following the individualized intervention. The differential influence of the classroom and individual interventions suggest that each intervention may target a separate group of symptoms. Study limitations are discussed and future directions are proposed.

Multicultural, inner-city youth are more likely to be exposed to traumatic events, but less likely to receive mental health services (Brown, Janes, Braunstein, & Gonzalez, 2005). The World Trade Center attack on September 11th increased the public’s awareness

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Pages 257-286
Elissa Brown
Professor of Psychology

- Awarded grant from the Substance Abuse and Mental Health Services Administration to become a member of the National Child Traumatic Stress Network

- Elected to the board of the American Professional Society on the Abuse of Children
Elissa Brown
Professor of Psychology

• Founder and Executive Director of Child HELP Partnership (formerly PARTNERS): a clinical research program providing evidence-based mental health services for traumatized children and their families
Alice Pope
Associate Professor of Psychology

• Ph.D., 1986, The Pennsylvania State University, Psychology
• Research interests:
  • Social cognitions, emotions, and behaviors related to successful and unsuccessful peer relationships in children, psychosocial adjustment in children with medical conditions
• Courses taught:
  • Assessment and Interviewing Practicum
  • Psychopathology Across the Lifespan
Predicting Adolescent Peer Problems and Antisocial Activities: The Relative Roles of Aggression and Dysregulation

Alice W. Pope
New York University Medical Center

Karen L. Bierman
Pennsylvania State University

This study examined the relative roles of aggression and other dysregulated behaviors in the prediction of adolescent peer problems and antisocial behavior. The social adjustment of 65 boys studied first in Grades 3–6 was assessed again 4 years later in Grades 7–10. At each time, peer ratings of aggressive, hyperactive-disruptive, withdrawn, and irritable-instinctive behaviors were collected. Aggression and withdrawal showed stability and were linked to peer difficulties in elementary school and in adolescence, but these behaviors indicated significant risk for adolescent aggression, victimization, and antisocial activity primarily when accompanied by irritable-instinctive behaviors. Results are discussed in terms of the potential role that difficulties regulating negative affect may play in the genesis of the particular constellation of irritable-instinctive behaviors studied here and the developmental significance of aggressive or withdrawal problem profiles that are or are not accompanied by these behavioral indicators of dysregulation.

Aggression represents one of the most prevalent, stable, and intractable of the childhood behavior problems (Olweus, 1993). Aggressive behavior contributes to concurrent peer rejection and, over time, predict delinquency, school failure, and substance abuse (Kaplowitz & Coie, 1990; Loebner, 1990). Multiple stages characterize the negative developmental pathway associated with aggression. Typically, aggressive behaviors emerge first in the context of coercive family transactions (Patterson, 1982) and then generalize to school, where they lead to rejection by mainstream peers (Bierman & Sevick, 1991; Dodge, Bates, & Pettit, 1990) and affiliations with deviant peers who, by early adolescence, provide a gateway into delinquent activities (Cairns, Neighbors, & Cairns, 1989; Dishion, Patterson, & Stoolmiller, & Skinner, 1991).

Although considerable emphasis has been placed on child aggression as the key driving force in this negative transactional model, recent findings suggest that not all aggressive children are likely to follow the same pathway toward impaired peer relations and social maladaptation. Indeed, only about one half of all children who are physically aggressive in elementary school are rejected by peers (Bierman, Smoak, & Asarnow, 1993; Cox, Terry, Lenox, Lochman, & Hyman, 1996). In addition, those children who are both aggressive and rejected often appear at greater risk for negative social outcomes than are children who are only aggressive (Bierman & Wagar, 1995; Cox et al., 1996; Dodge, 1993). These findings have led investigators to explore mechanisms that might account for the peer rejection and subsequent high risk for long-term social maladjustment of some aggressive children.

It is easy to understand why children dislike aggressive peers; more puzzling is the finding that some physically aggressive children are liked by peers in spite of their hostile behavior. One of the capabilities that may determine whether aggressive behavior will disrupt a child’s social relations is the extent to which the child is able to control the aggression and use it strategically to attain social goals, versus the extent to which the child’s aggressive responding reflects a disinhibited and reactive response to environmental and interpersonal frustrations (Cone & Lenox, 1994; Dodge & Coie, 1987). For example, research examining the types of aggressive behavior displayed by rejected-aggressive and accepted-aggressive children has suggested that, whereas both show elevated rates of proactive and physically aggressive behavior, rejected-aggressive boys are more likely to show reactive and poorly modulated forms of aggressive behavior, including tantrums, angry outbursts, and whining (Bierman et al., 1993; Dodge & Coie, 1987). In addition, aggressive boys who become rejected are more likely than accepted-aggressive boys to show multiproblem profiles that include disinhibited and dysregulated behaviors (e.g., hyperactive, instigative, and immature behavior) as well as aggression (Bierman et al., 1993; Dubow, 1988; French, 1988; Labey, Green, & Fordham, 1988; Lochman & LaPine, 1983; Pope, Bierman, & Munn, 1991).

It may be possible to conceptualize the developmental difficulties of high-risk aggressive-rejected children in purely behavioral terms. Perhaps this group of children is at higher risk for peer rejection and long-term social maladaptation simply because they have more behavioral problems. However, it may not be simply the number of behavior problems that differentially affects the developmental trajectories of these children; instead, the quality of the behavioral dysfunction may be important because it may provide a marker of social-emotional capabilities that affect the process of social adaptation over time.
Jeffrey Nevid
Professor and Clinical Director

• Ph.D., 1976, State University of New York at Albany
• NIMH Postdoctoral Fellowship, Mental Health Evaluation Research, Northwestern University, 1976-77
• Research interests:
  • Cognitive-behavioral therapy
  • Cultural differences in perceptions of mental illness
  • Smoking cessation
  • Pedagogical research
  • Measurement of implicit attitudes and cognitions
• Courses taught:
  • Assessment and Intervention Practicum
  • Objective Personality Tests
Kant, cognitive psychotherapy, and the hardening of the categories

Jeffrey S. Nevid
St. John’s University, USA

Contemporary models of psychotherapy owe a considerable intellectual debt to philosophy, even though the contributions of philosophers to contemporary practice in the field often go unrecognized. A case in point is Kant's epistemology, which is foundational to cognitive approaches to psychotherapy. Here, it is argued that the rigid use of certain judgments represented in Kant's conceptual scheme underlies patterns of disordered or dysfunctional thinking associated with emotional disorders. Kantian judgments of necessity, disjunction, particularity and universality have counterparts in contemporary conceptions of cognitive distortions. Moreover, Kantian epistemology has important therapeutic implications with respect to helping people with emotional disorders recognize and challenge rigidly held judgments or categories of understanding. The Kantian perspective also leads us to consider the cognitive frameworks or thought structures that underlie dysfunctional thinking patterns.

Psychologists often give a passing nod to the contributions of earlier philosophers to the development of psychological models of mind and behavior, if they pay them any heed at all. Yet the epistemological foundations of psychology as a scientific discipline did not arise in an intellectual vacuum. One philosopher whose work preceded the development of scientific psychology, but who nonetheless laid the seeds for much of modern psychological thought, was the 18th century German philosopher, Immanuel Kant (1724–1804), arguably the most influential philosopher of the modern era of Western intellectual thought. Kant's views have had perhaps their greatest influence in modern psychology in the area of cognitive science, especially his belief that the mind is actively involved in categorizing and organizing sensory impressions in order to create meaningful representations of the external world (Brooks, 1994; Robinson, 1995; Walker, 1978). Kant's conception of schemata as mental frameworks for understanding the external world also anticipated the use of the same term in Piaget's model of cognitive development (Piaget, 1954, 1955).

In the field of psychotherapy, Kant's view that reality is filtered through a set of cognitive templates or categories, popularized in the concept of 'Kantian spectacles', is
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- Ph.D., 1983, Adelphi University
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  - The role of institutionalized racism, sexism, heterosexism, and other oppressive ideologies in the paradigms of psychology and practice of psychotherapy in organized mental health
  - Understanding psychological resilience and vulnerability in socially marginalized people and their use in psychotherapy
  - Examining social privilege and marginalization via the development of multiple identity paradigms as more complex ways of understanding human identity
  - Using psychotherapy and psychological science to facilitate social justice
- Courses taught:
  - Cultural Diversity in Psychological Services
  - Psychology of Women
  - Ethics and Professional Issues
Beverly Greene
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• Recipient of 2009 APA Award for Distinguished Contributions to Psychology in the Public Interest
Psychology, diversity and social justice:
Beyond heterosexism and across the cultural divide

BEVERLY GREENE
St Johns University, New York, USA

Abstract
This article discusses the tendency to avoid examining the role of oppressive ideologies in mental health that facilitate social injustice, the role of oppressive ideologies in creating mental health problems, barriers to culturally competent interventions, and the discomfort associated with examining differences in psychotherapy as manifestations of power and privilege differentials that form the core of social injustice.

Keywords: diversity, social justice, heterosexism, race, multicultural
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• Ph.D., 1989, Emory University
• Research interests:
  • Application of empirically validated treatments for underserved populations, such as emerging adults who have dropped out of high school and are experiencing multiple problems
  • Phenomenology
  • Comorbidity
  • Currently, she is involved in the development of a treatment program for emerging adults who have experienced problems such as academic failure, exposure to trauma, and substance abuse.
• Courses taught:
  • Psychopathology Across the Lifespan
  • Assessment and Intervention Practicum
Learning and memory impairment in cocaine-dependent and comorbid schizophrenic patients

Mark R. Serper\textsuperscript{a,b,*}, Andrea Bergman\textsuperscript{c}, Marc L. Copersino\textsuperscript{a}, James C.Y. Chou\textsuperscript{d}, Danielle Richarme\textsuperscript{e}, Robert Cancro\textsuperscript{b}

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Abstract

Impairments in verbal learning and memory functioning have been found to be cardinal features among individuals with schizophrenia as well as among non-schizophrenic cocaine abusers. Cognitive deficits in these areas, moreover, have been associated with poor treatment response and short-term outcomes. Little is known, however, about the acute effects of cocaine abuse on schizophrenic patients’ learning and memory functioning. Consequently, a potentially reversible and treatable source of cognitive impairment has been virtually ignored. The present study examined the extent of verbal learning and memory impairment in a group of cocaine-dependent schizophrenic patients (n = 42) and a group of non-schizophrenic cocaine-dependent patients (n = 21) within 72 h of the last cocaine use using the California Verbal Learning Test (CVLT). Schizophrenic patients (n = 34) without any substance-use disorders were also tested in an identical time frame and served as a comparison group. Results revealed that all groups demonstrated significant learning and memory impairment relative to CVLT published age and gender corrected norms. Both cocaine-dependent and non-substance abusing schizophrenic groups presented a very similar pattern of impaired learning and recall performance across all CVLT task domains. Comorbid patients, in contrast, presented with marked deficits in their ability to learn and recall verbal information relative to either schizophrenic or cocaine-only groups. Moreover, the cocaine-abusing schizophrenic patients showed significant forgetfulness of the information that they did acquire during delayed recall conditions. The performance deficits exhibited by cocaine-abusing schizophrenic patients differed not only in relative severity of impairment, but also

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PII: S0165-1781(99)00123-5
Elizabeth Brondolo
Professor of Psychology

• Ph.D., 1989, Rutgers University

• Research interests:
  • Psychophysiology of interpersonal conflict
  • These studies were funded by several grants from NIH, as well as the American Heart Association and the Communication Workers of America.
  • Since 2000, Dr. Brondolo and her students have been actively researching racism or ethnic discrimination, specifically examining interpersonal racism (i.e., racism that is directly perceived and occurs in an interpersonal context).

• Courses taught:
  • Doctoral Research
ABSTRACT
Racial disparities in health, including elevated rates of hypertension (HT) among Blacks, are widely recognized as a major public health concern. Researchers have hypothesized that social stress, and in particular exposure to racism, may account for some of the between-group differences in the prevalence of HT and a portion of the within-group variations in risk for HT. However, there have been surprisingly few empirical studies of the relationship between perceived racism and blood pressure (BP) or cardiovascular reactivity (CVR), a possible marker of mechanisms underlying cardiovascular disease. This literature review examined published literature investigating the relationship of perceived racism to BP and/ or CVR, and variables, including self-reported history of HT or hypertension status, and CVR. Strengths and weaknesses of the existing research were discussed and the limitations of research avenues that may elucidate the biopsychosocial mechanisms potentially linking racism to HT. We hope this review inspires investigators to revisit this area.

INTRODUCTION
Racial disparities in health status, including excess rates of hypertension (HT) among Blacks, are widely recognized (1,2). However, the causes of these disparities are poorly understood. Researchers have hypothesized that social stress, and in particular exposure to racism, may account for some of the between-group differences in the prevalence of HT (3–8). However, there has been surprisingly few epidemiological studies of the relationship between perceived racism and blood pressure (BP) levels or hypertension status (6,9–13). Similarly, although the literature has grown, there have been very few published articles investigating the relationship of perceived racism to cardiovascular reactivity (CVR) and stress, a potential risk factor for HT (14–24).

The purpose of this article is to provide a critical review of the literature examining the relationship of perceived racism or ethnic discrimination to HT and/ or HT-related variables. This article is divided into two sections. The first section examines the findings and the methodological limitations of studies addressing the primary question: Is perceived exposure to racism associated with elevated HT? Particular attention is paid to issues related to the measurement of perceived racism and to the potential mediators and moderators of the relationship of racism to BP, including coping and socioeconomic status (SES). The second section of the paper provides a critical review of the literature examining the relationship of racism to CVR. These studies attempt to disentangle these two constructs by investigating the hypothesis that the relationship of psychological stress to HT is mediated through changes in autonomic modulation (25–28) and may shed light on the biopsychosocial mechanisms linking perceived racism to elevated HT. When reviewing articles on CVR, particular attention is paid to the nature of laboratory models of racism and the implications of race, ethnicity, and location.

The review is limited to published peer-reviewed articles on these topics. References were gathered using PsycINFO, MEDLINE, ERIC, and Sociological Abstracts and submitting the key words “ethnic discrimination,” “perceived racism,” “hypertension” in combination with additional key words (including blood pressure, cardiovascular reactivity, stress, and hypertension). Other references were obtained by checking the bibliographies of each article. This search strategy yielded a total of 46 articles, and 4 additional articles were identified through the search strategy (29–34).

Definitions of Racism
Chlerk et al. (20) defined racism as “the beliefs, attitudes, institutional arrangements, and enactments that lead to hostile individual or groups based on phenotypic characteristics or ethnic group affiliation” (p. 260). Conrad et al. (29) uses the more general term of ethnic discrimination and defined it as an unfair treatment received because of one’s ethnicity, where ethnic
Rafael Javier
Professor of Psychology

• Ph.D., 1982, New York University
• Research interests:
  • Psycholinguistic and psychoanalytic issues in research and treatment and on ethnic and cultural issues in psychoanalytic theories and practice, including on issues of violence and the impact on general cognitive and emotional functioning
• Courses taught:
  • Assessment and Intervention Practicum
A LATINO PERSPECTIVE ON THE ROLE OF ETHNICITY IN THE DEVELOPMENT OF MORAL VALUES: IMPLICATIONS FOR PSYCHOANALYTIC THEORY AND PRACTICE

RAFAEL ART. JAVIER, PH.D.*
MARCELA B. YUSSEP**

It is a rather complex and, at times, risky endeavor to make moral judgments as to the acceptability of specific actions with regard to oneself and others. This is so because it involves a definition of morality based on principles not always clearly evidenced to the observers or equally acceptable to the participants. It has been suggested that this is more likely the case when participants and observers are of different ethnic and cultural backgrounds and when the cultural mores that dictate their behaviors are based on different conceptions of reality and relationships.

It is our contention that morality, although assumed to have universal values, is intimately influenced in its development by culture and ethnicity. This is quite understandable if we accept the notion that moral codes are developed in the context of our relationships to one another and in the context of our cultural surroundings. This is a notion widely accepted by philosophers, social scientists, and behavioral scientists interested in understanding human interaction. Indeed, according to these scholars, a full explanation of transactions among individuals needs to include an understanding of their level of moral development (Gilligan, 1982; Haan, 1975; Kant, 1959; Kohlberg, 1981; Piaget, 1965; Rest, 1973). In this context, morality can be defined with regard to its impact on behavior as a complex web of guidelines or a priori and a posteriori moral principles that permeate and influence all aspects of human existence and is expected to determine the outcome of any human transaction (Kant, 1959).

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A Practice-Based Trial of Motivational Interviewing and Adherence in Hypertensive African Americans

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BACKGROUND

Poor medication adherence is a significant problem in hypertensive African Americans. Although motivational interviewing (MI) is effective for adoption and maintenance of health behaviors in patients with chronic diseases, its use for medication adherence is not well studied in this population.

METHODS

This was a randomized controlled trial with a 2 × 2 factorial design, comparing MI and usual care (UC) intervention arms. A total of 212 patients were randomly assigned to MI or UC, with approximately equal numbers in each arm. Both MI and UC groups were stratified by the Community Care Program in New York City. The primary outcome was adherence assessed by self-report and pill monitors. The secondary outcome was systolic blood pressure in MI and UC groups.

RESULTS

The frequency and intensity of MI contacts did not differ significantly between MI and UC groups. MI patients had lower systolic blood pressure and better medication adherence compared to UC patients (p < 0.05).

CONCLUSIONS

A practice-based MI counseling could improve medication adherence over time, compared to standard care. This was applicable in hypertensive African American primary care settings.

African Americans have higher prevalence of hypertension and poorer hypertension-related outcomes than whites. Poor medication adherence may explain the poor BP control in African Americans. Hypertensive counseling strategies should be effective in improving medication adherence of African Americans. The counseling was effective in reducing blood pressure and improving medication adherence in African Americans.
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THE VALIDITY OF DSM-IV PASSIVE-AGGRESSIVE (NEGATIVISTIC) PERSONALITY DISORDER

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Journal of Personality Disorders, 2007; 21, 1. ProQuest Psychology Journals

The validity of DSM-IV Passive-Aggressive (Negativistic) Personality Disorder

Passive-Aggressive (Negativistic) Personality Disorder (NEPD), listed in Appendix B of the DSM-IV, is not an officially recognized personality disorder. Its future as a discrete disorder is uncertain (Widiger, 2000). The NEPD occupies a role in some theoretical formulations of personality pathology (Millon & Davis, 1992), and many clinicians believe that passive-aggressive traits are not adequately represented by other PDs (Westen, 1992). In this study, 1156 psychiatric outpatients were assessed for Axis I and Axis II disorders. Thirty-five (3.02%) met criteria for NEPD. Participants with NEPD did not differ significantly from those without NEPD on demographic variables. The internal consistency of the DSM-IV’s seven NEPD items was 0.50. Corrected intercorrelation analyses, which account for the 7 error terms averaged 0.27. Participants with NEPD had higher rates of lifetime anxiety disorders, and almost 90% had an additional PD. An exploratory factor analysis suggested a two-factor solution that accounted for 43.4% of the variance. The first factor reflected the idea of a passive aggression that is unrelenting, while the second factor seemed to reflect a pattern of anger expression. A confirmatory factor analysis showed that the two-factor model fit the data better than a unidimensional model. We discuss implications of these results for the future of the NEPD diagnosis.

Passive-Aggressive (Negativistic) Personality Disorder (NEPD) has a long history in the classification of mental disorders. In fact, descriptive features that typify the disorder have been depicted in significant detail by many prominent clinicians for nearly a century under a variety of headings (Millon & Backman, 1999). Years before World War II, clinical theorists portrayed diverse and labeled characters and dispositions whose characteristics might now be classified under the passive-aggressive personality disorder designation (Millon, 1992).

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Personality Pathology and Its Relation to Couple Functioning

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The study aimed at understanding the relationship between personality pathology and couple functioning, both in terms of general functioning and communication specifically, in a sample of 146 psychiatric outpatients. The results indicated that couple communication was best predicted by a combination of the symptoms within each of the three personality disorder clusters and the total number of personality disorder symptoms while general family functioning was best predicted by the total number of Axis I disorders. No demographic variables were found to be related to the level of couple functioning. Future research needs to focus on understanding what makes it difficult for people with personality disorder traits to function in relationships. © 2006 Wiley Periodicals, Inc.

Keywords: personality disorders; couple functioning; family functioning.

One of the telling features of personality disorders (PDs) is their impact on a patient’s relationships with others. This influence can take many forms depending on the disorder, but the effect is there nonetheless. The interpersonal relationship may be impacted by the

Portions of this research were presented at the Annual Meeting of the Association for the Advancement of Behavior Therapy in Boston, MA, in 2003. Completion of this research by the first author was partial fulfillment of the requirements for Masters Degree in Clinical Psychology at St. John’s University, Jamaica, NY. The authors would like to extend their thanks for the helpful comments of anonymous reviewers and to all of the participants.

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Affective Ratings and Startle Modulation in People With Nonclinical Depression

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The study tested predictions based on the emotion-context-inconsistency (ECI) hypothesis of Rothermund, Gross, and Gade (2009) that a nonclinical sample of people with depressive symptoms would show increased response to both positive and negative stimuli relative to nondepressed people and would show an elevated response to negative stimuli. The study examined depressed, nondepressed, and control groups in response to positive, negative, and neutral stimuli. Overall, the results support the ECI hypothesis, with depressed and nondepressed groups showing increased startle responses to negative stimuli compared to controls. The clinical implications of these findings are discussed.

Keywords: Depression, startle modulation, emotion.

Depression is the most common occurring disorder of emotion regulation, affecting approximately 7% to 9% of women and 2% to 3% of men (Kessler, 2003). Its symptoms include depressed mood, loss of interest or pleasure in all or most activities, feelings of worthlessness, thoughts of death and suicide, and various symptoms such as abnormal levels of sleep or appetite (APA, 1994). The present study investigated the pattern of emotional reactivity to positive, negative, and neutral stimuli in people with nonclinical depression. Rothermund, Gross, and Gade (2009) suggested that people with depression show reduced emotional responses to both positive and negative events. This view, instead of the emotion-context-inconsistency hypothesis (ECI), posits that patients of depression show a reduced responsiveness both positive and negative events. The authors argued that the lack of empathy was adaptive in an evolutionary perspective because disengagement and disengagement from people that might have been harmful or harmful (e.g., during a fight or a flight). The ECI hypothesis predicts that depression causes, that will alter ongoing emotional responses, leading to disengagement. That is, depressed individuals will fail to adapt and respond appropriately to environmental changes. A similar view arise from the phenomenon of learned helplessness (Overmier, 2002), in which it was suggested that adverse environmental events lead to cognitive mechanisms that reduced motivation to engage with the environment. The ECI hypothesis makes a specific prediction about anxiety: People with depression will be especially prone to report or not to report to avoid stimuli, in these stimuli may be especially threatening. In the present study, we tested this prediction by examining the affective modulation of the startle response to neutral and neutral stimuli in people with depressive symptoms. The ECI hypothesis can be contrasted with two other theories: the positive anticipation hypothesis and the negative anticipation hypothesis (Rothermund, 2005). The positive anticipation hypothesis states that positive emotion is decreased in depression (i.e., anhedonia). The negative anticipation hypothesis states that in depression is associated with high negative emotion. In their study of these three competing theories of depression, Rothermund et al. found support for the ECI hypothesis for both the positive anticipation or negative anticipation hypotheses.

In this study, we used two ways of assessing emotion in depression: affective rating and affective modulation of the startle response, as studies using affective rating, depressed participants frequently mant plain positive stimuli less positively than healthy controls (e.g., Mann, Turan, & Domar, 2000). In summary, the data show that depressed individuals, typically measured by the startle reflex, are less likely to show an elevated response to negative stimuli, although pleasant affective modulation is attenuated (O’Connor et al., 2000). The authors’ accepted explanation of this finding is that the startle response is a
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From efficacy to effectiveness: the trajectory of the treatment literature for children with PTSD

Valentina Nikulin, Jeannene M. Herbergstater, Eliza J. Brown, Megan E. Doyle, Beryl J. Flinton & Gabrielle S. Carson

This review summarizes efficacious treatments for posttraumatic stress disorder, with a focus on the advances made within the last 5 years. There is considerable support for the use of trauma-specific cognitive-behavioral interventions, both individual and group formats. The research yielded pharmacological treatments largely rooted in that of psychotherapy and is currently investigational. Limitations of the studies are discussed and treatments that warrant further investigational engagement. The authors also review current advances in effectiveness and suggest future directions that are important in generalizing the interventions to underserved and high-risk populations. The article concludes with the authors’ speculations for the future of PTSD treatment.

Keywords: childhood PTSD, culture, effectiveness, efficacy, group treatment, individual treatment, posttraumatic stress disorder, psychopharmacology, intervention, PTSD, prevention, trauma.

In the USA approximately two thirds of children experience one or more traumatic events by the time they are 18 years of age (1). Traumatic events include child sexual abuse (CSA), child physical abuse (CPA), community violence, witnessing domestic violence, and natural disasters. Children’s traumatic trauma-related mental health problems include posttraumatic stress disorder (PTSD), other anxiety disorders, depression, and disruptive behavior disorders (2). PTSD is the most common sequel to a traumatic event and is associated with later interpersonal, vocational and physical problems (3-4). The awareness of those preventive consequences of PTSD has resulted in empirical advances in our understanding of its treatment. From randomized controlled trials, investigators have examined and found individual trauma focused cognitive-behavioral interventions to be efficacious in reducing PTSD symptoms and other trauma sequelae. Current research is moving towards enhancing generalizability, or effectiveness, of treatments when applied to real-world settings.

This paper summarizes current literature on the treatment of PTSD in preschoolers, children and adolescents. First, we review the diagnostic criteria for PTSD and its prevalence in youth. Second, we discuss psychosocial and pharmacological treatments that demonstrated efficacy in treating PTSD, as well as other outcomes of trauma exposure. Third, we discuss effectiveness, including barriers to mental health, cultural background, race/ethnic characteristics and psychosocial complexity. We conclude the paper with a discussion of the current status of research on PTSD treatment and a projection of the field’s progress over the next 5 years.

Diagnostic criteria & prevalence of PTSD

PTSD is based on both the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) criteria and the International Classification of Diseases, Tenth Edition (ICD-10) criteria. The diagnostic criteria for PTSD, outlined in the DSM-IV, states that a person must experience or observe an event that is perceived to threaten the person’s life and/or physical well-being, and causes intense fear or helplessness. ICD-10 lacks the subjective component in defining a traumatic event, defining it as “threatening and catastrophic, which is likely to cause distress in almost anyone” (5).

In both the DSM-IV and ICD-10 mandates, exposure to the traumatic event is associated with symptoms of re-experiencing (e.g., nightmares, flashbacks), avoidance/numbing (e.g., avoidance of thoughts, places, feelings)

Preschoolers’ Inhibition in Their Home: Relation to Temperament

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ABSTRACT: Researchers assessed 58 preschoolers’ reactions to an unfamiliar person and unfamiliar objects in their familiar home environment. Children participated in a 30-min procedure designed to elicit behavioral inhibition, including (a) a free-play period with a stranger present, (b) a structured interaction with the stranger, and (c) uncertain-stimulants: Behaviors representing the child’s reactions toward the mother, stranger, and novel objects were coded. Mothers completed a temperament scale. Preschoolers exhibited behaviors indicative of inhibition toward unfamiliar social and nonsocial stimuli; behaviors remained stable across increasingly intrusive episodes. The approach/withdrawal component of temperament was related to behavioral inhibition. Individual differences in mood did not appear to be related to differences in inhibition. Parent reported temperament was related to researcher-observed behaviors.

Key words: inhibition, preschoolers, stranger anxiety, temperament

YOUNG CHILDREN’S REACTIONS to unfamiliar people and situations have long been of interest to developmentalists. Early work in this area was primarily concerned with fear or “stranger anxiety” (e.g., Bronson, 1972; Lewis & Brooks, 1974; Searf & Salapatek, 1976; Schaffer, 1966; Sroufe, 1977) and typically focused on the first year of life. As researchers began to recognize the variability in infants’ reactions to strangers (e.g., Clarke-Stewart, 1978; Mangelsdorf, 1992; Rheingold & Eckertman, 1973), they widened their focus of study to include affiliation as well as wary tendencies, often with the goal of relating individual variation in infants’ reactions toward strangers to other aspects of socioemotional development (e.g., Calkins & Fox, 1992; Clarke-Stewart, Unem, Snow, & Ped-
Preschoolers’ Inhibition in Their Home: Relation to Temperament

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YOUNG CHILDREN’S REACTIONS to unfamiliar people and situations have long been of interest to developmentalists. Early work in this area was primarily concerned with fear or “stranger anxiety” (e.g., Bronson, 1972; Lewis & Brooks, 1974; Scarr & Salapatek, 1970; Schaffer, 1966; Stroufe, 1977) and typically focused on the first year of life. As researchers began to recognize the variability in infants’ reactions to strangers (e.g., Clarke-Stewart, 1978; Mangelsdorf, 1992; Rheingold & Eckerman, 1973), they widened their focus of study to include affiliative as well as wary tendencies, often with the goal of relating individual variation in infants’ reactions toward strangers to other aspects of socioemotional development (e.g., Calkins & Fox, 1992; Clarke-Stewart, Umeh, Snow, & Ped-
Sample Student-Faculty Research

THE ORGANIZATION AND THE NATURE OF IRRATIONAL BELIEFS: SCHEMAS OR APPRAISAL?

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Abstract

An important question that cognitive-behavioral and rational-emotive therapy (CBT/REBT) needs to address concerns the organization and the nature of cognitions we refer to as irrational beliefs (IBs). Some authors argue that IBs are evaluative (hot) cognitions and as such, they should be linked to appraisal theory, while others argue that IBs are organized as schemas (cold cognitions), and should be related to schema theory. The three studies in the present article address the issue of the nature of IBs, using schema theory as a research tool. Our findings indicate that whereas demandingness (DEM) and global evaluation/self-downing (GE/SD) seem to be organized as schemas (study 2), swishing/catastrophizing (AWF) (study 1) and frustration intolerance (FT) (study 3) can be better conceptualized as terms of appraisal. In addition, DEM seems to be strongly associated with GE/SD, AWF, and FT; this finding supports the CBT/REBT assumption about DEM being the core irrational belief.

Key words: irrational beliefs, schemas, appraisal

The Nature of Irrational Beliefs: Schemas or Appraisal?

Cognitive-Behavioral & Rational-Emotive Therapy (CBT/REBT) is the oldest form of cognitive-behavioral therapy (CBT) and was created by Albert

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Risk Factors Associated with Posttraumatic Stress Disorder Symptomatology in HIV-Infected Women

STACEY KATZ, Ph.D. and JEFFREY S. NEVID, Ph.D.

ABSTRACT

This study examined risk factors for posttraumatic stress disorder (PTSD) symptomatology in a sample of 182 HIV-positive women. The magnitude of HIV-related PTSD symptoms was associated with a greater number of HIV-related physical symptoms, more extensive history of pre-HIV trauma, less perceived availability of social support, greater degree of perceived stigma, and greater degree of negative life events. Hierarchical multiple regression analysis revealed three individual predictors of PTSD symptomatology: total impact of negative life events, total stigma score, and total number of present symptoms. Stigma emerged as the strongest individual predictor. Social support failed to moderate relationships between PTSD symptomatology and HIV-related physical symptoms and negative life events. These findings may inform helping professionals about risk factors associated with PTSD symptomatology in HIV-positive women.

INTRODUCTION

Although early studies reported posttraumatic stress disorder (PTSD)-like symptoms in reaction to physical illness, the diagnosis of a life-threatening illness as a qualifying stressor event did not meet the Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria (Criterion A) for PTSD until the 1994 revision. Since the criterion change, most investigations of illness-related PTSD have focused on psychological adjustment of patients with cancer after diagnosis.6-9

The diagnosis of HIV may be viewed as a traumatic event followed by continuous adjustment to a number of social, physical, and psychological losses.7 Investigators have begun to examine relationships between HIV infection and PTSD symptomatology. In one recent sample, more than half of HIV-positive patients met diagnostic criteria for PTSD based on self-reported posttraumatic stress symptomatology.8 Earlier research based on a preliminary study showed that 30% of a sample of HIV-positive homosexual/bisexual men met diagnostic criteria for the disorder in response to HIV diagnosis.9 Other evidence shows that HIV-positive patients experience above average degrees of trauma-related stressful reactions that would warrant therapeutic attention.7,8 To understand HIV-related PTSD further, investigations are needed to study both the prevalence of PTSD symptomatology and factors associated with increased vulnerability of the disorder in populations of people with HIV.

Prejudice and stigmatization often follow a diagnosis of HIV, which makes HIV unique and unlike any other progressive terminal ill-
Acculturation, Enculturation, and Perceptions of Mental Disorders in Asian Indian Immigrants

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Due to acculturation among Asian Indian immigrants, there is a need to understand cultural differences in the expression of mental disorders. This study examines the relationship between acculturation and mental health in Asian Indian immigrants. The study aims to explore how cultural factors influence mental health outcomes in this population. Specifically, the study investigates the impact of acculturation on mental health outcomes and the role of cultural schemas in shaping mental health perceptions.

Keywords:

Asian Indians
Acculturation
Enculturation
Mental Disorders

Asian Indians are the third largest Asian population group in the United States, representing 16.2% of the Asian population in the United States (U.S. Census Bureau, 2009). The Asian Indian population in the United States, which is among the fastest-growing ethnic groups in the country, has increased significantly since 1990 and 2000. By approximately 2007, there were about 4.1 million Asian Indians in the United States (U.S. Census Bureau, 2009).

Acculturation is the process by which individuals or groups adapt to cultural differences between the dominant society and their own culture. Enculturation, on the other hand, refers to the process by which individuals learn and internalize the values, beliefs, and behaviors of their own culture. In the context of Asian Indian immigrants, acculturation and enculturation play a significant role in shaping their mental health outcomes.

Acculturation refers to the process by which individuals or groups adapt to cultural differences between the dominant society and their own culture. Enculturation, on the other hand, refers to the process by which individuals learn and internalize the values, beliefs, and behaviors of their own culture. In the context of Asian Indian immigrants, acculturation and enculturation play a significant role in shaping their mental health outcomes.

Asian Indian immigrants face various challenges in adapting to their new environment. These challenges include language barriers, cultural differences, and social isolation. These factors can lead to mental health issues such as anxiety, depression, and adjustment disorders.

Mental health outcomes among Asian Indian immigrants are influenced by cultural factors such as cultural schemas and cultural values. Cultural schemas are mental structures that provide meaning and interpretation to experiences. Cultural values are the beliefs and attitudes that guide behavior and influence decision-making.

In conclusion, the relationship between acculturation, enculturation, and mental health outcomes among Asian Indian immigrants is complex and multifaceted. Further research is needed to explore the impact of cultural factors on mental health outcomes and to develop culturally sensitive interventions to support this vulnerable population.

References:

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