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Spiritual Coping in Children Diagnosed with Cancer

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Spiritual Coping in Children Diagnosed with Cancer

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Spiritual Coping in Children Diagnosed with Cancer

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Spiritual Coping in Children Diagnosed with Cancer

Jory L. Smith

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Abstract

Children coping with chronic illnesses employ a variety of strategies to help them defend against their illness-related stressors. In a study of children diagnosed with asthma, Ezop (2002), using the Children's Religious Coping Scale (CRC), found that the use of positive religious coping techniques led to a better adaptation to life and a more positive perspective on illnesses. The Ezop study also found that children and adolescents used positive religious coping moderately and made only limited use of negative religious coping.

The present study analyzed the positive and negative coping skills of adolescents diagnosed with cancer. Specifically, in a prior study adolescents in a pediatric oncology clinic, who were newly diagnosed with cancer, were interviewed about how they understood their situations, including the coping strategies they utilized, their social support, and their views of God, among other topics. The archival transcripts from these structured interviews were recoded for presence of the 20 positive and 9 negative coping strategies on the CRC Scale (Ezop 2002).

The findings of this study indicate that adolescent cancer patients used positive religious coping strategies more frequently than negative religious coping strategies. Both the frequency of occurrence and the number of words devoted to describing a coping strategy showed the same pattern of results. The most frequently occurring and extensively described positive strategy was "I think God will help me get through this," followed by "I go to church/temple/synagogue" and "I think God gave me [my illness] for a reason." The most frequently used and extensively described negative coping strategies were "I think God cannot help me" and "I just let God take care of me and I do nothing" These results provide evidence that Ezop's religious coping strategies are ecologically valid and arise spontaneously in the same patterns as found on the CRC scale.

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Chapter 1

Introduction

This study was designed to look more closely at the particular ways that adolescents cope with chronic and serious illness. Ezop (2002) examined how positive and negative religious coping strategies were used by children with asthma. Ezop's study found that children used positive coping mechanisms with moderate frequency and had a limited use of negative coping mechanisms. Ezop also found that those who used more positive coping mechanisms later scored higher in healthy adjustment. In the present study, data collected from twenty semi-structured interviews, conducted by Schulke et al. (in press) with adolescents diagnosed with cancer, were recoded to assess whether the adolescents' pattern of positive and negative religious coping styles was similar to that displayed in Ezop's study.

Coping and Resiliency

Compas, Conner-Smith, Saltzman, Thomsen, and Wadsworth (2001) define coping as the process of engaging personal resources to respond to a challenge, while resilience is the outcome of successful coping. The ability to cope is an integral part of life that determines whether people thrive or fail. Most developmental theories of coping are derived from adult theories. The most common adult theory on coping was described by Lazarus and Folkman (1994) who stated coping was best defined "as the process in which an individual assesses the stressful situation and then acts to either resolve the problem (problem-focused coping)" or manage the emotional

reactions to stress (emotion-focused coping). Both engaging with the stressor and avoiding it are coping responses, according to Compas et al. (2001). In the coping literature, problem-focused coping is also referred to as approach coping and emotion-focused coping is equated with avoidance coping (Altshuler & Ruble, 1986; Roth & Cohen, 1986). An example of approach coping would be seeking social support (Frank, Blount, & Brown, 1997) whereas avoidant or disengaged coping responses would include methods such as, "Getting used to it," (Sorgen & Manne, 2002) or denial and repression (Phipps, Steele, Hall, & Leigh, 2001). In her research on adolescents coping with cancer Ritchie (1992) found "while adolescents diagnosed with cancer are at risk for psychosocial difficulties, most are generally psychologically adjusted and are meeting developmental tasks" (p. 1500).

Adolescent Spiritual Coping

Spirituality has long been a subject avoided by the social sciences. Although much of science was rooted in religious ideology, today those who adopt a scientific approach are reluctant to give the role of spirituality a prominent place in theory or research. In contrast, many segments of our society continue to practice religion and spirituality as a component of their lives, especially when they face challenges such as serious illness. Thus, the disconnect between the emphasis placed on religion and spirituality by health professionals and their patients is interesting and potentially important in understanding treatment and recovery from illness. Benson (2004) argues it is long past due for us to recognize the importance spirituality plays in people's lives. Schulke et al. (in press) noted the importance of including spiritual coping in social services and clinical practices because of the value and meaning it can add to children and adolescents' lives. Numerous studies have called for more research to be done in the area of

spirituality and how it relates to coping (Dein & Stygall, 1997; Ezop, 2002; Gordon et al., 2002; Koenig, 2004; McGrath, 2004).

Ezop's Study

All children utilize some form of coping mechanism to respond to stressors in their life: from adaptive to mal-adaptive. Ezop's study looked at several different religious coping measures, including the RCOPE subscales (Pargament, Koenig, & Perez, 2000) and Pendleton's Eleven spiritual/Religious Coping Strategies (Pendleton, Cavalli, Pargament, & Nasr, 2002). Ezop also created her own religious coping scale with twenty positive spiritual coping strategies and nine negative spiritual coping strategies. Ezop's study (2002) reported a correlation between positive religious and spiritual coping and psychological, emotional, and social adjustment in children with chronic asthma.

Ezop's psychometric assessment of religious and spiritual coping, the Children's Religious Coping Scale (CRC) assesses children's use of religious coping with chronic illness-related stress. This scale was adapted from the Religious/Spiritual Coping Scale (RCOPE), a 21-point religious coping instrument developed and validated on 991 adults (Pargament et al., 2000). Ezop's CRC scale focused on the positive and negative religious coping strategies employed by children with chronic illness. The CRC items include 20 positive strategies such as, "I pray that God will make me feel better," "I think God will help me get through it," and "I think God is calming me." Examples of the nine negative religious coping methods include items such as, "I wonder why God lets this happen to me," "I wonder if God is mad at me," or "I think people at the church/temple/synagogue blame me for it." Ezop (2002) found that positive spiritual coping can provide a sense of control or comfort. She also found that children with

asthma who used more positive coping strategies had better health outcomes and social relationships. Other studies have also described how positive religious coping predicts spiritual growth while the use of negative religious coping predicted children's poorer adjustment during hospitalization and at follow-up (Benore, Pargament, & Pendleton, 2008).

One of the concerns with standardized tests is that they represent an artificial situation. The questions restrict possible responses options and all of the questions must (or should) be answered, so all (or most) of the test constructs are represented in the responses of all the participants. These forced responses to a limited set of options can cause critics to question whether these responses would ever occur spontaneously.

Schulke Study

Schulke, et al. (in press) conducted interviews with twenty adolescents who had been recently diagnosed with cancer and were undergoing treatment at a pediatric oncology clinic at a large hospital. Eleven of the adolescents were between 12-15 years old; while nine of them were between 16-18 years old at the time they were interviewed. The original semi-structured interview was designed to elicit responses about (a) demographic information and the structure of the family and friend networks, (b) the script of their cancer treatments, (c) coping strategies, (d) the positive and negative implications of having cancer, and (e) the role of religion and spirituality in their lives. The questions were purposefully open-ended to help grasp the meanings of each of the participant's experiences. Much effort was given to value each individual's particular experiences, rather than just attempting to describe group differences or the effects of an intervention. Schulke et al's., (in press) qualitative analysis focused on spiritual and theological issues as they pertained to the adolescents' particular health situations. Most of

the participants expressed a belief in God, but there were differences in the ways those beliefs were expressed and the role that the participants believed God took in their illness.

Schulke et al.'s transcripts, filled with discussions about a serious illness, coping, and the role of religion and spirituality, provide ideal data with which to test the ecological validity of the religious coping strategies described by Ezop (2002). It was hypothesized that, just as in the Ezop study, the amount of positive religious coping would be greater than the amount of negative religious coping. Specifically, it was expected that the frequency of occurrences and the number of words used to describe positive religious coping strategies would be greater than the frequency and length of description for negative strategies.

Chapter 2

Methods

Participants

Adolescents with cancer. This study used the archival, semi-structured interviews of 20 adolescents who had newly-diagnosed cases of cancer and were being treated in the pediatric oncology clinic of a large metropolitan hospital. These interviews served as the primary data for a qualitative analysis by Schulke et al. (in press). The semi-structured interviews were set up with the assistance of the hospital administration and nurses in the hospital unit. The semi-structured format was intentional to allow open-ended responses and hear the experiences of the participants regarding their illness, social support and religious and spiritual issues.

Schulke et al. reported that 11 of the youths who participated in the interviews were between 12-15 years old, while nine were between 16 and 18 years old. There were 10 male participants and 10 female participants. Eighteen of the youths were Caucasian, while one was Latino, and one was African American. Six of the adolescents were diagnosed with Leukemia, five with Hodgkin's Lymphoma, four with Osteosarcoma, and one child each with Cystic Lymphoma, Ewing's Sarcoma, Synovial Sarcoma, and Burkett's Lymphoma. One teen's specific cancer type had not been identified at the time of the interview. Nine additional adolescents who were eligible to participate in the study opted to not be interviewed, the majority of them being male. The first seven children were interviewed by one interviewer and the final 13 were interviewed by another. The study protocol was approved by the hospital's Institutional Review

Board and Human Subjects Research Review Committee of the university. The transcripts were released by the authors of the original study (Schulke et al, 2002) using a data-sharing agreement to which all had acceded.

Coders. In the present study, the transcribed interviews were coded by eight doctoral students in a clinical psychology program and one doctoral-level developmental psychologist. One of the coders was male and eight were female. All of the coders self-identified as Christian.

Instruments

Children's Religious Coping Scale (CRC; Ezop, 2002). The transcribed interviews were analyzed using the religious coping strategies described in Ezop's CRC. The CRC is an assessment tool that assesses the presence of positive and negative spiritual coping strategies. The tool incorporates twenty positive religious coping items and nine negative religious coping items which were identified through factor analysis. The Cronbach's alpha for the CRC was reported to be .93 in Ezop's study.

Procedure

The nine coders were trained in the 29 coping strategies that compose the CRC; the author worked through the CRC items and described what each one meant while the coders listened, asked clarifying questions and generated their own examples. The nine coders then coded one of the essays in unison, making sure that all coders were looking for the same criteria in our coding. When there were discrepancies, the coders discussed the differences and came to agreement about how the text should be coded. Once the author was satisfied that the coders had met the proper level of training in the 29 categories of religious coping, transcripts were

distributed and coders coded those transcripts individually. Each transcript was coded by two coders who worked independently.

Coders looked for any wording that indicated some form of religious coping that the adolescents used in their interviews. The coders then highlighted the relevant text and labeled the religious coping strategy with the corresponding number (see Appendix A) his or her initials to help identify who scored each of the interviews. After the coding, the coders cut out the coping strategies used in each interview. All the cut out strips were organized according to the coping strategy and the corresponding number written by the coders and separated into separate piles according to each of the 29 CRC coping strategies. After several hours the coding was finished and the strips were stored according to coping strategy. The coping strategies were then highlighted in the original word documents so word counts and frequencies could be calculated.

Inter-rater reliability. Inter-rater reliability was a critical factor in this research. Careful attention was paid to the training and consistency in the reading and scoring the interviews. Table 1 shows the Kappa coefficients for each pair of raters for each interview transcript. Kappa coefficients are a correlation based on a Chi Squared analysis. The Kappa coefficients range from .53 to .81, with a mean Kappa value of .70 (SD = .05). There were no significant differences among the Kappa coefficients of the nine coders, $F(8, 37) = 1.23$, $p = .32$.

Table 1

Inter Rater Reliability Correlation Chi Square Test

Interview Number	Rater 1	Rater 2	Correlation
1	NG	HL	.65
2	JG	HL	.71
3	OC	DM	.66
4	KG	DL	.72
5	NG	DL	.67
6	OC	RK	.61
7	DL	RK	.73
9	JC	KG	.71
10	RK	JG	.63
11	JG	OC	.69
12	JG	DL	.71
13	DL	HL	.74
14	OC	KG	.74
15	NG	KG	.75
16	DM	JC	.72
17	HL	RK	.74
18	RK	DL	.68
19	NG	OC	.69
20	JC	DL	.81

Chapter 3

Results

This chapter will address the hypotheses mentioned earlier. First, it was hypothesized that adolescents diagnosed with cancer would endorse a moderate use of positive religious coping strategies and a limited use of negative religious coping strategies, similar to the pattern described in Ezop's research (2002). Second, it was hypothesized that the adolescents would use more words to describe the positive coping strategies compared to the negative coping strategies. More specifically, it was hypothesized that more words would be devoted to explaining positive religious coping strategies than negative ones. Third, it was hypothesized that within the categories of positive and negative coping strategies, some of the strategies would be used more often and have more words devoted to them than others.

Hypothesis 1: More use of Positive Than Negative Religious Coping

After reviewing all of the interviews and data, it is clear that Ezop was right in her hypothesis that children facing illness moderately endorse positive coping strategies and have a limited use of negative coping strategies. The frequencies with which the 20 positive and 9 negative coping strategies occurred are shown in Table 2. Significantly more occurrences of positive strategies ($M = 9.15$, $SD = 9.90$) than negative strategies were observed ($M = 1.89$, $SD = 2.15$), $F(1, 28) = 4.65$, $p = .04$.

Table 2

Frequencies of Occurrence for Each Spiritual Coping Strategy for the Group of 20 Participants

	Spiritual Coping Strategy	Total Occurrences
+1	I pray that God will make me feel better	6
+2	I think God is watching over me	6
+3	I talk with a minister/priest/rabbi	4
+4	I thank God my illness [asthma (sic)] is not worse	5
+5	I ask God to help me understand it	0
+6	I talk with God and He tells me how to feel better	0
+7	I try to see how God may be making me a better person	8
+8	I ask others to pray for me	2
+9	I pray to God to take away my problems	3
+10	I think God gave some of us our illness' for a reason	27
+11	I think my family and friends are praying for me	13
+12	I think about what my faith says about fixing problems	15
+13	I think God will help me get through this	31
+14	I tell God to help me and he does it	0
+15	I pray that I do not die	0
+16	I think about God always being with me	21
+17	I try to get to know God better	8
+18	I go to church/temple/synagogue	27
+19	I read the bible	5
+20	I think God is calming me	2
-1	I just let God take care of me and I do nothing	5
-2	I wonder why God lets this happen to me	1
-3	I tell myself God tried to help me but it didn't work	1
-4	I get angry with God	2
-5	I wonder if God is mad at me	0
-6	I stop believing in God	1
-7	I think people at church/temple/synagogue blame me for it	1
-8	I think God cannot help me	6
-9	I think people didn't pray for me	0

Word Occurrence

There were significant differences found in the number of words the adolescents used to describe different coping strategies as seen in Table 3. For example, for the positive coping strategies "I pray that God will make me feel better" and "I think God is watching over me" each occurred six times during the interviews. However, the total words used to describe "I pray that God will make me feel better" were 45, with an average of 7.50 words used per occurrence. The total number of words used to describe "I think God is watching over me" were 133, with an average of 22.17 words used per occurrence. The average number of words used when describing a positive coping strategy was 145.85 (SD = 172.55) while the average number of words used to describe a negative coping strategy was 29.00 (SD = 54.96). Significantly more words were used to explain positive coping strategies than negative coping strategies, $F(1,28) = 3.88$, $p = .05$.

Coping Strategy Use Patterns

There were differences in the preferences for strategies within the broader categories of positive and negative religious coping. The most commonly utilized coping mechanism used was positive strategy #13, "I think God will help me get through it," used 31 times. The next two most common strategies were #10, "I think God gave some of us 'this illness' for a reason," and #18, "I go to church/temple/synagogue," both utilized 27 times. The fourth most common strategy was #16, "I think about God always being with me," used 21 times. The most commonly employed negative coping strategy was #-8, "I think God cannot help me," used a total of six times.

Table 3

Word Occurrence for Each Spiritual Coping Strategy

Spiritual Coping Strategy	Total Occurrences	Total Words Used in Occurrences	Average Words Used per Occurrence
+1	6	45	7.50
+2	6	133	22.17
+3	4	41	10.25
+4	5	237	47.40
+5	0	0	0.00
+6	0	0	0.00
+7	8	77	9.63
+8	2	50	25.00
+9	3	41	13.67
+10	27	534	19.78
+11	13	229	17.13
+12	15	388	25.87
+13	31	531	17.13
+14	0	0	0.00
+15	0	0	0.00
+16	21	260	12.38
+17	8	52	6.50
+18	27	248	9.54
+19	5	37	7.40
+20	2	14	7.00
-1	5	168	33.60
-2	1	5	5.00
-3	1	11	11.00
-4	2	14	7.00
-5	0	0	0.00
-6	1	2	2.00
-7	1	5	5.00
-8	6	56	9.33
-9	0	0	0.00

Chapter 4

Discussion

This study was designed to examine whether Ezop's assertion was accurate that children suffering from illnesses endorse moderate use of positive religious coping and limited use of negative religious coping (Ezop, 2002). The findings of this study indicate that in their discussion of their illness in the context of a structured interview, adolescents do tend to moderately use positive religious coping strategies and have a limited use of negative religious coping strategies. The study also looked at the particular number of words used in formulating the teen's coping strategies and found the same pattern; that more words were used to describe positive religious coping when compared with negative religious coping. Finally, the study looked at which particular strategies were endorsed more often than others.

Positive Coping Strategies Hypothesis

The interviews clearly demonstrated that the adolescents commonly used positive coping strategies to help make sense of their diagnoses and lives thereafter. Out of a total of 198 coping strategies identified in the interviews by coders, 181 were positive coping strategies and only 17 were negative coping strategies. This means that more than 90% (91%) of the coping strategies used by the adolescents were positive and less than 10% (8.6%) were negative coping strategies. This confirms my hypothesis that Ezop was right in her assertion that children moderately use positive coping strategies and have a limited use of negative coping strategies. My hypothesis

was correct in that children coping with cancer would employ a greater number of positive spiritual coping strategies and a much lesser number of negative spiritual coping strategies.

Limitations

One of the limitations of this study is that it was not a longitudinal study. Due to the original specifications of the interviews, they were not to be contacted again after the interview. It would have been helpful to track their lives and continue to monitor their adjustment or mal-adjustment after the initial period of diagnosis and treatment.

Although the quality of the interviews is very rich, a more formulaic structure to the interviews might have allowed for tighter scrutiny of the particular coping strategies used. Since the interviews were semi-structured, one could argue that more information could have been elicited in some of the interviews. The difficulty with a structured interview is that it would have not allowed as much freedom for the interviewer or respondents to explore certain topics as they arose.

Another limitation was in the training of the independent coders. Although they did attain a moderate level of inter-rater reliability in the scoring of the interviews, there still is a high level of subjectivity. More training and more structure regarding coding might have produced higher levels of inter-rater reliability.

Future Research

This study was limited in that it was unable to track the adolescents through time. A further study would be valuable if it were able to assess what sort of coping strategies were utilized by children with cancer and then track them as they aged, and also see their levels of adjustment. This might help shed light on the value that there appears to be in utilizing positive

coping strategies. It would also be helpful to further expand the studies to include other ailments and health issues that children face. This could be valuable for social workers, medical professionals, psychologists, and others in the helping fields because a goal of all of these fields is positive adjustment among clients.

If it could be ascertained that there is a certain level of healthiness and positive adjustment when positive religious coping methods are used, it might be more widely accepted in some of these fields, and therefore could be considered "best practices." Of course, positive coping strategies should only be expected or used by those who it was already a part of their lives. They should not be used as a source of intervention, but rather, seen as harnessing the individual characteristics that the child or adolescent already possesses.

Often religious coping, prayer, faith, and so forth are seen as second tier levels of coping or treatment. Although, we clearly do believe in the value of chemotherapy and other forms of treatment, we should not minimize the potential value of religious coping as well. Ezop's study clearly demonstrated there is value in utilizing positive coping strategies, due to the higher levels of adjustment found in her study of children coping with asthma.

Further research that would be valuable to the helping fields would be to parse out what components of positive coping lead to higher levels of adjustment. For instance, it might be asserted that optimism alone or a proclivity to believe in the value that suffering produces strength and determination produce greater levels of adjustment. It might also be contended that a higher being is actually heeding the prayers and thoughts of the children. While it definitely would be difficult to develop a way to measure these types of questions, there definitely would

be value in further defining what positive spiritual coping really is providing to these children and adolescents.

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Appendix A

Spiritual Coping Strategies

+1 I pray that God will make me feel better
+2 I think God is watching over me
+3 I talk with a minister/priest/rabbi
+4 I thank God my illness [asthma (sic)] is not worse
+5 I ask God to help me understand it
+6 I talk with God and He tells me how to feel better
+7 I try to see how God may be making me a better person
+8 I ask others to pray for me
+9 I pray to God to take away my problems
+10 I think God gave some of us our illness' for a reason
+11 I think my family and friends are praying for me
+12 I think about what my faith says about fixing problems
+13 I think God will help me get through this
+14 I tell God to help me and he does it
+15 I pray that I do not die
+16 I think about God always being with me
+17 I try to get to know God better
+18 I go to church/temple/synagogue
+19 I read the bible
+20 I think God is calming me
-1 I just let God take care of me and I do nothing
-2 I wonder why God lets this happen to me
-3 I tell myself God tried to help me but it didn't work
-4 I get angry with God
-5 I wonder if God is mad at me
-6 I stop believing in God
-7 I think people at church/temple/synagogue blame me for it
-8 I think God cannot help me
-9 I think people didn't pray for me

Appendix B

Curriculum Vitae

Jory L. Smith, PsyD

Newberg, OR 97132

Education

8/04 – 4/09	**Doctorate of Psychology** Graduate Department of Clinical Psychology (APA *Accredited*) George Fox University, Newberg, Oregon 97132
8/04 – 4/06	**Master of Arts, Clinical Psychology** Graduate Department of Clinical Psychology (APA *Accredited*) George Fox University, Newberg, Oregon 97132
8/94 – 5/98	**Bachelor of Arts, Christian Ministry** George Fox University, Newberg, Oregon 97132

Clinical Experience

10/10 – Present	**Senior Clinician** **Hazelden Springbrook** Mental Health Center 1901 Esther Street Newberg, Oregon 97132 Supervisor: Laura Schwerin, PhD **Responsibilities:** Provide mental health assessment to determine appropriateness for admission. Provide assessment, diagnosis, and treatment related to the mental health needs of clients under the supervision of a doctoral level psychologist. Function as a member of the multidisciplinary team providing input for assessment, diagnosis, treatment planning, and delivery of mental health services. Provide in-service training; lead the men's Compulsivity

group, men's Seeking Safety group, and men's Co-Occurring Disorders group, and compulsivity lectures to clients.

Hours: Approximately 40 hours a week (20 direct hours, 1 hour individual supervision, 1 hour group supervision, 18 support hours).

9/09 – 9/10

Postdoctoral Clinical Psychology Fellow
Hazelden Springbrook
Mental Health Center
1901 Esther Street
Newberg, Oregon 97132
Supervisor: Laura Schwerin, PhD
(503) 554-4319

Responsibilities: Provide mental health assessment to determine appropriateness for admission. Provide assessment, diagnosis, and treatment related to the mental health needs of clients under the supervision of a doctoral level psychologist. Function as a member of the multidisciplinary team providing input for assessment, diagnosis, treatment planning, and delivery of mental health services. Provide in-service training; co-lead the men's Compulsivity group, men's Seeking Safety group, and men's Co-Occurring Disorders group, and compulsivity lectures to clients.

Hours: Approximately 40 hours a week (20 direct hours, 1 hour individual supervision, 1 hour group supervision, 18 support hours).

8/08 – 8/09

Clinical Psychology Intern
The University of Maine
Counseling Center
5721 Cutler Health Center
Orono, Maine, 04469
Supervisor: Brent Elwood, PhD
(207) 581-1392

Responsibilities: Provide individual, group, and couples psychotherapy and clinical services to students. Provide prevention and outreach services to campus and community. Teach groups and classes on mental health topics. Career and intake assessments.

Hours: 40 hours a week (20 hours direct service, 3 hours supervision, 17 support hours).

7/07 – 6/08

Practicum III, Mental Health Therapist
Kaiser Permanente Medical Center
Skyline Clinic and North Lancaster Clinic
5125 S. Skyline Road, Salem, Oregon 97220
Supervisor: Robert Schiff, PhD
(503) 361-5400

Responsibilities: Outpatient medical setting providing psychological services: diagnostic interviewing, brief and long-term therapy to children to geriatric patients; individual, couples, and family therapy. Neuropsychological, cognitive and personality assessments. Integrated reports.

Hours: Approximately 20 hours per week at hospital (15 hours direct service, 2 hours supervision, and 3 support hours).

9/06 – 6/07

Practicum II, Counseling Center Therapist
Chehalem Valley Middle School
Newberg School District
414 N. Meridian Street, Newberg, Oregon 97132
Supervisor: Mary Peterson, PhD
(503) 554-2763

Responsibilities: Mental health services to troubled adolescents in brief and long-term psychotherapy. Collaborated with educators, counselors and psychologists to accurately address the needs of struggling students. Facilitated student groups focusing on anger management, living with autism, and social skills. Administered assessments to determine proper educational interventions.

Hours: Approximately 15 hours a week (12 direct service hours, 2 hours supervision, and 1 support hour).

9/05 - 6/06

Practicum I, Mental Health Therapist
Columbia River Mental Health Services
Community Mental Health Clinic
P.O. Box 1337, Vancouver, Washington 98666

Supervisor: Douglas Park, PhD
(360) 993-3129

Responsibilities: Brief and long-term psychotherapy, with an emphasis on community members with minimal social and economic resources. Primary treatment issues included major depressive disorder, substance abuse, schizophrenia, PTSD, and other psychotic and neurotic disorders.

Hours: Approximately 18 hours a week (13 direct service hours, 1 hour of supervision, and 4 support hours).

1/05 – 4/05 **Pre-Practicum Trainee**
George Fox University, Department of Clinical Psychology
414 N. Meridian Street, Newberg, Oregon 97132
Supervisor: Clark Campbell, PhD, ABPP/CL
(503) 554-2753

Responsibilities: Psychotherapy with undergraduate students in university counseling training center.

Relevant Work Experience

8/02 – 7/04 **Behavioral Intervention Specialist**
Chehalem Youth and Family Services
P.O. Box 636, Newberg, Oregon 97132
Supervisor: Stephen Haney, Human Resources Director
503-538-4874

Responsibilities: Provided one-on-one supervision for severely emotionally disturbed and academically challenged students at Newberg High School and an alternative school. Monitored, assessed, and adjusted children's academic, behavioral, and emotional needs. Collaborated with and assisted school staff to maximize each student's success. Controlled and administered psychotropic medications.

9/99 – 8/00 **Case Manager and Shift Supervisor**
Chehalem Youth and Family Services
P.O. Box 636, Newberg, Oregon 97132
Supervisor: Noelle Carroll, PsyD, House Coordinator
(503) 538-4874

Responsibilities: Case management for emotionally disturbed children ages 9-17. Implemented and developed treatment and behavioral plans. Charted and documented all information relevant to clients' records. Planned life skills training and completed required documentation to assure quality delivery of residential treatment services. Provided supervision and a safe environment for residents. Controlled and administered

9/98 – 9/99 **Youth Treatment Specialist**
Chehalem Youth and Family Services
P.O. Box 636, Newberg, Oregon 97132
Supervisor: Noelle Carroll, PsyD, House Coordinator
(503) 538-4874

Responsibilities: Worked directly with children ages 11-17 at a residential treatment facility. Provided behavioral, social, and life skill training through implementation of treatment plans. Worked in conjunction with case managers. Took on role of surrogate parent and ensured quality service delivery in the residential treatment program. Supervised study hour and provided tutoring services as needed. Recorded daily information regarding each child's progress; controlled and administered psychotropic medications.

9/97 – 5/98 **House Manager**
George Fox University
414 N. Meridian, Newberg, Oregon 97132
Supervisor: Jeff VandenHoeck, MA, BA, Residence Life Director
(503) 538-8383

Responsibilities: Created and maintained an effective community. Established and maintained credibility and rapport with residents and fellow staff members. Communicated all disciplinary problems to Area Coordinator with accompanying reports.

9/96 – 5/97 **Resident Assistant**
George Fox University
414 N. Meridian Street, Newberg, Oregon 97132
Supervisor: Jeff VandenHoeck, MA, Residence Life Director
(503) 538-8383

Responsibilities: Created and maintained an effective community. Established and maintained credibility and rapport with residents and

fellow staff members. Communicated all disciplinary problems to Area Coordinator with accompanying reports.

Additional Clinical Experience

8/07 – 4/08 **Graduate Assistant Pre-Practicum**
Graduate Department of Clinical Psychology
George Fox University, Newberg, Oregon 97132
Supervisor: Mary Peterson, PhD, (503) 554-2763

Responsibilities: Taught first year PsyD students basic counseling skills and specific intervention techniques. Evaluated students' video tapes of therapy sessions and papers.

8/06 – 12/06 **Graduate Assistant, Advanced Counseling Class**
Graduate Department of Clinical Psychology
George Fox University, Newberg, Oregon 97132
Supervisor: Kristina Kays, PsyD, (503) 554-2763

Responsibilities: Assisted undergraduate students in developing counseling skills.

Graduate School Leadership and Service Roles

6/07 – 4/08 **Student Council President**
Graduate Department of Clinical Psychology
George Fox University, Newberg, Oregon 97132

9/06 – 6/07 **Student Council Vice President and Treasurer**
Graduate Department of Clinical Psychology
George Fox University, Newberg, Oregon 97132

9/05 – 5/06 **Student Council Representative, Member at Large**
Graduate Department of Clinical Psychology,
George Fox University, Newberg, Oregon 97132

9/05 – 4/06 **Curriculum Committee Member**
Graduate Department of Clinical Psychology,
George Fox University, Newberg, Oregon 97132

4/05 – 4/08 **Multi-Cultural Committee Member**
Graduate Department of Clinical Psychology,
George Fox University, Newberg, Oregon 97132

9/04 – 9/09 **Student Affiliate**
American Psychological Association

Presentations and Teaching Experience

12/06 **Helping Your Child Cope With Holiday Stress**
Smith, J. (2006, November). *Helping your child cope with holiday stress*. Newberg School District, Parent Teacher Organization, Newberg, OR.

8/06 **Symposium: Prescription Privileges for Psychologists**
Smith, J., Campbell, C., Dutcher, S., Hoogestrat, T., Jones, L., Mours, J., et al. (2006, August). *Prescription privileges for psychologists*. American Psychological Association Annual Convention, New Orleans, LA.

10/08 **Study Skills**
Smith, J. (2008, October). *Study skills.* Husson University, Bangor, ME
Smith, J. (2008, October). *Study skills.* The University of Maine, Orono, ME.

11/08 **Interpersonal Effectiveness**
Smith, J. (2008, November). *Interpersonal effectiveness.* Husson University, Bangor, ME.
Smith, J. (2008, November). *Interpersonal effectiveness.* The University of Maine, Orono, ME.

9/09 – Present **Men's Compulsivity Lecture**
Smith, J. (2009, September – Present, Monthly). *Men's compulsivity lecture*. Hazelden Springbrook, Newberg, OR.

Research Experience

9/05 – 3/09 **Doctoral Dissertation**
Assessing Spiritual Coping Amongst Children with Cancer
Graduate Department of Clinical Psychology
George Fox University, Newberg, Oregon 97132

Passed Preliminary Orals: 4/07
Passed Final Oral Defense: 3/09
Chair: Kathleen Gathercoal, PhD

9/05 – 4/09 **Vertical Research Team Member**
Graduate Department of Clinical Psychology,
George Fox University, Newberg, Oregon 97132
Research team focused on development and implementation of research projects in the areas of rural psychology, professional psychology issues, marital and family therapy, and psychologist prescription authority.
Supervisor: Kathleen Gathercoal, PhD

References

April Boulier, EdD
The University of Maine Counseling Center
Director of Training
5721 Cutler Health Center, Orono, ME 04469
(207) 581-1392

Mary Peterson, PhD
George Fox University
Director of Clinical Training and Associate Professor
414 N. Meridian Street, Newberg, OR 97132
(503) 554-2763

Douglas Park, PhD
Portland Veterans Administration
Senior Clinician
3710 SW US Veterans Hospital Road, Portland, OR 97239
(503) 220-8262