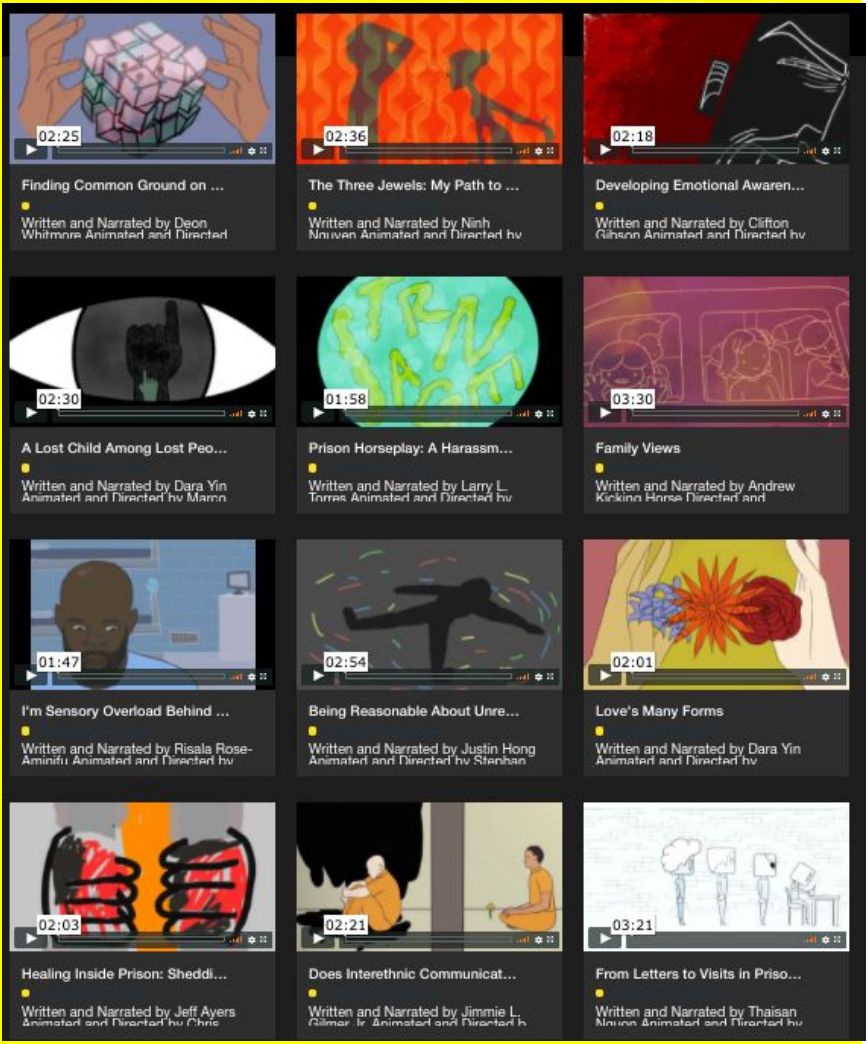
COMMUNICATION STUDIES PRISON BA JOURNAL



Volume 3 Fall 2020

Communication Studies Prison BA Journal

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Editors' note

Cal State LA's Prison BA Program is supported by the commitments and values of many participants developing academic excellence and student success through collaborative projects between incarcerated students and campus students. This issue reflects our efforts to develop innovative teaching as we build grassroots community and cultural connections, while providing opportunities for the dissemination of voices for social justice. The enclosed writings are testimonies wrapped in communications theories, where individuals sift amongst their past traumas and examine painful moments through the lens of courage, vulnerability, and integrity.

This issue further highlights that people are the sum of their experiences and reveal an honest reflection of how they cope with the environmental traumas that they travel through. Each of these men have failed but have learned from their failures and used that wisdom to succeed. Each of them have lost and taken an incredible amount, and yet, they persevere and make amends because it is the best course for them, not because it is what others would have them do. Each of these men live with the stinging reality of hopelessness and incarcerated death, and yet, they never give in to it—they rise above their confinement in thought and spirit.

One major theme of the current issue is "building resilience: a trauma-informed approach." The writings (with the exception of one) emerged from a course on health communication during fall 2019. At the time we did not know the world was on the cusp of a historic pandemic that within three months would result in a nationwide lockdown of the entire U.S. population followed by protests and uprisings against police brutality, racism, and a new urgency to rethink and reform our criminal justice system, our educational policies, and our economic policies. As a result, the writings addressing prison traumas and the need to build resilience

in the face of traumatizing prison conditions have gained a new resonance and relevance to the larger society facing the traumatic effects of living in the midst of a pandemic.

A few words about the health communication course from last fall that motivated the writings in this issue. Prison education can be restrictive in terms of options for using traditional methods to teach communication practices and skills. One alternative that helps to overcome these barriers is to incorporate a combination of "Teach-back" and performance methods into our curriculum. These strategies enable students to enact actual and ideal interactions between patients and healthcare providers. As a result, some students experienced an increase in their ability to understand, apply and practice communication concepts and skills, and to plan for and improve future interactions with healthcare providers. The classroom activities and students' subsequent reflections generated richly detailed research data for analysis that enabled students to cultivate or develop a repertoire of communication skills to use in professional and every-day life encounters. The benefits and limits of the course can best be summed up in the following quote from one of the students: "I absolutely feel empowered- in a way. What I mean is, I now have a new tool to use when encountering our crazy medical system. However, I do not feel this system is equipped with carrying the weight of an effective, patient- centered practice. But that does not mean I shouldn't try anyways, right!"

Insights like that indicate that not only are our students learning new coping mechanisms from CSULA professors but they also are applying them to everyday encounters reducing conflict in our communities. At the end of this journal you will be hard pressed not to admit that people incarcerated are better than their worst act, and in fact models of resilience.

Finally, In this issue we are proud to introduce the creative collaboration of Cal State LA's animation students with Lancaster students in producing a series of animation documentaries based

on writings from the previous issues and an earlier issue of Colloquy. Prof Zachary Zezima, who taught the animation course will introduce these works on the following page.

-- Clifton Gibson
-- Daniel Whitlow
-- Kamran Afary

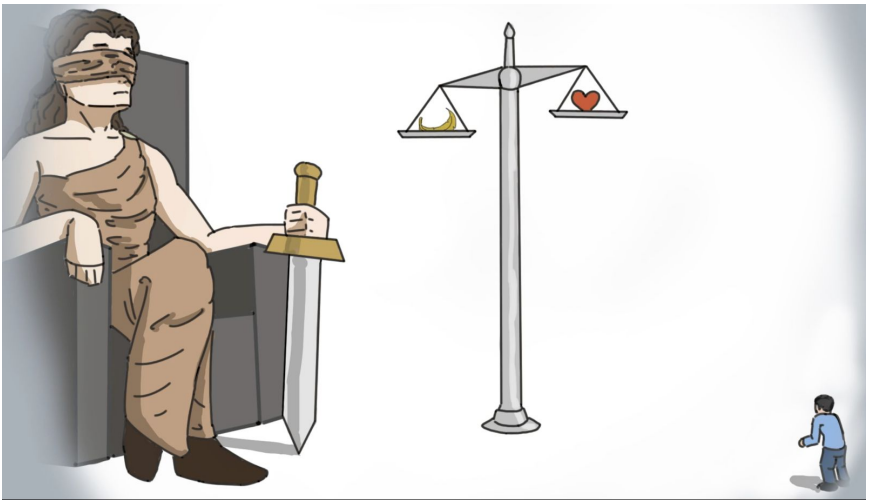
Introduction to animation documentaries

Zachary Zezima

In Spring 2019, students in my Animated Documentary class collaborated with Lancaster State Prison's BA Communication Studies students to bring their writings, reflections, memoirs, and poetry to life through the art of animation. These pieces of writing were already poignant and affecting on their own, but deserved a wider reach and audience. Students in my course read through past editions of this journal and chose pieces they most identified with. The authors of those chosen pieces then recorded themselves reciting their piece over the phone as Dr. Afary recorded. These recordings were used as narrations over the animated films, guiding the viewer through the story as the visuals added elements of the unseen and imagined. Some animation students were able to be in contact with their respective authors in order to gain more insight into how they wanted their stories to be told and portrayed. The final outcome was 14 short animated documentary films which amplified the voices of these incarcerated students, as well as illuminated and visualized the inner and outer lives of those within the modern prison system in the US.

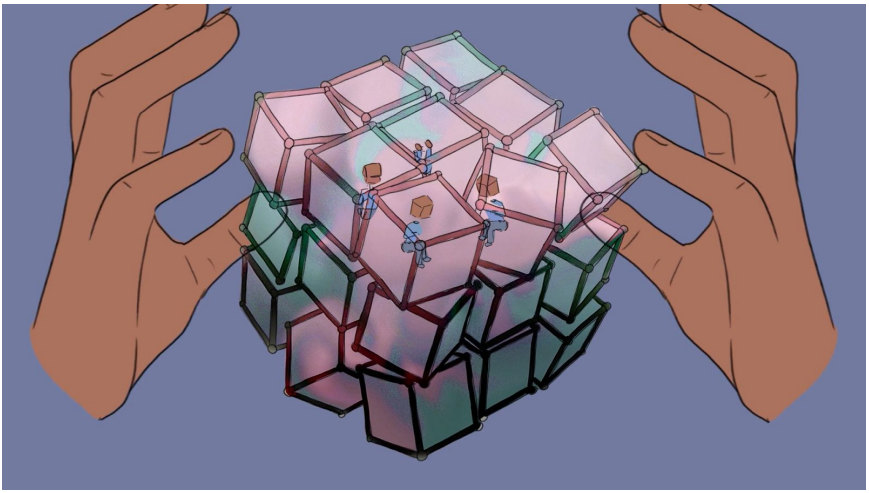
Personally, I believe in empathy and taking time to understand other people's motivations and decision-making. In my experience it is rare to meet a person who does not deserve this small act of kindness. Many incarcerated people are victims themselves of either society, their own families, institutions, and larger systems of oppression, to name a few, and are imprisoned as punishment instead of rehabilitated. I and my students hope this project brings a sense of humanity to this population that is often lacking in general sentiment.

View them at vimeo.com/showcase/7155653



Part I

On building resilience, a trauma-informed approach



A life trajectory of traumas: Developing resilience in the face of microaggressions

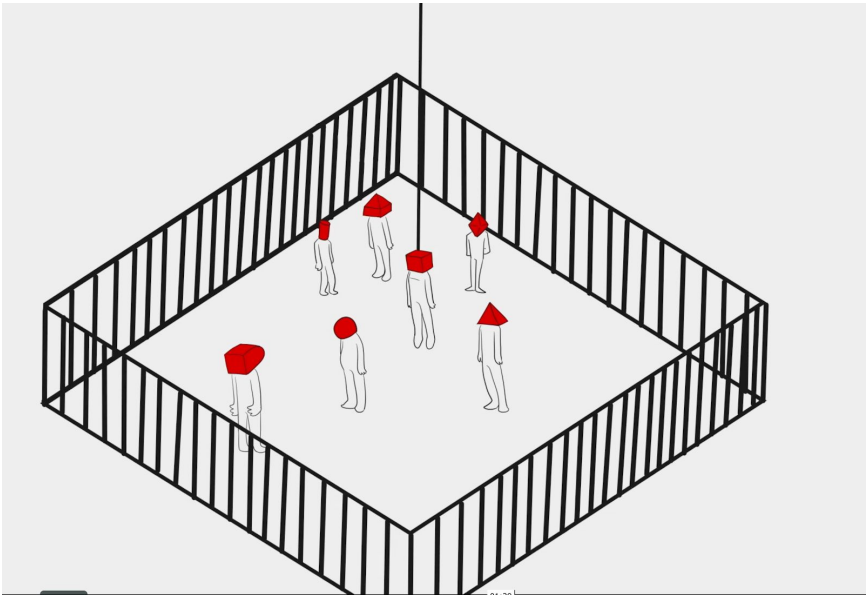
Dortell Williams

According to the California Department of Corrections and Rehabilitation (CDCR) website, the vast majority of its 125,000 wards come from the county of my commitment offense -- Los Angeles. Therefore, I can relate to our common experiences, risk factors, and environmental commonalities. Our experiences were, for the most part, wholesale poverty, parental neglect, myriad abuse, and being exposed to crime and violence at an early age. The culmination of such histories is recognized by behaviorists as patterning. The patterning of our experiences are referred to as adverse childhood experiences (ACEs): lack of social resources to cope or build resiliency, discrimination, parental separation, and parental illness to name a few. The environmental factors were shoddy dwellings, neglected schools and underserved neighborhoods, along with severely underserved schools. These environmental factors devalued our self-worth. The aggregate of this, or the message, whether real or imagined, was that we were not worth investing in.

I doubt that anyone was surprised that we ended up in prison. Not our parents, some of whom were criminals themselves, not our neighbors -- many of whom predicted our demise -- and certainly not our teachers. Unfortunately, our teachers were just as ignorant as we were when it came to recognizing our need for trauma-informed intervention and care.

For the vast majority of us, this was our reality, and thus, we too expected a dire end. In fact, for most of us, the ghetto refrain was "You'll either end up in jail or prison." It became a self-fulfilling prophecy, particularly because any real intervention was absent from the equation. When we did end up in prison, fulfilling our

fate as it were, we knew better than to expect the "cushy" motels and good living that the myths of the media perpetuate.



Indeed, prior to prison, it was the sentencing event that reinforced a devaluation so deep, we might as well had not been born. According to the Felony Murder Elimination Project, the vast majority of us sentenced to life without the possibility of parole were first time offenders. Most of us were between the ages of 18-25, officially referred to as Youth offenders when arrested, and yet the sentence implies nothing other than incorrigibility (Miller, 2002). A less sophisticated interpretation of this and other de facto LWOP sentences of life without the possibility of parole (LWOP) is that we were "trash," human trash. And what should trash expect in a penal colony? To be treated like trash, of course.

Upon entering the prison, incarcerated persons are most likely to encounter a phalanx of mean-mugged prison guards who set the "Us against them" tone. The officers threaten the incoming wards with statements such as, "This is our house, our turf; it belongs to us, and you belong to us." Again, more of the same. The same types of statements we were met with in our neighborhoods by the

police who vigorously occupied our stomping grounds (Serpas, 2015). These officers didn't mentor us, give us sound advice, or otherwise guide us. Their intent was to label, intimidate, control and eventually "own us" by stripping away our agency by locking us up.

What we found in prison was just more of the same; more of the same traumas and debilitating circumstances that were beyond our control. For many of us, we never had a chance. Our parents raised us in theft rings, or instilled violence as an acceptable means of expressing ourselves. Some of us were raised into gang families, but we certainly did not make the guns that proliferate our neighborhoods, nor did we travel to other countries to bring the innumerable tons of illegal substances that inundate our cities.

More of the same in prison means more neglect, abuse by guards and other incarcerated souls, and a system that exploits us at every turn. The exploitation comes in many forms, such as exorbitant pay-phone rates, menial prison work at a pay average of .08 an hour and the selected vendors we are forced to patronize for quarter care packages. Prison is a closed system that seems to frown on rehabilitation and self-betterment, and is a constant reminder that we are the "other," worth nothing to no one. We are left to question if it is all by design.

Of course, prison employees do not work in silos. Lawmakers, voters, architects, lawyers, unions and even psychologists play their roles. The very design of prisons is deleterious and malign; created to inflict harm. For instance, the cramped dimensions of the bathroom-sized cells - that we must share with another incarcerated person -- remind us of the impoverished and cramped space we endured in housing projects as children. While I am not advocating that prisons should be "cushy" motels, I am emphasizing that American prisons could be more humane.

Prisons should be places of true rehabilitation, not warehousing where the aggregate is devaluation, exploitation and worthlessness. Instead, these conditions -- a stainless steel sink connected to a

toilet at the front of the cell to deprive us of privacy, a metal bunk with a cookie-sheet-thin mattress, and an additional metal bunk and shelving, again, to be shared by two human beings for the rest of our lives, do nothing more than dehumanize. Again, the message is that this is all we'll ever live up to. Given that people of color are targeted for such extreme marginalization, despite research demonstrating that crime is perpetuated evenly among races, the disproportionality of incarcerating people of color is a clear message that minorities are expendable (Trcustine, 2015). These messages do not heal, they harm. These are the pains imprisonment is designed to inflict in the long and short term, physically and psychologically. Is there any wonder that California has the highest suicide rate in the nation? (CDCR, 2016).

What is interesting is how just about every prison condition one can name is also listed in the Manual of Statistical Mental Health Disorders as a causative factor of trauma: lack of privacy, lack of personal agency, dependence, violence (general and sexual), being controlled, deprivation of self-actualization, and family separation, among others. Personally, I have often asked the question: Can we really rehabilitate people in cages? Again, is it by design?

The very design of prisons is meant only to inflict harm. For instance, grey cells are intended to depress, to act as a depressant that harkens back to medieval dungeons. The problem with this in modern society is that we now recognize the psychological harm depression can cause, so prison physicians administer antidepressants. Yet the grey cells remain, but to what end?

If prisons are for punishment, then "Corrections and Rehabilitation" is a deceptive misnomer that belies the stated aims of voters and taxpayers and is but a hoax. If the pains of prison are purposeful, designed to inflict harm, then the aim is, and has been a success, as long-term imprisonment tends to lower the mortality rates of its wards (Troustine, 2015). I suppose it is better than being gunned down in the streets with excessive force. At times I question if it would have been better to be sentenced to death. Yet

for most of us, particularly those sentenced to life without the possibility of parole, death is coming a lot faster as a result of the debilitating conditions of our modern prison design (Haney, 2012). Until society comes to terms with what it really wants from prisons -- corrections and rehabilitation or painful punishment -- for us, prison is just a continuation of a life-long trajectory of debilitating trauma.

Healthy approaches to exercising resiliency

- Self-forgiveness
- Forgiveness of others
- Activities that build self-worth -- like trying new things and gaining proficiency in them
- Accepting failure as part of growth and refinement
- Exercising empathy towards others (giving others the benefit of the doubt, putting yourself in their shoes)
- Exercising compassion -- wishing the best for others and acting toward that goal, in spite of their actions
- Exercising patience
- Maintaining a positive attitude
- Talking to others (who exercise empathy and compassion)
- Exercising self-determination
- Journaling
- Listening to music
- Exercising
- Hobbies
- Yoga
- Meditating
- Outdoor adventure
- Breathing exercises
- Volunteering (helping the less fortunate)
- Sports activities
- Owning a pet

Developing a resilience plan

1. I had to learn that beliefs = attitudes, and attitudes = values and values = behaviors.
2. To maintain a healthy belief system, I learned to surround myself with people who think in constructive ways, do healthy activities, and have attitudes that are positive, harmonious, and fulfilling.
3. I learned to seek and consider constructive feedback from my friends (people who have demonstrated that they genuinely care for me) and take seriously any feedback that is independently echoed within my circle. In other words, if everyone is telling me the same thing, I begin to consider it seriously. I also never consider myself to have "arrived," but recognize that life is a continual effort at evolution and improvement. Likewise, I strive to intimately know my triggers and maintain emotional intelligence.
4. Every day I make an earnest effort to be healthy. That means concentrating on things that are good for me, such as eating right, sleeping at a consistent time every night, and getting sufficient rest for my body to perform at its best. I recognize

that my health is my most prized treasure, and without it, I can't do anything. So, I prioritize my health.

5. I also make sure to use my best coping strategies to confront life's stressors. That means not acting impulsively or in anger. It means listening more than talking, and considering those around me important because of the talents and contributions they add to my life. It means treating others with respect and dignity and expecting the same, but when they come up short, finding creative ways -- according to their personality -- to teach them how I wish to be treated. I also recognize that each day has its own challenges and pitfalls. When I have bad days, I make sure I do not project my negative experiences on to others, and I try to treat each day as its own event. I have learned to let go of bad events and negative interactions with others. I forgive. I have also learned to confront my problems (which I call challenges) and to never run from them (which is stressful in and of itself).

The trauma of microaggressions

Microaggressions are deceptively harmful because they are easily dismissed as small, innocuous events that amount to nothing. However, like chronic high blood pressure, the accumulation of consistent microaggressive behavior can take its toll on the recipient. Consider human marginalization, for example.

Marginalization is a form of microaggression in that it challenges one's self-worth, lowering a person's social status by causing one to perceive themselves as inadequate. To the microaggressor, excluding others, treating people unjustly and unequally comes with an assumed privilege that makes this behavior acceptable. In America, all too often, those typically marginalized are people of color, women, the elderly, people with special needs, religious minorities, and LGBTQ people. As one might imagine, the identity of many people in these groups transcend into other groups, i.e., a black, female lesbian possesses

three different marginalized identities. To empathize with her experiences would require a tremendous amount of insight.

More often than not, to possess a marginalized identity entails direct and indirect discrimination, and prejudice on a regular basis. These could include verbal aggression such as name calling, labeling and derogatory insults. Negative verbal expressions are just the beginning. Consider how it feels being on the receiving end of microaggressive behaviors, such as when whites roll their windows up at the sight of a black or brown person walking by in a parking lot? And what of environmental-structural barriers that impede a mobility-impaired person? Marginalization invalidates its subjects, making them feel unworthy and excluded. Over time these experiences are internalized, the person begins to question their worth, and it diminishes their will to participate in larger society. Sometimes microaggressions are committed by well-intentioned people, who are simply thoughtless. They may ask why the marginalized person doesn't speak English in public. These types of actions are psychologically damaging and emotionally harmful, particularly over extended periods of time and frequency. Microaggressions are defined in three branches: microassaults, microinsults, and microinvalidations.

A microassault is an overt prejudice that is intentionally expressed with the intention of damaging the target. Microassaults take form in overt discrimination, mistreatment or exclusion. The name-calling can be subtle or explicit, such as a racial slur, or a hate-laden expression of vandalism such as a swastika. Microassaults can derive from individuals, groups, and governments. Many Americans view the sentencing inequalities of crack versus cocaine as a microassault against the black community. Bullying is a more aggressive form of a microassault. Microinsults are just as damaging.

Though typically unintentional, a microinsult can be an indirect attack on the marginalized person. For example, when a

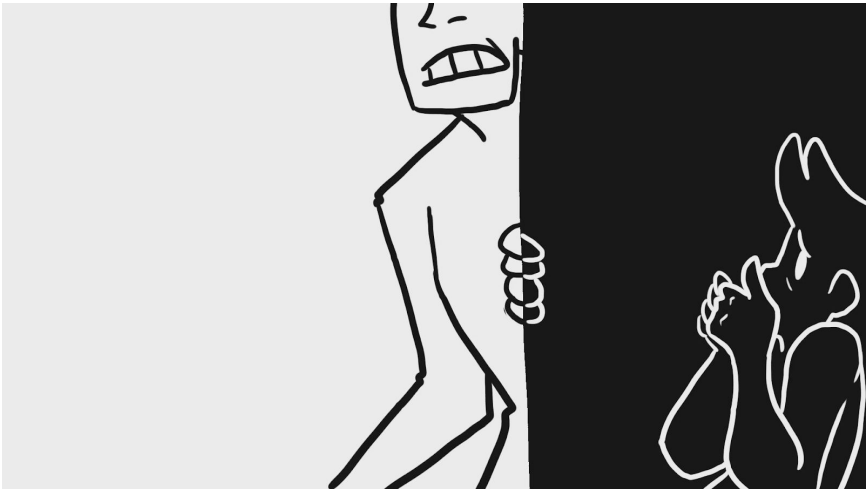
microinsult is veiled as a compliment, or a statement with a hidden message is made to a marginalized person, this undermines a person's identity. An example would be, "For a Mexican, you're pretty smart" or “All Asians are the same, no matter where they come from." These types of statements cause shame, disconnect people, and cause hurt, even generational hurt. Microinvalidations are likewise injurious and mischievous.

Microinvalidations minimize the realities, feelings, and experiences of others. Like microinsults, microinvalidations are typically made on an unconscious level, but they reveal a privileged and prejudicial mindset. An example of a microinvalidation could be telling someone that they are not worthy of a promotion because of their gender or weight. Another example would be Latinos who are told that they don't belong here in America (though North, Central and South America are all part of the Western hemisphere). Microinvalidations say "you're an ‘other’ and you don't belong." This malicious treatment, though uninformed, is a psychological detriment to the recipient. Again, microaggressions, at any level, take their toll.

Individually and collectively, microaggressions devalue and isolate others and disconnect the perpetrator and victim, perpetuating a hostile society where hate, hurt, and traumatization are ubiquitous. This is not an environment any civil and sensible person should desire to abide in. Kindness, compassion, and acceptance counter the hostility and damage that microaggressions disseminate, and educating others is the best way to oppose these antisocial expressions.

Source:

Levy, Jeff & Jones, Amber (2013, September-October), "Nothing small about microaggressions," Positively Aware, pp. 32-35



Desperately developing resilience: Creating healing in the face of trauma

Daniel Whitlow

For me, trauma comes from a myriad of negative experiences, as well as from an overall *lack* of positive experiences. From the ashes of my darkest days, when nothing made sense except the lie that I was worthless and beyond repair (a lie I believed and repeated to myself like a abusive mantra), I stumbled on pieces of what would become a three-part process capable of creating resiliency against the harmful and cumulative effects of trauma within me.

Desperation / motivation

A much-needed conversation with a friend sparked an inspired series of flames, which led to this method, followed by years of practice acknowledging my own failures and successes with healthy (and not-so-healthy) coping mechanisms, and learning from each step even when it hurt more than healed, even when it felt more false than real. At times, I felt as though I would learn nothing about myself, thinking *this whole process is silly—it isn't going to work*. I felt as though nothing could relieve the desperate aching wracking my always exhausted spirit and heart. Little did I know, developing resiliency required more than my time—it required sacrifice and vision, a complete surrender to truth and honesty with myself and adopting a lasting willingness to resolve and push away the ubiquitous doubts and self-defeating tendencies surrounding my shameful new identities as a "prisoner," "murderer," and "drug addict."

I have a clear memory, from when I was in my early 20s, of how deeply trauma affected me. I was walking laps around the prison yard, having just finished smoking marijuana. I was very

high and emotionally unstable, to say the least. I looked at the drab, slate grayness of the walls and barbed-wire fences and thought, "This is a graveyard." I looked at the faces of the men around me and thought, "There is death in their eyes," and when I saw my own face in the mirror I thought, "I am dead, too." I completely gave in to the vicious assumptions that because I had done terrible things I was: 1) a cold, uncaring sociopath—consistent with the messaging in my trial—and, 2) incapable of redemption or change. I felt condemned to collapse into a protracted decay, marching towards a distant grave in the iniquitous skin of a monster that I could never remove. I was desperate to change. The conversation with a friend happened the same day, and he challenged my faulty notions by forcing me to take responsibility for my actions with the understanding that once I could accept what I had done, I could work towards changing myself for the better. He told me that I had to learn that even though those new identities were true, at least in some measure, I didn't have to define myself by them. I didn't fully grasp the profundity of his advice all at once but, as I continued to hone my self-understanding and developed positive coping strategies, I found more balance in my life. I began to feel good, comfortable with who I was, more alive than ever before. That crucible of suffering I experienced—that constant, painful daily process of inching closer to the "me" I wanted to be—represented small steps toward emotional and spiritual maturation. Although it's a constant and continuing struggle, through that personal evolution, I developed resilience to trauma's deceptive murmuring.

A self-reflexive methodology

The process has three parts: 1) Recognition, 2) Deconstruction, and 3) Realignment. Another way of describing these steps is: 1) acknowledgement of the trauma and its effects/impact on my life (and the lives of others), 2) understanding where the trauma came from, how it formed, and why it affects me as it does and, 3)

finding healthy alternatives to recondition myself to respond (as opposed to react) and/or replace the potentially harmful effects with more constructive solutions and/or options.

* *Recognition* – This first step represents awareness and acceptance. We must first recognize trauma's presence—that we are dealing with trauma. I believe this is the most difficult part because we unconsciously (or overtly) seek to avoid confronting our fears and hurts as a defense against pain, suffering, etc. We must open ourselves to our flaws and defects, we must objectively observe our judgments and decisions, and must have the courage to acknowledge how trauma has infected the way we react/respond and act in our lives.

For example, my drug use was a way for me to avoid being myself and dealing with the painful circumstances of my life. I enjoyed the high, certainly, but more importantly, I was able to escape myself. I hushed shame's insistent voice and, within the high, created more and more distance from who I thought I was—an angry, bitterly resentful, and desperately defective child who hated himself. Drugs allowed me to reimagine myself, to be who I wanted to be. Whoever that was made no difference; I just didn't want to be me. I had to recognize that. I had to become aware of my frantic need to be someone else and find the nerve to ask "Why do I want to escape myself? What have I done to provoke such an aversion of self?" The willingness to ask these questions is the desired outcome of this step.

The challenge lies in taking the plunge, so to speak—finding the courage to admit and accept our traumas. Before we are able to heal, we must first know we are hurt.

* *Deconstruction* – This step represents reflection and deep understanding. A person must reflect back on the

circumstances of their lives that connect to the feelings associated with the trauma they now acknowledge. Deconstruction seeks to break down a person's experiences, to find the causative dynamics that trigger and explain traumatic behavior, providing a deeper, clearer perspective.

For example, I looked at how my father (and later, my stepfather) neglected me. When I thought of their neglect, I felt ashamed, as if I was worthless or broken, because they didn't want me. I internalized that sense of brokenness, blaming myself. By taking on the blame, I found stability. It wasn't healthy or right but I knew I was faulty and found a measure of solace (albeit poisoned) in knowing I was the problem. The knowing provided a foundation for me to build on, and I created an altar where I could sacrifice parts of myself that I despised whenever I wanted. I lived a life of avoiding myself. I used the opinions of my friends to define who I was, and who I was changed as their opinions changed. If a friend was sad, I became sad. If they were angry, I was angry. If I said something that offended them, I would feel like a traitor and would do anything necessary to win back their approval. I realized all these things and finally witnessed my manic and traumatized behavior by deconstructing the abandonment I experienced with my father and stepfather. I finally saw the source of my discontent. The realization, discovery and comprehension of trauma's effects on us is the desired outcome of this step.

The challenge lies in seeing the unseen, so to speak—taking the time to objectively observe our actions and thoughts, not from our biased perspective, but rather from an externalized distance, so we can see trauma personified. Sometimes we must consider what trusted individuals in our lives tell us about ourselves.

* *Realignment* – This step represents restoration and moving forward. Once we acknowledge trauma in our life and go through the arduous process of acquiring a deeper understanding and awareness of our traumas and how they affect our lives, we need to develop healthy ways to cope moving forward. This means learning from our mistakes and understanding our experiences. Due to what we learn and appreciate, we create opportunities to make ourselves into better people. Realignment does not remove or abolish trauma—I don't know if such a thing is possible. What realignment signifies is adaption and maturation. We must find ways to deal with our stresses and traumas that are healthy and promote continued growth and we can do so through what we learn from the first two steps.

For example, once I saw that my feelings of worthlessness came from the neglect and abandonment I experienced with my father and stepfather, I realized those feelings were illusions trauma created to lock me inside a vicious cycle of self-destruction and abuse. I clearly saw how I punished myself with drugs and negativity. I understood where my feelings came from, why I felt like I had no personal value, and why I tried to find value in others' opinions of me, not from within myself. I realized those feelings of valueless-ness and lack of intrinsic value (from my standpoint) were not because of some sinister defective nature, but rather because of trauma and its effects, and that realization unlocked my ability to grow. I began to invest more time into creating value of my own, either through music or writing or some other creative project, as well as pursuing my college education, despite having a poor academic history. I found the more creative and scholastic risks I took, the more value I found in myself. Part of this process also included listening to my family's support of me; having the willingness to absorb and appreciate the positive opinions people had of me, and having the courage

to filter out the negative opinions of others, too. Through this step, I learned that I am the architect of my own value and, as such, I have the final say on how I see and feel about myself, amongst other things. Realignment represents victory over trauma, though sustaining that triumph requires constant maintenance—any regression could allow for trauma's reemergence into our lives, so we must be proactive in our own wellbeing and these steps helped me do that.

The challenge lies in trying our best-pushing past failure, learning how to improve, and understanding that so long as we invest our best into each situation, win, lose, or draw, we can hold our heads up high. We are not perfect and we should never expect that.

In our own image

Ultimately, these steps were a way for me to understand and chart my own growth, which was important to me. I understand that it may not work for others, but I believe all people experience trauma and suffer its effects, just as I believe all people can develop resiliency to it. There is a need for models like this that help provide guidance and direction to those who are dealing with or negotiating trauma, whether each person designs their own or academia settles on the most efficient ones available. I do not know if either option is best (or both) but the chance to construct my own model for personal growth came as a healthy and fortuitous byproduct of going through tough times and recognizing that I needed something to help me. I was able to focus my energies into a positive and private project, and creating this model was one of the most foundational steps I took as I walked an unknown and oftentimes scary and intimidating path. This template is like I am: a product of my influences and experiences, failures and successes, joys and disappointments. It is as flawed as I am, it is as curious and abstract as I am, and it is as supportive

and forgiving as my supporters have always been; it is me, and I hope—if nothing else—it feels human and encourages others to explore their own traumas.

Trauma Informed Care:
Overcoming the limitations and barriers of prison with anxiety/uncertainty management theory

James Cain

Development of a personal resiliency plan addressing my ability to overcome the limitations and barriers of prison is best understood through my established daily program. It is within the practices of this program that I am able to stay well, mitigate harms associated with stress, and maintain a balance that is conducive with rehabilitation and becoming the best possible version of myself. I translate this program into a cohort resiliency plan by *Keep-doing,* or focusing on four areas of life that strengthen my spiritual, emotional, physical, and intellectual well-being; I *Stop-doing* the behaviors that once harmed my overall health and well-being, and *Start,* or continue *doing* the things that help me build positive relationships and change former ways of thinking that now enable me to be proactive in my life and thus cope more effectively with present and future challenges. By having a balanced and proactive program, I am able to maintain resiliency that supports my wellness, mitigates harms associated with daily stress, and enables me to live harmoniously even with the difficulties of prison.

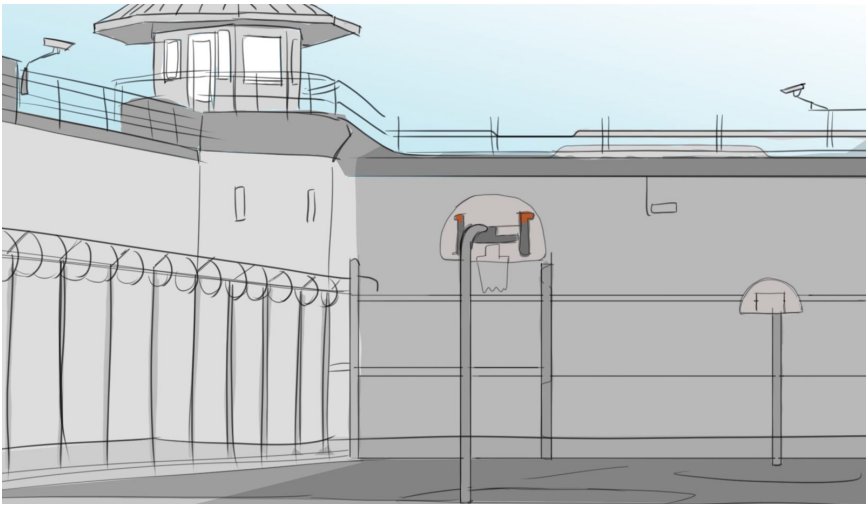
I view my personal application of a daily program through the lens of William B. Gudykunst's (1985) Anxiety/Uncertainty Management Theory (AUM). Gudykunst developed AUM out of Charles Berger's uncertainty reduction theory. Anxiety and Uncertainty Management Theory predicts that people arrange their life worlds in ways that minimize anxiety and uncertainty. I find AUM is verified through my application of a program. Cultivating and perpetuating a program is the effective coping mechanism I have developed to mitigate and manage anxiety and the

uncertainties associated with serving Life Without Parole (LWOP) with a predominantly antisocial population.

I am able to maintain balance and resilience from the turmoil of prison by addressing four areas in my life each day. The first thing I do each day is address my *Spiritual* life by immersing myself in prayer and meditation on the Word of God—The Bible. My connection and devotion to God in these ways supports feelings of hope and my assurance that God has my back in all contexts of life. I tackle my P*hysical* well-being through stretching, working out 3-5 days a week—including the application of full body routines, cardiovascular exercise, and maintaining a balanced diet. I focus on my *Intellectual* life by applying myself to Communication Studies through the Bachelor degree program at Cal State L.A., as well as by reading for pleasure. I attend to my *Social & Emotional* needs by proactively interacting with my Cal State peers, with friends and acquaintances, as well as through the social interactions I cultivate through my entrepreneurial business, "Cain's Custom Crafts" in which I build hobby products to suit fellow prisoners' needs (i.e., wall-hooks and fasteners, clothes hangers, vent-air regulators w/filters, custom boxes for mailing home hobby projects, and nearly anything a prisoner can imagine). Having such an effective and well-rounded program means I am able to stay connected to my Creator, maintain good physical health, stay socially connected, intellectually stimulated, provide for my needs, avoid idleness, and mitigate exposure to the banalities of prison.

I have come to realize through the 18 years I have served in prison that failure to have an effective program can result in the worst of outcomes like insanity, self-medication, poor health, and hopelessness. This makes the creation of a program vital to a prisoner's life. I figuratively equate the four important aspects of my program to the four legs of a chair. I use this analogy because chairs with four legs are inherently stable. And as long as I address each of these legs in my daily life, I am able to maintain a stability necessary for consonance—or harmony, wellness, and a resiliency

necessary for coping with the daily stress and challenges of incarceration.



Resilience as a mission and vision:
A collaboration in alignment with Cal State LA

Resiliency is our shield against all of life's storms, tumults and adversities. Resiliency is the mental ability to recover from discomforts such as depression, illness or misfortune. Resiliency can be exercised and strengthened, it can be increased with purpose and practice. Below is a model of resilience resources based on the official Cal State LA mission and vision.

Dortell Williams on Communication – Talk to a trusted confidant, someone who has proven they care about your well-being; talk to a counselor or a trusted and open professor to help you purge and realign your mental state. Talk to a stranger on public transportation, or a patron at the coffee shop. The worst thing to do is to internalize a traumatic event or problem. Internalizing is harmful in the following ways: 1. You don't get the guidance that you need; 2. The problem festers, causing internal imbalance that could manifest in trauma reenactment such as irritability, drug abuse, negative projections onto others or, in a worst-case scenario, explode in an irreversible act.

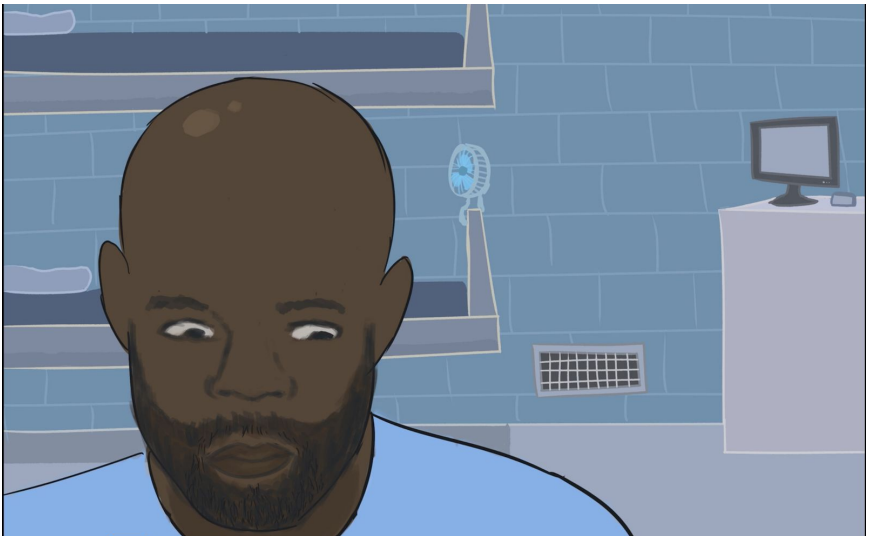
Allen Burnett on Storytelling – Storytelling can be accomplished in many ways: 1. You can read stories about the problematic topic; 2. You can write a narrative of the event with *your* preferred ending, or according to your truth, express it in poetry, song, a rap or a secured diary. You could compose a theatrical script, start a blog or even write a book.

Duncan Martinez on Culture – Culture can be a building block towards resilience. Long-term culture clues us in on our stock; it tells us what we're made of historically. Many African Americans

draw strength from the knowledge that they come from a line of kings. Likewise, some Mexican-Americans take pride in their Aztec heritage, just as some Central Americans delight in their Mayan history. People with European, Jewish, Asian and other nationalities also find resilience in learning what their ancestors have either endured or achieved. We all have rich histographies to investigate and pull from. Similarly, as Cal State LA students, faculty and administrative personnel, we all share in the fulfilling history of achievement – in spite of life's adversities – that we create as individuals and a proud collective.

Marvin Johnson on Creativity – Our artistry and creativity can also serve as a source for resilience. A well composed musical arrangement, a detailed portrait, a masterfully performed theatrical work, or a beautiful handcrafted item can remind us of our unique abilities and worth. Few things in life can compare to a genuine expression of creativity to boost confidence and self-esteem like the birth of creativity that comes from within.

Jimmie Gilmer on Success – The ability to overcome and achieve – despite hardship – is a great way to foster self-confidence, prove to ourselves exactly what we are made of and push forward. For no achievement comes without obstacles of some sort. And the best success is shared success, like the model we have created at Cal State LA.



Retelling life experience to make sense of trauma: remembering Butch

Terry Don Evans

When I was five years of age, my aunt used to walk me to school, so I could attend kindergarten class. There came a point in time when she was no longer able to walk me to school; so we trained my German Shepard dog, named Butch, to walk me up one block from the school, at which time I commanded him to go home. Butch was also trained to return to the same location, one block from the school, and wait for me to get out of class, in order to walk me home.

One morning, that initially seemed very gloomy, for some strange reason, while on my way to school, I observed a man whom I knew as Mr. Murphy opening the security gate that protected the neighborhood grocery store's entrance (this event transpired on the Southside of Chicago, in early 1963). On this particular morning, Mr. Murphy failed to turn off the store's security alarm before opening the gate. As he clumsily fiddled for the keys, two Chicago officers arrived. They and Mr. Murphy got into a verbal dispute and both police officers mercilessly beat Mr. Murphy to the ground, leaving him unconscious and bloody. I was disturbed by the event and asked the officers why they did that to Mr. Murphy. They told me the man is a drunk and was trying to break into the store. I told them that his name was Mr. Murphy and that he worked there at the store. They told me to go away and that I did not know what I was talking about.

Two or three days later, I was waiting for Butch to arrive to walk me home. My aunt taught me that if, for some reason, Butch did not come after waiting 15 minutes, I should head home on my own. Butch did not show, so I proceeded to go home. As I came closer to the same store where Mr. Murphy worked, the same

police were trying to capture Butch. Butch saw me and started barking. Before I could say anything, the police officers ordered me to get back. They said this dog was sick. Butch raised up on his hind legs to try to push the officer away, and then both officers shot and killed Butch. I ran up to try to help Butch and one officer grabbed me. I told him to let me go. He said that they received a radio call concerning a wild sick dog. I started crying and hitting the officer. He said the dog was rabid. I told the officer my dog's name is Butch, not rabid - I had no idea the officer was

referring to a medical disposition. Then all of a sudden, a woman turned the corner, her leg bleeding as she was chased by a German Shepherd foaming at the mouth. That dog did in fact look

similar to Butch. The police officers shot and killed that dog too. They tried to apologize for shooting my dog, but that did not ease my pain. Soon after, my aunt came around the corner searching for me. She too cried once she discovered what had occurred and tried her best to comfort me, which had very little effect.

It would not be until almost 45 years later that I discovered how traumatized I was from both occurrences and their long-term effect on me. That is, I seem to have incurred a severe dislike towards anyone in a position of authority who abuses his or her position of power. I did not realize that that was what was going on with me until I enrolled in Alternatives to Violence self-help class. Since being helped to discover these traumatic-experiences, I have become a much better and well-rounded person. The class helped me to view situations from a new perspective and to really try to understand the reason for the conflicts I used to have with authority figures. I am now on alert to make sure that ugly face no longer surfaces within me.

By reengaging that experience, I was able to discover a trauma and my response to the traumatic event,that trauma, which has perplexed me for decades. This in accordance to Stephen Madigan, MSW, MSc, PhD, who spurned the concept of a thick description, which evoked my conscious explanations of why I responded that

way at that point in time. Since then I have been able to describe my true notions, desires, whims, moods, goals, hopes, intentions, purposes, motives, aspirations, passions, concerns, values, beliefs, fantasies and commitments with more clarity.

In conclusion, this re-telling renders my experiences of life sensible to myself and to others who can relate. According to Jerome Bruner, "all considerations of one's unique expressions of life, meaning and experience are inseparable- events are linked together in particular sequences through the temporal dimension-thought past, present and future – and according to specific plots." This notion has helped strengthen my decision-making, self-care, emotional regulation, social support, action and problem-solving orientation, realistic and positive thinking, personal confidence/self-efficacy, and personal meaning under adverse conditions.

References

Bruner, Jerome and Madigan, Stephen. (1986) "Foundation workshop handout." Vancouver School of Narrative Therapy.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Building resilience with service dogs: *Paws for Life* bootcamp

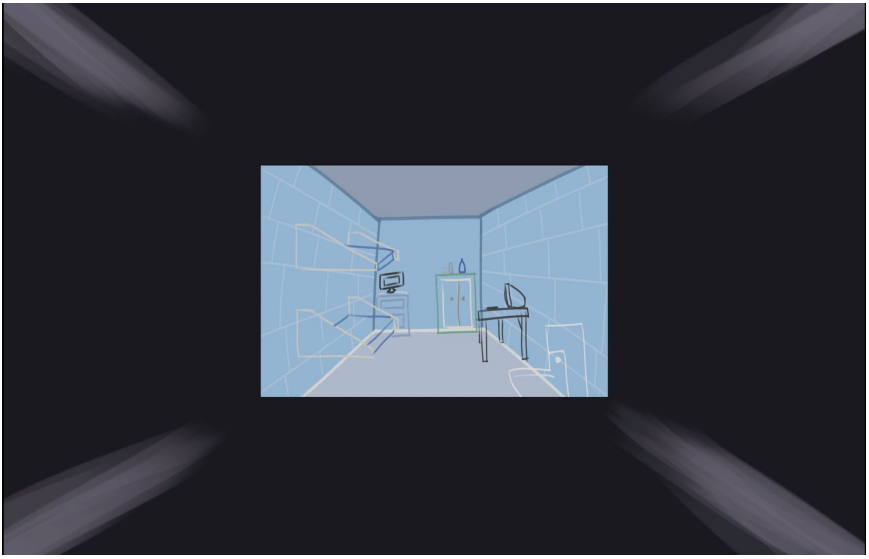
Tin Nguyen

A good example of a naturalistic approach to health communication is the boot camp to match Paws For Life (PFL) service dogs with veterans that are diagnosed with Post Trauma Stress Disorder (PTSD). Before the veterans can go home with our service dogs, they must go through a nine-day bootcamp to learn all they need to know about our service dogs, such as the commands and tasks that our service dogs know. We cannot just send the veterans home with our service dogs without them knowing how to care for our dogs or understanding all the concepts of the commands and tasks. Therefore, the boot camp is essential and intense.

During the first boot camp that PFL had, I was able to participate as a participant observer. As a participant observer, I had the privilege to observe the bond developed between the veterans and service dogs. For instance, on the first day of boot camp, after orientation, the veterans were allowed to spend time with the service dogs that were matched with them.

On the following day, we began to teach them five blocks of ten commands, and approximately five tasks. I watched how the service dogs went from being stubborn to the veterans' commands to becoming utterly obedient. This showed a bond was developing between the veterans and the service dogs, and through the bond, a communicative link was established. Out of the group, the most profound bond was the bond between Bronson (service dog) and the veteran he was matched with. This veteran had not laughed in the two years since he came back from military service. At one of

the boot camp meetings, he mentioned how Bronson had helped him with his anxiety, and panic attacks. He stated that he had not been to the movie theater for nearly two years but the night before had been the first night out to the movies that he was able to attend with his family. He said that the darkness in the theater would always trigger his destructive behaviors, and anxiety attacks. Bronson, in a down position at his feet, made him feel safe. He went on to show a video clip that displayed him sitting and eating with his back to the isle where people walked behind him without triggering his panic attacks. As a matter of fact, he was laughing while he was eating, with Bronson at his feet. From this naturalistic approach, I was able to learn a lot about the positive impact that PFL's service dogs have on our veterans with PTSD. Service dogs can be a great help in resiliency, and I would recommend them for anyone.



A patient-centered allegory:
Chronicles of patient-provider communication

Duncan Martinez

Part I: Wandering Through the Park

There is a type of panic that sets in when I have to go to the bathroom that is difficult to explain. When I tell people that I have to pee, they know what that feels like, but that's not what it's like—it is not like the normal feeling, it is so much *more*. The difficulty in explaining it is important because of context: when people hear that I am having trouble, they get that, but it means nothing to them—it is too simple. But, the feeling, the panic, as I like to call it, does not feel like anything I have ever known. There is no perspective, and thus, no understanding. This is difficult everywhere, from my sessions with the doctor to my interactions with friends. At times, their inability to understand is as difficult to deal with as the actual problem.

The problem, though, the panic, is subversive. Slowly, it took over most of my life, to the point that I lived next to my toilet. I had to. It took a form, a visualization, that was ruinous—a terrible part of that was that it took the form of something I used to cherish.

There is a park in Boston, where I used to walk. It runs along a waterway, and there is a section of entangled paths that create a sort of maze. During the day it is no big deal, there is just enough of the city or waterway to see what is going on. But, at night, there is no light. There is nothing in that morass—you are lost in a maze of black. I loved it, loved the idea of being in the middle of it, being lost was meditative. I would actively try to get lost in it, wandering thoughtlessly. It was peaceful, free, and made me fall into deeper thoughts in a way that I could not do

otherwise. Later, when I no longer lived in Boston, I would go there in my mind, get lost to that park, that kind of an idea. Again, meditative.

That was the image the panic took. Instead of me being lost and that being a beautiful thing, I was lost with panic: chased by the panic, unable to find my way out, to be free of anything. I would close my eyes to the park even as it was daylight outside. Running in flight, the idea of fleeing screaming, from some *thing* that was there to get me. Running with and from the panic.

The process of getting past this was difficult, but enlightening. I had to recognize rationally that I was not the panic or even the need to pee. I was simply possessed by that need, inhabited by that panic. Seeing things from that perspective changed everything else. I was able to see clearly what was happening. I was still lost in the park for hours every day, but at least I knew what that meant (or, what it didn't mean). But, how to get past it, how to be myself again?

I took charge of the imagery like a lucid dreamer does with dreams: I made it mine again. This did not happen overnight, but it happened. I made the park what it was before, took the moments of panic and resignified them as meditative again. I made what had been mine, mine again. When I feel the flight, I relive the old thoughts, the relaxed thoughts—the deep thoughts of something complex or interesting. I delve deeper into those instead of the panic. I do not let the panic control me. Certainly, there is still panic, there is still a physical need that can be all-encompassing. But, instead of it being everything, it is simply what it is: a physical manifestation. By taking control of my life, my moments, I was able to relax (to a degree) and by relaxing, survive. Instead of needing to know the toilet was right there, I just needed to know where I might find one. It is still a difficult medical issue, but now it is a survivable one.

It is still hard to explain to others, still difficult to explain the feelings and what they do to me, but I am in control of what I

can control—a difference that is astounding. There have been times where I have talked myself off of even some of the physical manifestations (when I get bad, I cramp up, doubling over and unable to stand when at the worst). People tell me to breathe, to relax, not understanding that the panic prevents that. Again, it is so hard to get people to understand. Once I was able to control and limit the panic, to breathe, and to take a moment to gain control—I was able to do the things I used to do all the time.

I was able to live. When we are surviving our day to day it is something inherently less than when we can actually live. It's like being stuck, internally, at Maslow's lowest rung. Being free again, was huge. Is huge. I am a human being again.

Part II: Wandering through the Park

There is a sort of blackness that comes with pain and confusion, a way of thinking that allows for nothing light or positive; a place filled with doubt and loss. It is a dire place, one we have all likely felt and understood. For me, it is a place, one I used to walk late at night when I was lost. And you could get lost there, lost in the darkness, lost along a series of paths between a street and a waterway in Boston. The waterway had been famous and the paths had been well groomed, but neither was true anymore. Everything overgrown, it was easy to get lost, especially at night. I would let my legs take me where they would, and when I had no idea where I was, I felt a sort of comfort in not knowing. It was a place of isolation, utter darkness, and yet a place of solace. It has been obviated by pain, now, as I sit older and no longer there: when I feel lost, my mind recreates that, and instead of solace, I feel a sort of panic.

Panic. For me this is most associated with having to go to the bathroom. A simple task that most take for granted, but, for me has become one of the great labors in life. I have a bladder issue, and when I have to go, I *have to go*. Moments can go by with no problem, but quickly, the panic starts to kick in. This has gotten

better in recent months, but going back: if I did not get to a toilet right away, everything else ceased to exist. I lost focus, time, feeling only the rising tide and pain—it was incredibly painful. Going back to the darkness above, I would get in that maze, lost to everything and feel nothing in the world but the need to find a toilet. To make matters worse, I have to sit down. Every time. Running through the maze, falling, finding my feet, running again. A sense of something else, behind me or ahead, it was there—ready to end me. The panic racing through my mind as I raced through the maze. The only answer, a toilet. Something tangible, a place where I could make the pain and anguish go away. Painfully.

I started to control it slowly, to get a measure of myself into those moments. Instead of letting the panic take hold, I would fight it. Instead of flight through the forest, I would try (try!) to get my head in control. Slowly. A focus, a place, a memory—I would go back to Boston, back to the idea of what it used to be. I would slowly let all of the positives in my life help me up. I have great support. This is an affirmation, a way to help you get anything started. You, of course, have to do the hard work yourself. You have to make the change, the growth, get back up when you have fallen down. I took their help as a strength, when my mind wanted only to run and hurt, to find solace again.

I would still hurt, still feel the intensity of the need (that was physical, there was only so much I could tamp it down, but I would push it aside, not let it be the central thing that governed my actions. Yes, it hurts, yes, I need to use the toilet *right now*, but, instead of folding over and falling victim to myself—I stood tall, stood in the midst of the suffering and let it be a distant thing. I let myself be the maze, the paths, and found that solace amidst the fury of everything else. The need something less, somehow, to the strength of keeping distance.

The effects were the same, I would still be cramped for hours or days, still suffer through all sorts of trauma because of

it—that could not change because it was physiological. But, I could control what I could control; I could take my own thoughts as my own. I could be strong in the face of the pain instead of being controlled by the pain.

It is still hard to explain to others, still difficult to explain the feelings and what they do to me, but, I am in control of what I can control—a difference that is astounding. There have been times where I have talked myself off of even some of the physical manifestations (when I get bad, I cramp up, doubling over and am unable to stand). People tell me to breathe, to relax, not understanding that the panic prevents that. It is so hard to get people to understand. Once I was able to control and limit the panic, I was able to breathe, to take a moment to gain control—I was able to do the things I used to do all the time.

I could be me. When I think of resilience, this is what I think of. This process, and the strength it took every single time. I went through this every day, at least once, and usually several times. I went through this and grew with each chance.

Growth is resilience and resilience growth.

Talking About Peeing: Provider Communication

Being in prison, things are a little different, from expectations to how things actually work. For example, to go to the doctor's office, I wear leg-shackles, am handcuffed, and the handcuffs are locked to a black box at my belly—I am not able to move much at all. Entering the office, I am already anxious: the guards who accompany me are armed and ready to use their guns. They even joke about it. In the office, I am the elephant in the room, everyone trying not to stare at the guy in orange with the Hannibal Lechter handcuffs.

Escorting me into the room, I am surprised at the size: easily thirty feet by twenty, with a table in the center and something like six nurses busy around the space. I know I am

there for a cystoscopy, and I understand that is a camera going up my penis, but I only know that because family has explained it to me. I have never spoken to the doctor nor has anyone in the office said a word to me—I am in the suite where things happen, but know nothing.

I am more anxious as I approach the table. It does not look comfortable, and considering what is about to happen, I am inherently uncomfortable for that simple reason: a camera is about to go up into my penis.

The nurse tells me to pull my pants down to my ankles, pull my shirt up to my armpits, and to lie down. It takes a few minutes for me to do this, and no one bothers to help. Imagine your wrists attached to your belly-button, and try to get your pants around your ankles. I manage this and then lie down on the table, completely bare (essentially naked) as nurses jet around the room. The two officers are male, but all the nurses are women. No one is staring at me, but the feeling of being exposed makes me more anxious. The nurse who asked me to get on the table finally places a thin napkin over my privates as she pulls a tray beside me.

There is a television at the end of the table and harsh lighting above. The room has that antiseptic smell of hospitals, and even that is not comforting. Nothing here is comforting. I am about to have a camera inserted in my penis, and I do not know what that means. No one has told me anything and there looks to be no one about to. I have assumed at this point that the doctor will talk to me, explain whatever is going to happen. I am ready for the doctor to help settle me down—to make me comfortably happy.

After what seems like forever, the doctor finally comes in. He glides to the table, removes the napkin as he grabs a large syringe from the tray. With no preamble, no wait, no discussion, he grabs my penis and inserts the syringe. The ampule, the part with the medicine, is huge. He squirts all of it into my penis, right into the urethra. Without pausing, he clamps a clamp around the

base of my unit and starts feeding a thin tube into me. He finally speaks, "You can watch on TV if you want."

I am here because of pain when I urinate, frequency of urination and a severe inability to urinate. Everything down there hurts and hurts a lot. The tube going into me hurts like crazy. The idea of it hurts even more—the anxiety is not helping.

The way it works is this: the camera is equipped with a tube that lets water flow through it. This is hooked up to an IV bag, and the doctor controls the amount of water with the base of the tube. Generally, as I understand it, the doctor just lets it flow—more water means more lubrication. For me, the pressure is immensely painful. As the camera breached the sphincter and enters the bladder, my bladder goes from not that full to FULL in an instant. I immediately begin to cramp with the pain, pulling my legs up slightly. I moan with it.

The doctor ignores me and just stares at the screen, where my bladder is on display. He is in there for what feels like hours before he pinches off a piece of the bladder wall (doing a biopsy) and says, "You might have just felt a pinch, it's not a big deal." It was more than a pinch, but that does not matter—at this point, nothing I feel matters to anyone but me.

He takes another biopsy, and then pulls the camera out. I am full to bursting, in massive pain, and cramping as badly as I ever have. Cramping is the only word I know, but seems *less* somehow. My midsection contracts painfully, and it gets worse and worse until I can pee—the only relief. The worse it gets, the harder it is to pee. The harder it is to pee, the worse it gets.

He grabs a metal container, basically a bucket, and shoves it into my hands. "Pee in that," he says. I know immediately that there is no way this is going to happen. If I was alone in this room, I could not pee, not like this. I am restrained by the shackles, and the fact that the black box digs directly into my bladder means nothing to anyone. The pain is so intense, the cramping so severe, there is no way. Without the restraints, on a toilet, by myself, it

would take me minutes to get this out of me. In this room, with everyone now staring, no way.

I tell him there is no way I can pee, and after he tells me to try again, he finally relents. They send me into another room, where there is a high chair (like one for a little kid) that the bucket goes under. I am expected to pee here, with the officer and a nurse watching. Again, no way.

I am taken back into the room, and I ask if they can drain me somehow, explaining that this hurts SO MUCH. No, the doctor will not do that. "You need to pee," he explains, so that he knows it still works.

It does not. I am not able to pee, not even as they run others through the room. I am not able to pee for the hour or so that I sit in the office waiting for that to happen. I am not able to pee until we finally get back to the prison—at least two hours later. Understand that I can barely walk minutes later, can barely keep from screaming with the pain. No one cared, no one cares.

The fact that no one cared is the entire problem, I was just another procedure in an afternoon of procedures. The doctor did not care about the fact that I was in pain, that I was hurting. He, honestly, was a terrible doctor. A few simple things could have made it so much easier. Had he spoken to me beforehand, talked me through everything that was going to happen, I could have saved us both a bunch of trouble. I could have told him how much it would hurt, and how impossible peeing would be at that point—for a variety of reasons. If he had simply used something like the teachback method, my life would have been so much better. He did not really communicate at all.

When a provider fails in so many ways it is obviously wrong. I hoped that this was simply because I was in prison, an inmate, and those connotations led to lack of care. I have been told by many free people that that is not the case—this sort of treatment is common.

Sad, I always thought being a doctor was pretty cool. Something to aspire to. Fixing people is a lot more rewarding (if you care) than turning a wrench.

You'd think, right?

PART II

Performance Scripts

Building resilience Stories: Actual vs ideal scenes

Jimmie Gilmer

Part I: A bad example

Narrator: Jimmie was dyslexic when he was younger, but they didn't call it that then. In general, one was labeled either slow or retarded. Imagine how these one-dimensional labels made the subject feel? Jimmie's father, Frank didn't help by scolding him for his not-so-perfect efforts to read.

[Jimmie and Frank, Jimmie's father, riding down the street in the car]

FRANK: Son, what's that sign coming up say?

JIMMIE: Sttt…ssssis...sttttt...

FRANK: Say it, boy! What the heck's wrong with you?

[At that point, Jimmie stopped talking to his father for three years. Jimmie had begun to internalize his feelings, seeking avoidance as a coping mechanism.]

Narrator: Jimmie's father did much more harm than good by chiding and shaming Jimmie. When we make others feel stupid, or otherwise inadequate, they often take on those roles, believing the lie. This type of treatment often leads to life-long self-esteem issues that plague them for life. They can become "people pleasers," who make poor decisions to make others happy, rather than thinking for themselves. As a result, they are often cheated from reaching their fullest potential, and then everyone loses.

Part II: A Good Example

Narrator: It should be remembered that it is encouragement and support that motivates people, not shaming and scolding. Everyone is different; and we all learn differently, at a different pace, and through different mediums. We must teach with compassion, allowing the individual to be themselves, and learn in a way that is

most conducive to their long-term health. Some people are slower than the "normal" milestones of others, but are still exceptional in their own unique ways. Jimmie is now a thriving Cal State LA student.

[Jimmie and Frank ride down the street in the car.]

FRANK: Son, what's that sign coming up say?

JIMMIE: Stttt…ssssis…sttttt...

FRANK: Take your time, Jimmie. I got you. Take your time, I believe in you, son.

[At that point, Jimmie stops and concentrates. He is encouraged by his father's support and wants to show his father that he can do it.]

JIMMIE: It says “stop”! “Stop”!

Narrator: Frank's support motivated Jimmie to push through until he got it, and indeed, Jimmie got it.

Rising on affirmations

James Heard, Duncan Martinez, Dortell Williams,

Narrator: This script is designed to demonstrate the power of positive affirmations in our lives and how they can be used as a source of resiliency when negative assertions are made against us, or when we tend to be our own worst critic.

[Fourteen-year-old Eric Sandoval is standing in the hallway of his high school when he sees his soccer coach, Mr. Alfred Malveney, walking swiftly toward him. Malveney has a reputation of being mean, aggressive and abusive. Eric feels his body tense up as he notes Malveney approaching.]

MALVENEY: You stupid punk, why didn't you cover your man? You cost us the game!

[Eric mentally shrinks to the floor as Malveney yells and points at him. Malveney storms off. Actor should shrivel down slowly to the floor.]

Narrator: Tracey MacKhintosh, Eric's English teacher, walks by Eric in the shadow of Mr. Malveney. She is oblivious to the abuse Eric has just suffered.

MacKhintosh: Hi, Eric! You did great on your test. Your superb writing ability is going to take you to wonderful places in the world.

[Eric ponders in his head for a moment. He considers the positive affirmations he has heard from others in the recent past. Actor should voice the following:]

ERIC'S MOM: You're such a good little man, Eric; so talented. I appreciate your art, your respect for others and your generosity. The world needs more people like you, son!

ERIC'S BROTHER, TOM: Bro, when you were playing soccer yesterday, I was cheering for you and three girls came up to me and asked me for your hook up. They think you're hot. Obviously, you got swag, bro!

ERIC'S FRIEND, JACK: I appreciate your help with my homework, Eric. You're really smart.

Narrator: As the words of those close to Eric resonate, he finds strength in their comments.

[Eric slowly rises as Mr. Malveney's words melt off of him.]

ERIC: Forget Mr. Malveney. Yeah, we lost that game, but what about my last three winning games? I'm not stupid. I am a good person, and I am a smart person.

Narrator: Eric was able to quickly bounce back from the helpless feelings he experienced as Mr. Malveney tried to tear him down. This is called resiliency.

Reality Check

Tin Nguyen

Narrator: Two fifteen-year-olds ventured into a café where known gang members hang out. They sat at a table, ordered some drinks and food. They then began to boast that they were no longer boys but men, and had a reality check, a taste of the real world.

(Tin and Can excitedly talk and take all their surroundings in—music, crowd, and women.)

Waitress comes to the table and places two glasses of milk: "You boys enjoy the milk."

(Tin and Can are offended.)

Can (mean mugging): "What the F! Take this s**t out of here!"

Tin (also mean mugging the Waitress added): "B**ch!"

(The Waitress rolls her eyes and takes the milk back to the kitchen. While Can and Tin mean mug everyone who laughs. The boyfriend approaches, and both Can and Tin jump up. The boyfriend pulls out a gun and shoots twice. One at Can's heart, and the other toward Tin, he then runs off. Can and Tin fall to the ground. There is silence as Tin checks himself and goes to Can, lying there, dying. Tin holds Can in his arms.)

(Tin recites the poem.)

On the ground in bloody shirt,

Watching my best friend die without a good-bye.

Listening to his dying breath,

Forever echoing in my heart, it'll be kept.

As his young face turned blue,

I prayed that this nightmare was not true.

(Tin raps.)

O' Fools keep on Slipping, Slipping, Slipping.

Never again, 'cause fool I'm not,

Mess with me, you're going to get got.

I joined a gang, and started to bang,

Got a gat and some prison tats.

Earned my bones, while my heart turned to stone.

Loved by few, hated by most,

But respected by all.

A monster you call me, so a monster I shall be.

Rage! Rage! Rage!

(As Tin ends, he slowly turns to face the wall, and places a "Smile Now" mask on, breathing heavily. Another actor, playing an older version of Tin, approaches Young Tin.)

Older Tin: Tin, turn around.

Young Tin: I don't go by Tin. I go by P24706.

Older Tin: Please, turn around.

(Young Tin finally does and is surprised.)

Young Tin: Dad?

Older Tin (smile): No, I'm you—at 46. Please, sit. (They do) Tell me, why are you so angry?

Young Tin: Where do you want me to begin? At 8? 15? 17? Etc.?

Older Tin: Let's start at 15.

Young Tin: Man, it's bulls**t. We were kids, just kids wanting to be men. We didn't even have our driver's license yet, and they shot at us. They killed him; they killed Can; **I killed Can!**

Older Tin: Why did you say, you killed Can?

(Behind the mask Young Tin sniffles.)

Young Tin (a long pause): If I didn't call the waitress a b**ch, her boyfriend wouldn't have shot at us.

Older Tin: Tin, look at me, and please take off your mask.

(Young Tin sniffles and turns his face away.)

Young Tin: I don't want you to see me cry.

(Slowly, older Tin turns young Tin's face back, and delicately removes the "Smile Now" mask.)

Older Tin: Reality check, it's not your fault, and boys do cry.

Notes: I dealt with a significant trauma that had a violent ripple effect by writing a creative nonfiction. I was able to realize that it was not my fault for the shooter's action, and it is okay to grieve for my best friend.

Teacup: Rituals of Grief

Adapted from "Let Me Down Easy" by Anna Deavere Smith

"For Us The Living:

Some Traditional Practices to Soothe the Minds of the Living."

Terry Don Evans

Almost every culture on this planet has a tradition in which they acknowledge members of their culture that have 'given up the ghost'. The Ghost being the force (spiritual energy) within living things that infuses and animates the physical body to constitute the actualization of living entities.

Jarold A. Walton:

Certain tribes in Africa have a practice of visiting the graves of their ancestors and pouring 'spirits' out on the graves to honor their ancestors. This practice morphs, in America and other parts of the urban Western world, to 'pouring out a portion of

liquid libations on the ground "in memory of those (close associates) who cannot be here (because they are dead) 'R.I.P.'"

Jesse Crespin:

There is also "El Dia de los Muertos" (The Day of the Dead), a practice that honors those who have passed away. This Day of the Dead is a Mexican and South American cultural practice that mirrors "Halloween" in America.

Robert Mosley:

Three of the Qur'anic admonitions used to soothe the human mind (of the believers) are:

"And never think of those who have been killed in the cause of **THE GOD** (Allah - God Almighty) as dead. Rather, they are alive with their Lord, receiving provision.

"And say not of those who are slain in the way of **THE GOD** (Allah - God Almighty) that 'They are dead'. Nay, they are living, though you perceive (it) not.

"There will be circulated among them a cup from a flowing spring."

Optional reading (actor 4):

Arabic Phonetic rendition

Wa Laa Tahsabenna Al la beena quteluuu fee sabeel Allah, am waataa baa bal ah yaa-u-endaa Rabbehem yurzaquun.

Wa Laa ta quluu lemanee yuqtalu fee sabeel lahee, am waa tub al ah yaa-u wa laaken la ta sha-u-ruun.

Yutaafu Alay hem Bekaasem mem-ma-een.

Terry Don Evans

The Buddhists of Tibet are taught to prepare for death during every moment of life. They think of death, though not in a morbid way, all the time. This in turn gives greater richness to every moment of life.

Jarold A. Walton:

Before a Buddhist practitioner goes to sleep, they turn their teacup upside-down next to their sleeping location. Upon awakening, the cup is turned right-side-up to receive the blessings of the day. The tea ceremony is one of the traditional ceremonies of blessings in the Buddhist traditions.

Robert Mosley:

In the evening, when someone has died in Tibet, as the tradition of the tea ceremony takes place, you put their teacup upside down, never to set that person's cup right side up again. If there was any tea in the cup, it is poured into the palm of the hand that turns the cup, signifying the fleeting fluidity of life in this world.

Jesse Crespin (actor 3 leads, others join in):

(While sitting around a table with five place settings – representing the Tea Ceremony. Actor 34 pours out each cup of Tea. Then he takes the cup to the empty seat (the one that cannot be there) and pours out the contents through his palm and fingers.

After reflecting a moment, Actors 3 places the cup down on the table up-side-down. Then all four of the other people present raise their cups and drink the contents.)

End

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Part III
Research proposal & autoethnography

Stress and resilience: College students during emerging adulthood (research proposal)

Terry Bell, Samual Nathaniel Brown, Thaisan Nguon, Larry Torres, and Dara Yin

This paper was prepared for COMM3300: Methods of Communication: Social Science, taught by Dr. Mu Wu)

Introduction

College education is important and it is necessary for college students to adequately perform their duties. Although all professors have been in the shoes of college students, as time passes, circumstances change, and some events become a blur within the mind. We chose this topic to raise the awareness of professors, students, and administration of the stress that college students endure throughout their journey of education.

Stress is a huge contributor towards bad health. Often, our ability to effectively cope with stress or recognize stress within ourselves is absent. Drugs, suicide, and other unhealthy behaviors can be the result of stress, which makes this topic significant. Education can't be acquired without a clear-headed student, or for that matter, a breathing student. Recognizing the problem is the start of resolving the problem. Through this proposed project, students could be more aware and proactive. Also, professors and administration could be more mindful and help decrease stress levels of college students through empathy.

As college students of Cal State Los Angeles cohort 2, we genuinely understand the detriments of stress through experience and observation. As Cal State LA students, we feel obligated to

highlight stress so that our fellow Golden Eagles can obtain the maximal education.

Emerging Adulthood

Denise Solomon and Jennifer Theiss (2013) state that:

"Our self-concept evolves throughout our lives, but changes we experience are especially striking in the period from adolescence to adulthood (around ages 18 to 25) known as emerging adulthood. During this time of life, people in our society are often less constrained by their families and not yet burdened by the responsibilities of adulthood (Arnett, 2000). This relative freedom allows emerging adults to explore a variety of identities before settling on the relationships, jobs, and worldviews that will define their adulthood. This is also a tumultuous phase of life. One study found that college students who believe that they haven't reached adulthood engage in more risky behavior, like illegal drug use or drunk driving, and experience more depression than students who consider themselves to be adults" (Nelson & Barry, 2005 p. 88).

Stress

Stress has been defined as "a state of anxiety produced when events and responsibilities exceed one's coping abilities" (Seaward, 2018). There are also physiological definitions of stress which in combination with others have informed the psychoneuroimmunological (PNI) approach. PNI, as defined by Pelletier (1988), is the study of the intricate interaction of consciousness (psycho), brain and central nervous system (neuro), and the body's defense against external infection and internal aberrant cell division (immunology). PNI is in the field of holistic medicine which defines stress as the inability to cope with a perceived (real or imagined) threats to one's mental, physical, emotional, and spiritual well-being, which results in a series of

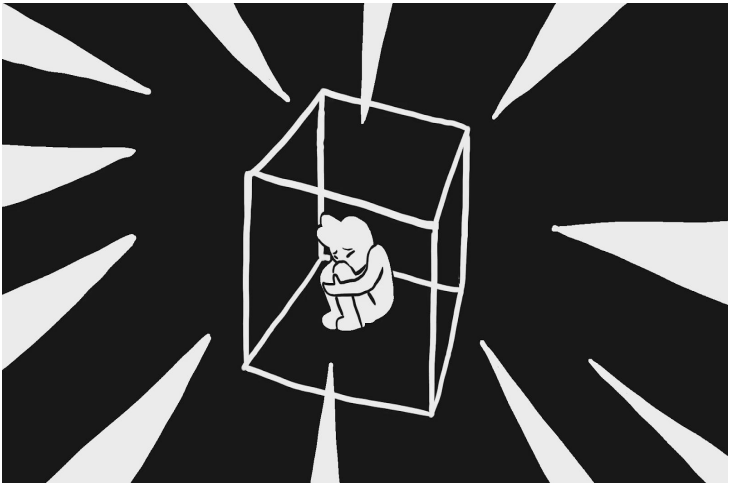
physiological responses and adaptations (Chopra, 2000; Dossey, 2004, as cited in Seaward, 2018).

Stress is a significant factor during college. Seaward (2018) describes the college experience as a transition from a period of dependence to independence. Some of the common stressors that college students encounter include: roommate dynamics, professional pursuits, academic deadlines (exams, paper, and projects), financial aid and school loans, budgeting money, lifestyle behaviors, peer groups and peer pressure, drugs and alcohol, exploring sexuality, friendships, intimate relationships, and starting a professional career path.

Resilience

An informational pamphlet provided by the community *Sustaining Futures* cites that the American Psychological Association defines resilience as adapting well in the face of adversity, trauma, tragedy, threats, or even significant sources of stress. They also cite Bonanno, Westphal, Mancini (2011), who describe resilience as a stable trajectory of healthy functioning after a highly adverse event. Sustaining Futures lists the characteristics of resilience in individuals as follows:

> "Resilient individuals are flexible, accept that adversity happens, have realistic expectations and optimistic thinking, maintain appropriate professional boundaries, use problem focused or emotion focused coping, focus on what is going right, have confidence they can cope, seek social support, and are attentive to people, places, and things that may adversely affect their emotional and physical well-being" (Sustaining Futures 2019).



Literature Review

Melinda J. Ickes, Joanne Brown, Brandy Reeves, and Pierre Martin D. Zephyr (2015) examined the differences between undergraduate and graduate college students in respect to stress and their coping strategies. The aim of the study was to: (1) determine differences in stress levels among undergraduate and graduate college students; (2) determine differences in coping strategies among undergraduate and graduate college students (p.15). The study surveyed a random sample of 1,139 college students at the authors' institution (University of Kentucky) and found that almost 80% of the participants reported moderate levels of stress or higher.

Despite finding no significant difference between undergraduate and graduate college students regarding levels of stress, there were some very interesting discoveries in the realm of coping strategies. The study found that regardless of academic classification, the top three strategies among responding participants were sleep (69.6%), exercise (66.1), and food (56.8%). The study was able to identify five coping strategies (out of a list of twenty) that possessed significant differences between undergraduate and graduate students. These coping strategies were: cigarettes/tobacco (p<

0.001), drugs (p= 0.04), exercise (p= 0.001), pets (p= 0.007), and social support (p= 0.002). The study revealed that, "Undergraduate students were significantly more likely to use cigarettes/tobacco and drugs whereas graduate students were significantly more likely to use exercise, pets, and social support" (p.17) as coping strategies.

Interestingly enough, a CART analysis showed that social support was the most important variable to best explain differences between undergraduate and graduate students. Some 505 students reported using social support as a coping strategy and well over half of them were female. There was a large emphasis in this study on promoting the application of social support as a coping strategy to all students because of its impact on stress levels, well-being, overall life satisfaction and happiness (Chao, 2012; Cohen et al., 1983; Lundberg, McIntire, & Creasmen, 2008).

In order to paint a clearer picture of what undergraduate and graduate students face in terms of stress, the authors could have asked about sources of stress as they surveyed levels of stress from their participants. This could help identify what contributes to the differences in stress levels and which coping strategies would best be suited to address certain situations.

Dr. Ahmad M. Thawabieh and Dr. Lama M. Qaisy (2012) conducted a study at Tafila Technical University to assess the level of stress and its sources in the student body. The study aimed to answer the following questions: (1) What is the level of stress the university students have? (2) What are the factors associated with students' stress? (3) Are there any statistically significant differences […] in the stress level attributed to gender, college, student cumulative average (C.A.), income, and Students Study Level (S.S.L.)? The study found that a moderate level of stress existed and that *social, academic,* and *physical* factors played a role in that stress. Interestingly, the mean stress level score of social factors scored highest followed by academic, and then physical factors. In so many words, Thawabieh and Qaisy (2012)

suggest that mean stress level score for social factors are highest due to—among other things—the traditionally conservative social life that exists in the community and separation issues between students and their respective families (p. 116).

Dana Balsink Kreig (2013) conducted a longitudinal study to compare students' expectations and experiences of college and examined the relationship between violated expectations and stress (p.635). The author predicted that violated expectations would be associated with higher stress (p.637). The study observed expectations and experiences of four domains (Academic, Family, Social, and College) across three timelines.

The first timeline surveyed ninety-nine incoming first year college students during the summer prior to matriculation to measure levels of expectations. The second timeline surveyed the same group of students during the fall semester of the first year to measure levels of experiences (66 students participated). The third timeline surveyed the same group of students during the fall semester of the senior year to measure levels of experiences (36 students participated). The data in the study suggested that, "when the academic and social experiences were worse than expected, students reported an associated increase in stress" (p.641). This is what Kreig (2013) called violated expectations and predicted that more symptoms of stress would be reported when this phenomenon occurred.

However, it is important to note that a violated expectation of the family domain garnered no such increase in levels of stress. In fact, the study suggested that senior students were associated with higher levels of stress when they lacked involvement with their family (e.g. parents). An interpretation of this data can be that with the right manipulation, the family domain can serve as a stress mediator, if not coping strategy.

The four domains are also sources of stress and if the study was able to reveal the duality of the family domain then there should be no restrictions on the other three as researchers of this topic search

for solutions in stress reduction. Sometimes, the best way to change how people react to certain things is to change the meaning of those things.

Misra, Crist, and Burant (2003) conducted a cross-sectional survey of international students at two mid-western universities in the United States. The purpose of their study was to find direct and indirect relationships between life stressors, academic stressors, perceived social support, and reactions to stressors. They further hypothesized that social support would reduce stress.

Stressors and the Stress Process

In the study Misra, Crist, and Burant (2003) conducted a study utilizing 143 interactional students that focused primarily on four constructs: life stress (primary stressor), academic stressor (secondary stressor), perceived social support (stress mediator), and reactions to stress (stress outcomes). They employed Thoits' (1995) specifications of the three major conceptual domains of the stress process: stressors, stress mediators, and stress outcomes. Stressors were defined as environmental, social, or internal demands that caused an individual to adjust their behavior. Misra et al. (2003) also incorporated Pearlin (1989) in defining stressors and their dynamic, identifying three types of stressors: life events, chronic strains, and daily hassles (Misra, Crist, and Burant, 2005).

The interplay of stressors in the stress process is described as one in which one stressor triggers another, in some cases resulting in the development of a cluster of stressors (Thoits, 1995; Pearlin, 1989; as cited in Misra et al., 2003). Misra et al,. (2003) refer to Pearlin (1989) again to emphasize the importance of understanding the full array of stressors in an individual's life, stating how a failure to do so results in a misleading or incomplete inquiry (Misra et al., 2003).

Social Support

Misra et al. (2003) describe social support as a mediator of stress. According to Mallinckrodt and Leong (1992) social support provides a powerful coping resource for students experiencing stressful life changes. They further explain, using Dunkel-Schetter and Bennett (1990) along with Wethington and Kessler (1986), that the perception of social support has a stronger influence on mental health than the actual receipt of social support (Misra et al., 2003). In a sense, social support may not be enough to mediate stress if one does not believe it to be an available resource. The second implication is if a person believes they have social support, but it is not available, then they may still benefit from the outlook alone.

The results of the study supported the hypothesis that life stress would predict academic stressors and reactions to stressors. The outcome agrees with their description of the stress process. The problem with the description is that the categories may overlap. If it is true how stressors may develop into clusters, then it may not be clear as to what the primary and secondary stressors are. Individuals may be subjective in their perceptions and priorities therefore making it difficult to delineate primary and secondary stressors. In some cases, a secondary stressor could occur simultaneously with a primary stressor. In cases where this happens, the placing of a stressor in any category is subjective. It may well be that stressors function more like a cluster than a domino effect-like process.

Stress factors in adolescent community college students

Ahern and Norris (2011) studied the factors that increase and decrease stress in adolescent community college students. They used a self-administered questionnaire for the purpose of determining what factors decrease stress in adolescent college students. Ahern and Norris predicted that women would report a higher level of stress than men, and that resilience and other protective factors would be associated with decreased stress (Ahern, & Norris, 2011).

Citing Miller, Pope, and Steinman (2005), Ahern and Norris discuss how adolescence is considered a turbulent time of developmental stress. Adolescents experience developmental challenges during this life phase which can be complicated by the stresses of attending college (Ahern, & Norris, 2011)

According to Ahern and Norris (2011), the "American College Health Association (ACHA) National College Health Assessment" for 2009 indicated that students (N=80,121) ranked stress as the "highest health impediment" at 33.9%. The data also demonstrated that at least once in the past school year students felt hopeless (62.1%), overwhelmed (983.6% sic), exhausted (91.8%), sad (78.8%), and depressed (43%). Findings also reported how students had seriously considered or attempted suicide (9.0%) (Ahern, & Norris, 2011).

Rutter (1985) describes protective factors as those factors that could modify, ameliorate, or alter a person's response to some environmental hazard that predisposes a maladaptive outcome.

Resilience is considered a protective factor but, in this study, it was considered separately from the other protective factors.

Financial support was considered a significant protective factor in this study. Ahern and Norris (2011) cite Jackson (1999) stating that financial security during college, whether in the form of financial support and/or income, has been associated with less stress by the students. Studies have shown that college students lacking financial support are more likely to be stressed and have psychological problems (Ahern, & Norris, 2011).

The results of this study indicated mean scores for stress and resilience showing that the samples of students were moderately stressed and moderately resilient. The first hypothesis was not supported because males reported a higher level of stress than females. Findings also showed that the protective factors other than resilience had little impact on stress.

It is important to note that participants in this study were predominantly male (59.6%) and Caucasian (77.6%). The sample in this study is not generalizable to the wider population. Whether intended or not, because of the use of a predominantly white male sample, this study is biased. It reflects a longstanding and problematic tendency of marginalizing women and minorities in quantitative research.

Hypothesis

The proposed independent variable would be the students' grade level whether freshman, sophomore, junior, or senior. The dependent variable would be the overall level of stress of the students. The mediating variables would include social support (e.g., family, friends, significant other), and the student's financial stability. We propose there would be a relationship between student's ability to cope with stress and the successful navigation of their academic careers.

Proposed Methods

Sample

An ideal collection of study participants would be a convenient sample and survey of students 18-24 years old who attend California State University, Los Angeles located in Los Angeles, California. Additional criteria for study participation would include **(a)** enrolled and present in the general education class on day of data collection, **(b)** 18-24 years old, **(c)** able to read and write in English, and **(d)** physically able to complete surveys.

Variables

This study would include demographic variables and the study variables of physical health, mental health, emotional well-being, financial support, extracurricular activities, and stress.

List of Proposed Variables

Demographic: Participants would be asked to complete questions related to age, gender, race/ethnicity, grade point average (G.P.A), class (freshman, sophomore, junior, senior), and living situation.

Financial Support: Participants would be asked to indicate whether they received financial support from school.

Physical Health: Participants would be asked in general "How do you rate your physical health?" The feeling will be measured using a 5-point Likert scale ranging from 1 (Not well at all) to 5 (Extremely well).

Mental Health: Participants would be asked in general, "How do you rate your mental health?" The feeling would be measured using a 5-point Likert scale ranging from 1 (Not well at all) to 5 (Extremely well).

Emotional Wellbeing: Participants would be asked in general, "How do you rate your emotional wellbeing?" The feeling

would be measured using a 5-point Likert scale ranging from 1 (Not well at all) to 5 (Extremely well).

Stress: Participants would be asked to indicate the degree to which they experience stress on a daily basis, using a 5-point Likert scale ranging from 1 (Very little stress) to 5 (A lot of stress).

Procedures

Ethical approval, including waiver of informed consent, would be obtained from both the institutional review board of the University (IRB) and the University's administration prior to data collection. The explanation of the study and the study questionnaires would be distributed during general education daytime classes. Upon entry into the classroom, the potential participants who met the study criteria would be given an explanation of the study. Potential participants would be informed that by completing the study materials, they were agreeing to participate. Students who consented to participate would complete the study materials at that time. After the study materials were completed (about 10 minutes), they would be collected by the primary investigator (first author). No identifying personal information would be collected as a part of the proposed study.

Data Analysis

The descriptive statistics for demographic characteristics and study variables would be computed, and correlational analyses would be conducted to assess interrelationships among study variables.

Discussion

We estimate that the results would indicate that university students have an increased level of stress correlated with academic stress factors. This assumed finding is supported by other research indicating the same, when the academic and social experience was worse or more challenging than expected, students reported an increase in stress (Kreig, 2013).

We expect that students would vary in stress levels and what the causes of the varying stress levels would be. Specifically, we imagine that all students would report dealing with the stress that accompanies balancing being a college student with emerging into adulthood. However, we anticipate that stress scores would be lower for seniors and higher for freshman. The reasoning is that the longer students spend in college the more accustomed they would become to dealing with stress and deploying coping strategies. The first year myth (Stern, 1966) has grown less dramatic due to increased sources of information about college life. Nevertheless, because we have no source of data, we can only speculate.

Limitations of the current study

Other than the obvious lack of data and ability to conduct this study, we also acknowledge that this proposed study would be conducted at a very liberal public university and would be limited to a very small convenient sample. There is predominance of Hispanic and female students in the potential sample pool. We understand that it would be useful to draw from a non-convenient sample spanning more than one university and indicative of a sample not so populated by one ethnic/racial group.

Conclusion

College students emerging into adulthood experience increased levels of stress when they did not feel they were functioning optimally with their academics. Based on the studies we referred to for this proposal, we assume that there will be variances in stress levels based on ethnicity, financial situations, and other factors we would explore through this study. Unfortunately, because we do not have access the conducting this study, we cannot know how much these factors would ultimately affect the outcome. However, based on the studies we referred to, social support—so long as it comes from a healthy source and is recognized by the student as healthy—seems to promote stronger coping skills in the students, thereby decreasing stress and increasing wellbeing. Even though we are not able to conduct this

study, we feel confident that it would continue to emphasize and support increased interaction between students and their loved ones/support systems.

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The framework of memorable messages

Dortell Williams

ABSTRACT

This ethnographic paper examines the formative communications I received and interpreted as a youth, and how these communications influenced decisions I made as a youth and emerging adult. The framework under which I will make this examination will be memorable messages (Knapp, Stohl and Rearoon, 1961). This framework posits that "when we share our thoughts with others, they are often unknowingly affixed to the memories of past events, and so the cycle continues" (Tilley, 2001). This seminal work of Knapp et al., is usually interrogated in positive messaging and the potential effect that such messaging has on their receivers. In this paper, I will examine the framework of memorable messaging in the context of lived experience from a negative perspective, and the harm that negative messaging can generate.

Throughout our lives we are inundated with many types of messages, some positive and some negative. The positive messages we receive as children and on throughout our lives can help us build resiliency for those counter messages that may sink in and cut, or perhaps, burrow within subtly and direct us unconsciously. The work of Knapp Stohl and Rearoon (1961) advances the idea that messages we receive throughout our lives, particularly from authority figures as youth can guide, protect and even inspire. However, there seems to be no inspection as to what effects we might suffer if the majority of memorable messages we receive are negative and deconstructive.

The negative messages and their effects are the rubric for which I will critically view the construct of memorable messages. I will use my own lived experience as context to test this construct of Knapp at all. Based on my own experience, I advance the view that memorable messages can deconstruct a receiver as well as construct a receiver. Context is paramount here, either in a positive context or negative. My experiences were negative and thus, deconstructive.

I was raised in a dysfunctional household where communications were abusive. I was called names like stupid; told I would not be worth anything; told I would be "just like [my] father," who was irresponsible, suffered from substance abuse disorder and was a chronic womanizer. My interpretation of the labeling and prognostications were that they were my fate; I could do little to avoid them. I assumed inheritance was a "controlling" factor. Nevertheless, I strove against the negative labels and predictions as best I could with what I had. Yet, striving alone, with no counter balance to these negative messages, or direct guidance as to how to avoid them, stacked the odds against me. I recall many times when I did well and was praised for my efforts, but as it turned out, it was the negative messages that had the most effect. Imagination and interpretation played their role in the negative messaging I received.

Like most children, I was a curious soul. I asked many questions, and more often than not, those questions were met with dismissals. For instance: "Mom. why did they shoot that man like that?" My mom's response was usually something like, "I don't know. Don't worry about it." Likewise, with my dad: "Dad, why did the police steal your motorcycle?" To which he would reply, "Because they are crooks!" This communication avoidance left me to my own imaginative devices. Thus, I created my own interpretations as to why people mistreat and kill other people. I assumed that it is a dog-eat-dog world, and to survive one must be ruthless. The ensuing violence I witnessed in my heme, in the

Neighborhood, on television, and at school only reinforced my interpretations. My summation of the police (all police and authority figures) being "crooks" is that they shouldn't be trusted, a conjecture that fits neatly into my larger interpretation of the dog-eat-dog world.

In addition to receiving many negative messages within the family. I also received a series of negative messages outside the home. One in particular manifested as I was approaching high school graduation. At that critical fork in the road, I approached my counselor about college prospects. After quickly reviewing my file, he noted my 2.85 GPA and that I was a class clown (seeking

either attention or to be meaningfully challenged). The counselor concluded

that I was "not college material." At that point, I made the decision to join the emerging crack cocaine trade. As a result, I ended up fulfilling all of the negative suppositions foretold of my life, culminating with a life sentence in prison. Ironically, it was in prison that I finally received the

attention I was seeking ---- but from other prisoners —- and was actually challenged beyond my boredom. It was in prison that I was able to earn my way to the Cal State LA BA prison program where I maintain a 3.9 GPA. The literary review contextualizes my assumptions that negative memorable messages can indeed be equally as destructive as positive memorable messages can be constructive.

According to the Memorable Messages construct, individuals receive innumerable messages throughout their lives, yet "there seems to be a few periods of time in which people perceive as a major influence [these messages in] the course of their lives" (Knapp, et a1., 1981, p. 27). Knapp et al., assume that the most influential messages are "typically brief; the recipients perceive themselves to be the sole target of the message, and the messages often conform to simple rule structure, for example, id-when. Exactly what was said is not important. Therefore, what is

paramount is the interpretation of the message by the receiver. According to Gidden (1979) and his definition of Structuration Theory, there are three primary concepts in social theory: 1. practices or "observable patterns of activity that are meaningful to their participants…"; 2. systems, or types of practices that build and maintain relations among, and between groups," and 3. structure, which refers to the rules and resources that communicators utilize as they take part in system practices (Lindlof et a1., 2019, p. 65). In America our structure of communication contains both connotative and denotative expressions. While denotative is overt and more precise in meaning, the connotative expression can lead to confusion as the receiver is left to interpret the exact mind of the source.

The second tenet of Structuration Theory also has three prongs; The first being that of meaning, which happens when one person interprets another person's expression by attaching a particular interpretation and action. Lindlof offers the following Hollywood action film exchange: "Was that a

threat?" "No. That was a promise." Here the meaning is nuanced and the interpretation has a potential for duality, confusion. The second dynamic of this three-prong process of Structuration Theory is power. Power is the primary influence when the source of the message is from a person in a position of authority. The final tenet are norms, which stem from the source's legitimacy, for example, their moral appropriateness (Lindlof, 2019, p. 66). Again, interpretation is king.

According to Knapp et al., regardless of how the receiver constructs or recalls the message, the most important aspect of the memorable nature of messages is how the message is "perceived," according to the receiver's current social and emotional needs (p. 36).

The reason why people remember certain messages and perceive them as more important than others is an elusive phenomena. Whatever the reasons for which particular messages remain as

memories, they have consistent components: 1. The messages are typically brief: 2. they are remembered for long periods, particularly if they comport to one's needs or belief system; 3. the receiver believes they are the sole target of the message, 4. the message often conforms to simple rules, and 5. usually the recipients were requested to participate in forming the message (Knapp, et a1. 1981, pp. 27—41). ‘

Crook and Daly (2012) argue that message interpretation has health consequences (p. 2). It is important to identify the characteristics and context of the message itself (Thoits, 1995), for example the source, valence. etc. These assumptions lead me to the following questions:

1. Can negative Memorable Messages deconstruct a person's psyche?
2. Can negative Memorable Messages from others lead to self-destructive behavior that becomes an imposed prophecy on others?

My lived experience concurs with the construct or Memorable Messages, but inversely. Rather than influencing my thoughts and actions in a productive manner, as positive Memorable Messages are assumed to do (Knapp et al,. 1981, p. 27), my life was unraveled by the effects of negative Memorable Messages imposed on me by authority figures in my young life.

As Knapp et al. (1981, p. 27) predicts, these negative Memorable Messages had a profound influence on my cognitive process, my self-concept and my ensuing behavior -- in both instant and future actions. As assumed in the literature, the form of these messages was, indeed brief and structured: "Are you stupid? (connotative). "You are stupid," "You aren’t college material," (denotative). There is no need for a Memorable Message to be a tirade. As predicted by Knapp. et a1 (1981. p. 27) a brief message is enough to permanently attach. Save for the if-when function of the

Memorable Message construct, every other aspect of it applied to my lived experience.

Believing I was the sole recipient of the message, it was natural for me to personalize and internalize the message, as Knapp et al. (1981) assert. Furthering the credibility of the Memorable Message construct, all of the messages I received were delivered by authority figures in my life: my

parents, teachers, my counselor (Lindlof, 2019, p. 66). Furthermore. Gidden (1979, as cited in Lindlof, 2019), who theorized that the "patterns of activity " in delivering messages meaningful to the recipient, are expressed in a system orientation (connotative or denotative), and are structured, such as in rules and resources (paternalistic or authoritative) (p. 66) Whether the message was delivered by my parents, a teacher or my counselor, each had legitimacy in their authority and superior experience than I, thus asserting their ethos. The internalization of these negative Memorable Messages, with little or no counter, resulted in a series or unhealthy outcomes. As a youth, I certainly had no inherent psychological resources to counter these negative memorable messages.

As Crook and Dailey (2012) argue, my cognitive health, that is, my self—esteem and natural pursuit of self-actualization were perverted as a result of negative Memorable Messaging (p. 2). The construct of Memorable Messages fit within the framework of my lived experience like a block in a polygon. And I am not alone.

My lived experience and the effects of negative Memorable Messaging seem to reverberate throughout the adult male prison system. I was able to glean this hypothesis from over 800 hours of facilitating cognitive behavioral therapy classes for my peers. During the course of ten years, I facilitated classes such as victim sensitivity awareness, parenting, and effective communication, among others. During this tenure, the vast majority of personal stories of peer participants hinged on negative Memorable Messages. Based upon my lived experience and observations, I

believe negative Memorable Messages can deconstruct a person's psyche. I also believe that negative Memorable Messages from others can lead to self—destructive behavior that becomes an imposed prophecy on the receiver.

These findings are salient because they allude to a malicious preventable pattern of maladjustment and self-destructive behavior among youth. As a society, we not only desire that our children be safe, and that others be safe in shared environments, but that they grow up to be productive, contributing members of larger society.

My lived experience agrees with almost every tenet of the Memorable construct. Therefore, as a society, we have a choice of which types of Memorable Messages we deliver. As social scientists, we possess a deontological appointment to further examine this construct with a Meta-study that includes women and non—conforming gendered people.

This study was limited to my lived experience, as compared by informal observation of my imprisoned male peers who suffer similar ills as a result of the internalization of negative Memorable Messages. Restricted to an all-male penal institution, I was very limited in scope and liberty to conduct research on a protected class, and as part of that protected class, my research was further restricted. It is thus my hope that a larger study be conducted, appraising the Memorable Message construct, from a toxic perspective and larger more encompassing lens.

The power of group therapy

Allen Burnett

Group therapy has been validated by behavioral scientists as a successful, evidence-based method for healing, problem-solving, personal and collective realignment, and sobriety maintenance, among others. The reason for the success of group therapy is that it fosters self-reflection within a support group of similarly situated individuals who offer testimonials of common tragedies and triumphs that others can learn from and apply to or avoid in their own lives. This validation comes without a professional guide. The absence of a professional guide in group therapy is acceptable because research assumes that the lived experience of the collective makes the individuals within the group the experts.

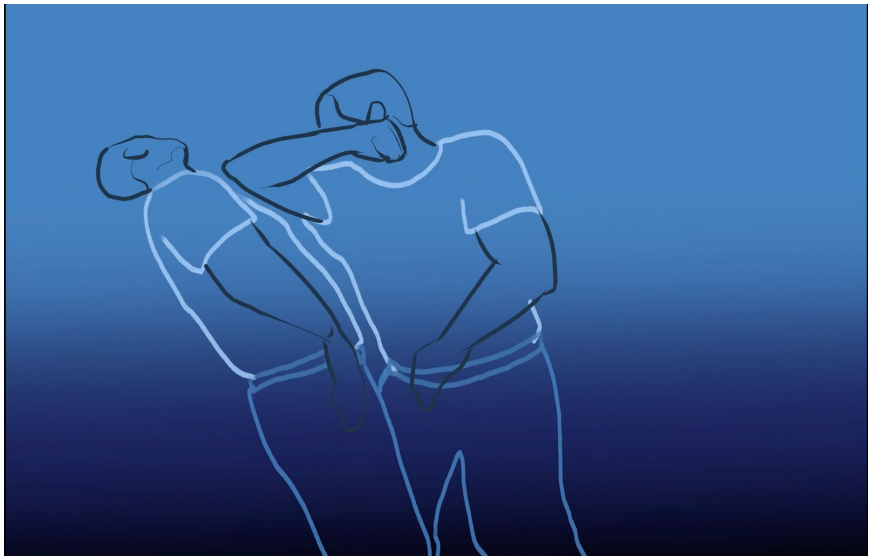
The following exercise is designed to be an impromptu practice therapy session on the topic of microaggressions. Microaggressions are slights: verbal, behavioral, and environmental degradations that cause humiliation and attack self-worth. Microaggressions are hostile or derogatory attitudes

expressed through marginalization, discrimination or negative actions against another who is seen as the "other". They can stem from implicit or explicit bias or ignorance, but result in a feeling of being minimized, categorized or stereotyped by a person of a dominant group.

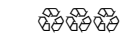
The learning objective for this exercise is to gain a larger understanding of this phenomenon and to expose the commonalities of these experiences in hopes of magnifying a sense of empathy among the group. The first step is to agree on a unique set of rules as to how the group will function and behave. Such as: Will questions be signaled by raising one's hand? Is there an agreement on confidentiality? etc.

Typically, the group sits in a circle to emphasize equality, but again, this arrangement may be voted on by the group. Each person may then introduce themselves and perhaps share a sentence on how they feel, which could begin with the facilitator of the group. Once the circle has made its round, the facilitator will again lead by sharing an experience where they perceived themselves being the subject of a microaggression. Each group member can follow in succession, volunteer or wait to be called on at which time each member should have the right to "pass" (again, the group should decide the process).

At the end of the session, each member should state how they are feeling as a "check out" -- to ensure everyone is emotionally secure. The group can then set a follow up date, mix and mingle or conclude.



Q&A: Random selection of class prompts



What are some of the key differences and key assumptions between scientific and interpretive approaches to conducting research in health communication? Give two examples for how each approach applies to the study of health communication.

Marvin Johnson: [On one hand], the scientific approach to health communication research assumes that the examination of a statistically significant number of cases allows a researcher to make generalizable conclusions to a larger population of subjects. On the other hand, the interpretive approach assumes that: (1) the nature of truth is subjective. (2) Participants may hold multiple and varied meanings they must reconcile in order to communicate or co-construct a shared social reality. (3) Significant meaning situates or contextualizes. (4) The goal of research is to reveal and make understandable the subsisted experiences, and the participants' understanding of their own lives. [More so], the difference is that for the scientific paradigm, the researcher needs a larger sample population and data count to assign a value. In contrast, the interpretive paradigm allows for a smaller number of subjects and allows for a subjective application by the researcher in reference to the principle of boundary and how the phenomena researched exists in the context of the lived experience.

What is naturalism? Is it associated exclusively with an interpretive approach to research? Please explain why or why not.

Daniel Whitlow: Naturalism is a research design that emphasizes and highlights the complex experience contained within a provider-patient communication event. This includes the content of

what is said, the manner in which it is said, the environment where said, and the people involved in the interaction. Consequently, for that reason, even though naturalistic studies use predominately-interpretive approaches, the scientific approach retains an important role.

Darren Robinson: Naturalism is performing research in a normal setting where health care communication takes place. If I want to understand how people really talk during a support group, or talk to providers in a hospital room - a very stressful place - then I need to observe this give and take communicative exchange without intervening or disturbing the natural interaction - my observation as a researcher. Naturalism does not have to apply just too interpretive research. For, I, as well, could observe heaps of interaction and work towards generalizing concepts from many naturalistic observations. The ability to generalize and create larger concepts is the central idea of the scientific perspective. There can be multiple optional methods used in the scientific perspective for research purposes, inclusive of naturalism.

Give an original example to study some aspect of healthcare delivery using a naturalistic approach.

What is an intervention? Are interventions associated exclusively with a scientific approach to research? Please explain why or why not.

James Cain : An additional type of research design for studying patient/provider communication is the intervention research design. The intervention design is scientifically orientated and involves the manipulation of variables for effect. Typically, the social scientific researcher will apply this

style of research to manipulate aspects of communication between the provider and patient to see what affect the manipulation will have on the interaction. Any time a researcher is concerned with the way in which a variable affects another variable; they are

approaching the study of phenomena from a scientifically based perspective.

Marvin Johnson: A researcher uses an intervention in an attempt to determine if a health communication behavior is amenable to modification or not. An example of a scientific intervention in health care communication is the use of Donohew and Palmgreen's Activation Theory of Information Exposure to tailor a health care message to a particular population based on the overall group's

level of sensation seeking (Donohew, et al., 1980). However, interventions do not need to remain

grounded in the scientific perspective. I would argue that narratives are an area ripe for an intervention. For instance, a chaos narrative relating to illness might be subject to an intervention, where the researcher tries to change the subject's constructed worldview. Narrative studies are interpretive in nature - how does the subject see the reality in which he or she lives? However, a researcher might select subjects that produce chaos narratives (where the individuals feel that their lives have spun out of control because of illness) and target these individuals for an intervention with the desired result being a change of the subject's view of his or her reality.

Dortell Williams: During the presentation of Mosley, Walton, Evans and Crespin, it was impressed upon me how the course text, a rather simple text honestly, was actually reiterating the approaches to general research, but in the Health Communication context. Of course, our papers are based upon approaches such as the choice between scientific or interpretive. Rather than given a topic and then asked to design a research paper, the approach of this text is to give us situations or context and to then consider if it is scientific or interpretation. Speaking for myself, this approach caused me to think about the same things trained to consider, but in a different way.

Duncan Martinez: As we look at these topics, one thing paramount is that communication means everything in health

settings. The importance is not one-dimensional, either: everyone has not only needs, but also responsibilities in the arena. We think of doctors and their ability to communicate as key--we think of this as 'bedside manner'. That is only one aspect of true communication. Yes, they have to have an understanding of how to keep their patients at ease. Going deeper, the provider needs to ensure that the patient clearly understands the communication. This is just as true for the patients to ensure that the provider understands what they have to say or express. The patients need to understand that they have a tremendous responsibility in their own health: if they do not say something, they are the ones who will lose. Everyone involved shares responsibility.

Group Interjection

We agree, as quoted in the Reader, the paternalistic model of healthcare is provider directed and hierarchical even though patient care often requires open dialogue among patients, providers, and family members (Jones & Stubbe, 2004). These roles traditionally develop predicated on task-oriented and verbally prevailing discussions between doctor and patient (Graugaard, Holgerson, Edie, & Finst, 2005). There is also the biomedical model that integrates, communication mirrors, the scientific approach converging in hard science, for example, physiology, biochemistry, and genetics - without trepidation whether or not the patient comprehends the issues. This model dominated the 1970s and 1980s ousted only by research that confirmed how patients' psychological, social, and relational physiognomies work - in union with biological matters that form the patients' understandings with disease and sickness. Accordingly, this resulted in the more state-of-the-art bio-psychosocial model of care that defines the patient as a whole person - not just as a set of biological symptoms and test results (Engel, 1980). This clinical interviewing in healthcare approach manifests an opportunity regarding the interpretive approach to medical care based in the constructivist framework (Delia's, 1977), (Health Communication Theory, Method, and Application, 2015). The above-mentioned are

the challenges that the patient faces when communicating with their healthcare provider. We as researchers seek ways to improve the communicative interchange between all involved.

For example, clinical equipoise involving more than one treatment method will allow the patient enhanced information concerning ailment(s) and affliction(s). Additionally, concordance permits patients to experience motivation similar to shared identity orientation - doctor/patient communication. The importance relates to decrease in medical error(s) lessened by the patient's informed ability and knowledge concerning treatment and how it is managed. The patient-centered communication approach reacts directly to the needs and aspirations of the patient and it rotates around three core attributes: (1) consideration of patients' needs, perspectives, and individual experiences (2) provision of opportunities to patients to participate in the care, and (3) enhancement of the provider-patient relationship (Epstein, et al., 2005).

Epilogue

The scientific and interpretive approaches to research concerning provider-patient communication establishes that communication is quantified by high quality scientific research studies that measure behaviors that show that this specific communication process directly impacts healthcare delivery - including quality, safety, and other phenomena. That is tightly fitted measurements can show both direct and indirect effects on health and health outcomes.

Naturalism as it pertains to this subject incorporates the naturalistic research design and seeks to describe settings, occurrences, and interactions in terms of what is said - the content, how it is said - the manner, where it is said - the context, environment, and to whom it is said - the participants. Naturalism is an orientation or method that values investigating the total environment within which the communication and other factors interact all-inclusive.

Subsequently, these components are interrelated; naturalism recognizes that communication occurring between participants is

more than the sum of its individual parts. In naturalistic observation, the observation transpires in the actor's natural environment and behavior is disturbed as little as possible by the observation process; often, the actor is unaware of being observed - participant observation uses audiovisual recording to capture as much detail as possible. For this reason, naturalistic observation is also known as unobtrusive/inconspicuous or non-reactive research so as to emphasize that actors do not react to the presence of the observer (McBurney and White 2007). See also Extraneous Variable/Evidence, Laboratory Research.

Interventions connect exclusively with scientific research since tightly fitted measurements can show both direct and indirect effects on health and health outcomes. Intervention research design methodologically manipulates some aspect of patient-provider communication to see what effect the manipulated variable has on outcomes of the interaction. This is accomplished by use of audiovisual recordings, surveys, or interviews to capture as much detail as necessary. For instance, scientific and interpretive analysis use transcription similarly in that they both predicate measures of behavior ascertainable to show that specific communication processes directly influence healthcare delivery, including quality, safety, and other phenomena. For example, scientific analysis consists of coding frequency and type of talk. Interpretive analysis encompasses coding single cases, collections of cases, or deviant cases for key interactional features. The scientific strategies apply interaction analysis systems to the recorded consultations such as coding frequency and type of talk. The interpretive strategies pertain to transcribing and analyzing the communication. However, a patient must be proficient in health literacy - the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions that may affect their health and the ability of the healthcare system to provide effective high-quality care. It consists of four components: (1) cultural and conceptual knowledge, (2) oral literature, (3) print

literacy, and (4) numeracy. Physicians are at this time trained in listening, speaking, writing, reading, numeracy, and skill differentiation, authority differentiation, and temporal stability.

In other words, subjective research in reference to doctor-patient communication examines the exchange and interchange of the communication between doctor and patient in a medical encounter, tracking how the doctor's behavior influences the patient and vice versa. However, due to the complexity of conducting that type of work, seldom is it done. The limitation in this area of study has primarily fixated on communicative behaviors enacted by the doctor in the medical encounter (Cegala and Street, 2010).

McBurney, Donald H., and Theresa L. White. *Research Methods*. 7th ed., Thomson Wadsworth, 2007.

Thoughts on the *Teach Back* method

Jesse Crespin

This is a brief description of two recent encounters I had with the dental department. I feel compelled to share these experiences because they are a real-life enactment of our Health Communication class. Although there were two very different encounters, they both revolve around the same issue — the treatment plan for one of my teeth. Both encounters encompassed very different communication styles, styles that were performed by both the dental professionals I encountered, as well as myself.

Firstly, let me briefly describe that, in order to actually see the dentist, a prisoner needs to fill out a medical request form explaining an issue they are having. Once the prisoner turns in this paperwork, it is reviewed and then an appointment is made — keep in mind that this process can take up to a few weeks or even a month. Sometimes, if the issue is severe enough, the prisoner might be called in right away, however, that is not the norm. But, to those of us who are incarcerated, that is what almost seems normal, because we are currently living in an environment that encompasses an ineffective healthcare communication system. Oddly enough, even though there are a lot of people who have medical issues that need to be attended to, the medical system performs the least amount of work by leaning on their paternalistic approach to treating their patients with "you're okay, because what I say goes."

The sad reality is, this seems to be a reasonable explanation as to why — after turning in a medical request regarding some form of healthcare issue — it takes so long to be seen. As for me, well, I needed the dental office to refill a filling that had fallen out.

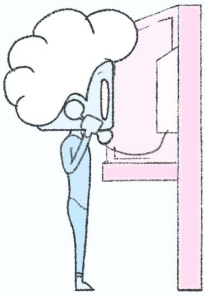
The pain I experienced was minimal, but still irritating nonetheless, yet it took well over three weeks to hear from the dental department. My initial encounter with the dentist was wrought with a paternalistic — almost verbally assaultive — approach based solely on what seemed to be my status as a prisoner. As I tried to explain that a filling had fallen out, the dentist interrupted me by saying that the tooth in question never had a filling — even though the x-ray of the tooth still showed a fragment of the filling still attached. What's worse was the dentist's statement that the only way to treat my tooth was by pulling it out. I asked why couldn't it just be refilled, and was told that if I wasn't a prisoner, my tooth could be treated appropriately, but because of the fact that I'm a prisoner, they were not going to treat it as salvageable. So, I asked for some information about the policy/procedure from which they were basing their decision on and was told that I would be rescheduled in about a month for an appointment to pull my tooth.

Although I never received an answer to my question regarding the policy/procedure behind the dentist's decision-making process on how to treat my tooth, I felt that a month was enough time to inquire about it, so I did. After turning in the necessary paperwork, I waited for a response that never came. What did arrive, however, was an appointment to see the dentist to undergo the procedure of pulling out my tooth. So, I prepared myself to become an active participant in the decision-making process regarding the treatment of my tooth, which lead me to the PACE process discussed in our textbook. What resulted from using this technique was a very positive and effective communication encounter that seemed to be way more patient-centered than the initial encounter.

After, letting the dentist know that I was present, by explaining my concerns regarding the removal of my tooth, I asked a series of specific questions I had prepared beforehand. During this process,

I also checked in with the dentist to make sure that I had a clear understanding of what was being said — I did this by using the teach-back method; by repeating in my own words what the dentist was telling me. Although the treatment plan was still the same — to try to pull my tooth — the dentist responded to my questions in a more patient-centered manner. This type of encounter elicited a sense of empowerment, where I felt comfortable, as well as confident, in expressing my concerns regarding the plan proposed for treating my tooth.

Overall, I was satisfied with the latest encounter I had with the dentist, and today I still even have my tooth — it just hasn't been treated yet. Nevertheless, when people invest a little bit of time and energy into trying to communicate effectively — especially with a healthcare professional — then they can contribute to the process of triggering a more positive encounter.



On the evolution of the trauma informed approach

Robert Mosley

Post-Traumatic Stress Disorder (PTSD) was not defined until 1980, even though we named it before as "Shell Shocked." Now, in 2019, the symptoms designate as Post Traumatic Syndrome (PTS). Because of accuracy failure, the 'D', for 'disorder' was eliminated. The 'D' presents psychosocial dysfunction, a category (much like shell-shocked) without favorable implications for the majority of the impacted persons. A 'syndrome' may represent a condition or pattern, without including the 'disease' connotation. Trauma may be physical, social, or psychological. A 'financial trauma' is an example of a psychosocial trauma. Each type may convey some type of PTS. Consider the impact of a trauma.

There are three impacts of trauma. First, in the emotional brain there exists reliance on basic, or inherent, automatic responses. Fight or Flight represents a hostile token of powerful negative emotions. These automatic responses gain stimulation from traumas. Second, an alarm system in the brain becomes terribly distorted — perceiving danger everywhere. This happens with continued high volume of similar traumatic experiences. Third, trauma's perceivable impact's meter is the ability to appraise, balance, enjoy, and rationalize experiences.

Two methods of handling traumas are to excuse them or justify them. By excusing, one acknowledges the trauma, but denies responsibility for it. Excusing may include refusals and apologies or 'concessions'. A full apology, the more readily and socially acceptable excuse, indicates five steps: 1) Expression of remorse; 2) recognizing a more appropriate action, (that could have been taken); 3) rejection and disparagement of the misbehavior; 4) expressing intention to behave appropriately in the future; 5) penance, or an offer of compensation. A person may apologize

even when they are not the origin of the trauma, nor a participant in the delivery of the trauma. By justifying, they may deny, minimize, associate a higher loyalty, or rely on some sad story as rationale for the experience. Justification usually accompanies developmental traumas.

Developmental trauma does not heal instantly, it takes time to heal. We must be able to access a calm brain. Look at the work done by the Center for Disease Control (CDC). The CDC's studies conclude that childhood trauma is the single most powerful predictor of progressive public health. Childhood trauma happens in the crucible of relationships. We help people heal when we promote communicative connections, both internal (personal) and social. Revealing and confiding traumatic experiences through narratives may generate a greater understanding and unburden the emotion from the act of concealment. Concealment, usually immediately accompanies traumatic experiences. Concealment may occur through defining 'trauma'.

What does trauma mean? The tendency of definition causes us to associate “trauma” with “problem”. Oftentimes we are unable to recognize and admit that the source of our problems is ourselves. As part of the internal connection, it serves to realize that whenever you seek to divorce yourself of a problem, you must eliminate the problem at the source. Ideally, you are the source of the problem. The “problem” needs not be a “problem” for all. A (the) “problem” does not have a “problem” with itself but may have a “problem” with you. In which case you need to understand why (it) is a “problem” for you. This is a practical and experiential wisdom. You must beware though, because problems are like poisonous snakes. If you get too close to them (the poisonous snakes), or comfortable with them, they can cause harm to you. However, you have great difficulty avoiding them throughout your life. The act of avoiding them may itself be a traumatic experience.

In dealing with, and communicating traumas, some of us have been taught, "If it doesn't kill you, it will make you stronger." However, all 'killings' do not occur instantaneously. Some poisons take time to complete their destructive actions. In the same way, some traumas take time to reveal their destructive effects and simultaneously, dealing with the trauma, becomes traumatic itself. How are we going to teach back? How are we going to deal with the traumas in our lives? Is there an objective (true) standard (empirical) definition of trauma? On the other hand, is trauma a subjective experience?

A limitation in the definition of trauma is that it only denotes a negative experience. Some traumas can be reframed as both positive or negative. Consider, for example, the physical trauma that must take place during surgeries. Often many people experience trauma and are unaware of it or so conditioned to the experience they do not realize it as trauma. However, a surgery does qualify as a significant event.

Categorizing and identifying significant events in the traumatic category better enables conceptual management. Thinking of traumas as significant events in your life, you are able to look back with 20/20 vision seeing when and how you made decisions which affect your current life's position. Unlike most things in life, traumas can be predicted. However, their total effects still are rather random.

Trauma comes with living. For some entities to live, some others must experience trauma, up to and including death. This comes as part of the 'chain (or Cycle) of Life'. Living is similar to white water rafting on a relatively uncharted river. At some places, the current is explosive, and at others, it is calm. There are submerged boulders and other flotsam undetected until you are in contact with them.

Most of the time, as you slow down and look at a situation objectively you realize harmful events, that you considered significant events in retrospect, as potentially avoidable. However,

there are some perpetrated upon you, regardless to how much energy you expend to avoid them, and others that come upon you like a black ant on a black rock at midnight on a night with a new moon. That you survive, to reflect upon your experiences, designates your resilience, which in turn makes you stronger. Then, the quality of your survival (the degree or magnitude of your resilience) represents how you deal with the contact, if you still live.

Resiliency in motion and best practices in health communication: Closing thoughts

The following are the various roads of resiliency that the students have traveled. Many of them initially had no resiliency and they resorted to the phenomena called trauma reenactment. This is where people respond to their traumas in negative ways. Resiliency is the ability to overcome adversity. It is the mental ability to quickly recover from depression, illness or misfortune. Below are some of the ways that the authors in this collection build and utilize resiliency as a health communication practice.

Stephen Houston:
I practice positive thinking, which is fortified by my spiritual beliefs. I have defied the odds against multiple sclerosis, so I look back on my past success to propel me forward. I know that any given adversity isn't the end of the world, I count my blessings and always consider how things could be worse. I think it is important to realize the importance of trauma, and then recognize how it affects us individually. Once I did this, I put the knowledge I have about trauma into practice. This is how I reduce the harm of stressors. Personally, I believe in strengthening my personal and healthy relationships as a means of resiliency.

Allen Burnett:
I believe in empowering people with the information that could expand their lives. In my family, there is a history of diabetes, heart disease, and stroke. Health Communication, as it is explained in the CDC and NCI definition possibly could have had a tremendous effect on my family's overall health, as well as my community. I practice positive thinking, recognizing the things I cannot change, and dealing with adversity head on (for the things I can change). I remind myself of the refrain: "This, too, shall pass."

I also try to foster relationships with positive people, and I trust my higher power.

Dortell Williams:
I recognize through research that beliefs and attitudes equal action. So, I try to maintain balanced beliefs by maintaining healthy relationships with positive and successful people who can give me constructive feedback. I go to people who I know care for me and mean me well. I also try to do healthy practices: getting seven or eight hours of sleep, eating in a wholesome way and exercising regularly to reduce stress. I also recognize my triggers and counter them with coping strategies like patience, avoidance of negative things, and going with the flow when it's out of my hands or too small to worry about. Sometimes I just have to let things --situations or things people say or do-- go.

Jarold A. Walton:
I like reading self-help literature and being in touch with family and my college associates. I also exercise, avoid negative people, take responsibility for my actions and try to make connections with people in my profession. I like to think and say positive affirmations out-loud to myself. I also like to stick to a schedule of positive rebuilding. And I make sure to avoid the company of those who are not like-minded. Health communication is about sharing the truth about health. Only when you involve the people who are "living it", can you get the real answer.

Tin Nguyen:
By using the paradigms inclusively in the research of service dog training, we may obtain data that reveals the dynamics of service dog training in health communication.

Marvin Johnson:
Disease doesn't just affect health, it causes suffering for the afflicted patient, his or her family, friends, and even strangers who meet or engage with the person.

Darren Robinson:
People can get really sick and not be heard. I broke my neck several years ago, and because I was being treated for a serious condition, the doctor didn't hear my complaint.

Thomas Wheelock:
Active listening is so very important in doctor/patient care. The communication between the two groups can become strained as there is communication loss. You have to hear what the other party is saying and not just what you want to hear.

Duncan Martinez:
...the most important part of health communication is the interaction between the doctor and the patient. It is central to everything else that happens, and, if poor, can lead to serious problems that are hard to get past.

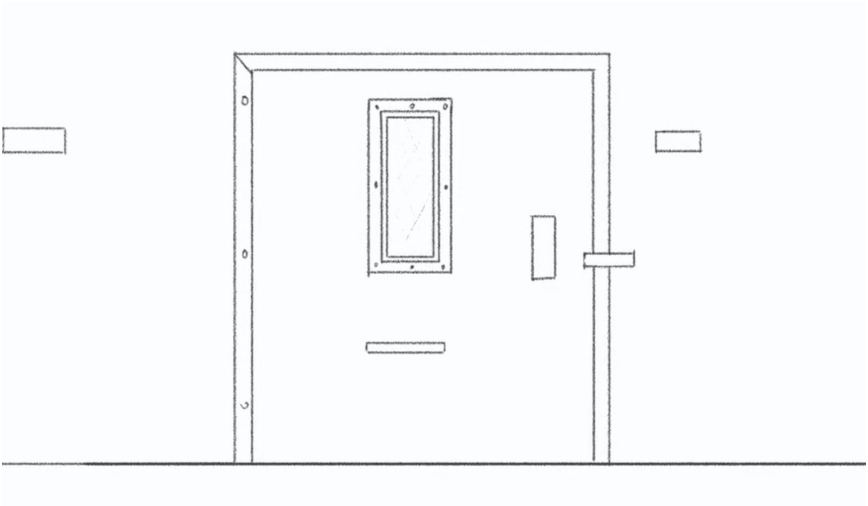
Daniel Whitlow:
The more we understand about what may happen if messages get scrambled or missed all together between patient and physicians, the better we can refine communicative techniques and prevent confusion.

James Heard:
It is critical to create a basic definition for researchers, teachers, and laypersons alike to encompass the broad scope of health communication. After reading this text, it is my goal to create a definition acceptable to the layperson, academics ,and professionals.

PART V

Supplements

Glossary of terms and handouts



GLOSSARY OF TERMS

Trauma: is a widely defined term that includes many aspects. Here we will concentrate on four of those aspects: physical trauma, emotional trauma, generational trauma, and physiological trauma. Trauma triggers the fight, flight or freeze response.

Physical trauma is defined as serious injury to the body, often due to an accident or violence. Violence, for example, could be a domestic attack, perhaps with fists, which could also cause emotional trauma. Physical trauma is likely to leave scars, cuts, bruises and the like.

Emotional trauma is defined as an injury that results from experiencing a highly stressful or horrifying event where the person has no control, feels powerless, and threatened by injury or death. These feelings could occur as a result of witnessing domestic violence, being robbed at gunpoint or being trapped in a ditch, for example.

Emotional trauma could result from a personal experience or a situation where one is simply the witness of an event. This type of situation would be considered indirect traumatization. Examples might be witnessing a hit and run, or witnessing a store clerk being robbed.

Furthermore, with emotional trauma, the threat does not have to be real; simply perceiving an event to be a threat is sufficient to cause a cognitive reaction. A person unreasonably fearful of a plane crash, or the police, perhaps because of adverse events s/he has heard about, could cause the same mental and physiological response. This perceptual experience is common with generational trauma.

Generational trauma (also known as historical trauma) is often transferred through stories from one generation to the next. A person from the second generation could also be impacted by simply witnessing the natural reaction of an event by a person from the first generation. For instance, dissociation is one of the many responses to trauma. Dissociation is the careful avoidance of a person, place or thing. Dissociation from an ethnic group might occur because someone from an ethnic group caused harm to a person of the first generation. After hearing the story from the first generation, a person from the second generation may experience a physiological response (sweating, tremors, anxiety) when they experience or perceive a similar threat.

Physiological trauma can be an additional sub-set of experiences as a result from any of the above trauma types. Physiological trauma is defined as damage to the psyche, affecting beliefs and worldviews, and in extreme cases, causing Post Traumatic Stress Disorder (PTSD).

This condition can result from a highly stressful situation or event. Some of the symptoms of PTSD are intrusive thoughts or reoccurring memories, nightmares of the traumatic event, insomnia, or lack of concentration.

Adverse Childhood Experiences (ACEs) are considered traumatic or highly stressful events during childhood in which the youth experiences physical or verbal abuse (e.g. being called names like stupid), as well as sexual abuse. Also included in this paradigm are neglect, abandonment, witnessing violence, instability (frequently changing neighborhoods or schools), the violence of poverty or being prohibited from natural childhood development (such as having adult responsibilities heaped on them as a child).

Traumatic reenactment does not mean that one reenacts the exact trauma they suffered, but rather it is the expression of one's trauma through the symbolic language of behavior. Trauma can be reenacted through negative and destructive behaviors such as drug

use (as a way to escape the trauma), joining a gang, domestic violence, isolation, aggression, cutting, etc.

Dissociation is the separation of the mental functions of consciousness, memory, identity, and awareness of the environment, which usually functions as an integrated whole. This cognitive selectiveness is used by the person's unconscious faculties to protect them from a repetition of the event by shielding memories in selective compartments as an avoidance function. Dissociation can also be a conscious decision to avoid a person, place or thing.

Stress is an internal emotional pressure suffered by humans or other animals as a result of external pressures. Chronic stress can result in some of the same symptoms as trauma-related events.

Consequences of Chronic Trauma: When constantly faced with traumatic situations, humans adapt to survive. They cope with the stressful environment until the "abnormal" becomes "normal." This adaptation can be destructive when one adopts maladaptive mechanisms to cope, such as avoidance, numbing, dissociation (often a trance-like state), or disengagement. This type of maladjustment contributes to their worldview and belief systems, which can become warped as a way of coping with the traumatic event. As a result, people often commit actions they wouldn't otherwise commit in order to survive (e.g., substance abuse, joining a gang, violence).

Responses to trauma may include:

- Reexperiencing the traumatic event through intrusive thoughts, flashbacks, or nightmares that trigger fear and make concentration and rest difficult.
- Numbing and dissociation, through destructive behaviors such as substance abuse, cutting, bullying others or fatalistic ideation.

- Avoidance of people, places, or things that correlate to the trauma or remind them of the event.
- Hyper-arousal and hyper-vigilance are expressed by being especially "alert" for extended periods, unable to trust others, even when there is no immediate threat.
- Impacts our sense of identity and our perspective, worldviews and belief systems.

Resiliency is our defense against stress and trauma. Resiliency is defined as an individual's successful adaptation to adversity or a stressful experience.

7 Components of Resilience

Based on Dr. Tony Salerno's resiliency measures

Attitudes, feelings and behaviors associated with resilience:

Decision-making

- I gather information before making important decisions
- I calmly make decisions
- I take time to think things through before taking action
- I discuss decisions I consider with people I trust
- I examine the upside and downside of my decisions

Self Care and Emotional Regulation

- I know how to calm down when I feel stressed out
- I eat healthy foods
- I get enough sleep
- I include physical activity/exercise as part of my lifestyle
- I take a break when I feel I'm taking on too much
- I get help to stay physically healthy by keeping appointments with medical providers
- I engage in recreational and other activities that I find enjoyable and relaxing
- I can laugh at myself and my circumstances to cope better
- I don't spend much time thinking about my weaknesses and failures

Strength of Social Support

- I have cohort that help me out when I'm having a tough time
- I have supervisors who help me out when I'm having a tough time
- I have family members who I trust and I can rely on

- I reach out to others when I struggle with decisions and problems
- I am able to support other people when they need it
- I take part in community and cultural activities
- I know what people, places and things cause me upset
- I reduce encounters with people, places and things that are harmful to my wellbeing

Action and Problem Solving Orientation

- I am confident that I can successfully cope with life stresses
- I take action to solve problems I face
- I speak up for myself when needed
- When I am stressed, I look for solutions
- I am able to bounce back from bad experiences
- I don't give up easily
- I'm open to trying new approaches to solve problems
- I'm open to feedback from others

Realistic and Positive Thinking

- I focus on what's going right in my life
- I think positively even when I experience disappointments
- I remind myself that bad times will pass
- I believe that I'm OK and other people are OK
- I question some of my negative thinking
- I accept that there are somethings I just can't change
- I forgive myself for mistakes I have made
- I recognize that bad things that have happened to me are not my fault
- I realize I'm doing the best I can in light of my life circumstances

Personal Confidence/Self-Efficacy

- I work towards goals that mean a lot to me
- I'm hopeful about the future
- I am confident about achieving many of my goals
- I am confident that I can change for the better

- I have many personal strengths

Personal Meaning Under Adverse Conditions

- I recognize that I have learned important insights from overcoming stressful events in my life
- I have spiritual values that help me get through difficult situations
- I can make sense of the bad things that have happened to me
- I can use what I learned from the bad things that have happened to me to help others
- I have found healthy ways to express my stressful feelings through creative activities (education, physical movement, drama and art, music, writing etc.)
-

Masks of resilience created by students in COMM 4500 Fall 2019. These masks were used for a narrative questioning exercise in class

10 Elements of Competence for Using Teach-back Effectively

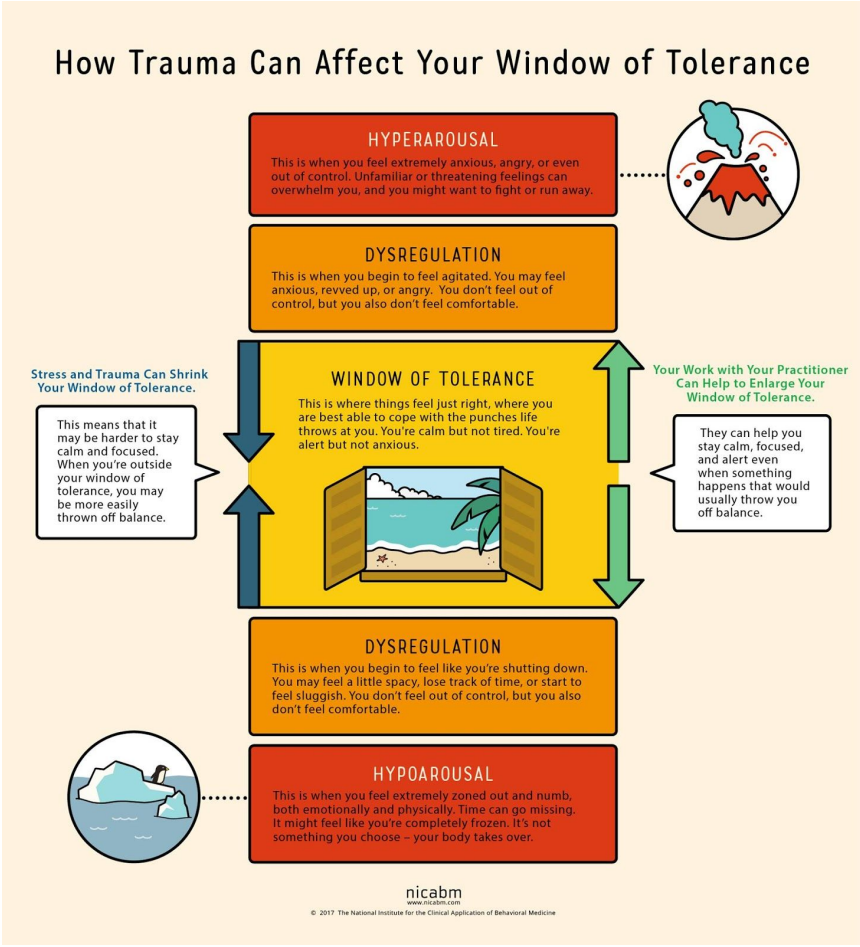
Adapted from Schillinger, 2003

1. Use a caring tone of voice and attitude.
2. Display comfortable body language and make eye contact.
3. Use plain language.
4. Ask the patient to explain back, using their own words.
5. Use non-shaming, open-ended questions.
6. Avoid asking questions that can be answered with a simple yes or no.
7. Emphasize that the responsibility to explain clearly is on you, the provider.
8. If the patient is not able to teach back correctly, explain again and re-check.
9. Use reader-friendly print materials to support learning.
10. Document use of and patient response to teach-back.

What is Teach-back?

- A way to make sure you—the health care provider—explained information clearly. It is not a test or quiz of patients.
- Asking a patient (or family member) to explain in their own words what they need to know or do, in a caring way.
- A way to check for understanding and, if needed, re-explain and check again.
- A research-based health literacy intervention that improves patient-provider communication and patient health outcomes.

Window of Tolerance (handout)



https://www.debbieaugenthaler.com/window-of-tolerance/

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