Comment

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Comment on the January 2015 Cover of the *American Psychologist*

Wendy M. K. Peters
Community and Health Psychology, The NETT, Ltd., Dayton, Ohio

Consuelo E. Cavalieri
University of St. Thomas

They say a picture is worth a thousand words. Yet it was not the beautiful wintry mountain scene on the cover of the January 2015 edition of the American Psychologist (Vol. 70, Issue 1) that spawned a conversation with almost as many comments on the Society of Indian Psychologists (SIP) listserve. Instead, it was the caption positioned metaphorically under the tip of the iceberg—or in this case, the snow covered mountain peaks—that said "Squaw Valley Meadow."

Although a seemingly innocuous word to most people, a majority of SIP members wanted to share what the term *squaw*, hereinafter deemed "s-word," invokes for many Native individuals as well as in the collective cultural memories of American Indian peoples. As a voice representative of Native peoples, the members of SIP are acutely aware of the many issues that need to be redressed, both within our own communities and in our relations with non-Native society. In the case of the cover art caption and the ire provoked by the use of the s-word, the members of SIP opted to take an opportunity to educate versus confront, and to inform versus chastise or accuse amid this polarized political climate of interracial tensions.

Appreciative of American Psychological Association (APA) CEO and *American Psychologist* Editor Norman Anderson's subsequent heartfelt apology, and realizing that the picture and location name was not an intentional insult or purposeful use of an offensive epithet on the part of APA, SIP seeks to educate the world about the issues that most impact Native people, particularly at the institutional level. We also believe that this incident was a significant opportunity to look both within and without—for introspection and communication—to better address such matters.

Historically, the s-word has come to reflect a derogatory characterization of Native women that is too often used in threatening racist and sexualized contexts. It is but one example of a gendered cultural meme that reflects the dominant societal attitudes regarding American Indian and other Native women. Even Amnesty International has recognized that "violence against women is one of the most pervasive human rights abuses . . . [and] Sexual violence against Indigenous women today is informed and conditioned by this legacy of widespread and egregious human rights abuses" (Amnesty International USA, 2006, p. 1). Similarly, the United States Department of Justice (Tjaden & Thoennes, 2000) has published that Native women are 2.5 times more likely to be sexually assaulted compared with all other races, and one in three Native women report having been raped within their lifetime. Research has also found that most of those acts are committed by non-Native men, mostly White men.

Likewise, although this gendered violence does have historical, colonial origins, it has become so pervasive that it is also sustained from within our communities. As professionals, we witness the relentless impact of this violence daily—in our communities, on our clients, with our research participants, our students, and sadly, even within our own families. Indeed, many, if not most of us live life in the midst of headwind, but live our lives we must.

In light of this occasion and by group consensus, SIP seeks to approach a new level of discourse that incorporates the span and the spectrum of cultural values and sensibilities, not just of the APA membership, but of all people. In the end, although the use of the s-word—even in official names of certain places in America—is still offensive and hurtful to many Natives, it is merely the tip of the iceberg. Rather, what lies beneath is, as Dr. Maria Brave Heart so aptly characterized, like a deck of cards, where every card stacked on the deck is another trauma, and most Natives experiencing historical trauma (the vast majority, we fear) feel the impact of the entire deck (Altaha, 2015).

We conclude our rebuttal with a message that is twofold. First, we hope that by openly elucidating these truths about the oppression of American Indian women and the ripple effect it has in our communities that, you, as reader, professional, student, citizen, or human being, will promulgate the necessity for mitigating the continued marginalization and indifference that is far too common in the lives of Indigenous peoples and their communities. We ask this not as victims of the dominant majority but, instead, as your colleagues and fellow professionals whose numbers are small and resources limited. More than most ethnic populations, we sorely lack the staffing, Indigenous-centered treatment options, and other structural resources to address these devastating problems.

Second, and of utmost importance, is that we, as Indigenous peoples not seek to blame the mistakes or ignorance of others in our woundedness. Banning the use of a Native word cannot erase the past and merely serves to discriminate against and discredit our own languages (Bruchac, 1999). Rather, we must reclaim our identity as individuals who yet carry the sparks of our great and dignified societies within us and recognize that the legacy of our ancestors is the gift that has enabled our peoples to endure and sustain themselves unto this very day in the face of overwhelming historical atrocities. Similarly, we must all recognize that we are part of an ever-growing, diverse global community in which education, tolerance, understanding, and cooperation are all essential for the continued survival of all our relations.

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Correspondence concerning this article should be addressed to Wendy M. K. Peters, Community and Health Psychology, The NETT, Ltd. E-mail: wpetersphd@gmail.com

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Chronic Pain and the Adaptive Significance of Positive Emotions

Anthony D. Ong
Cornell University

Alex J. Zautra
Arizona State University

M. Carrington Reid
Weill Cornell Medical College

The February–March 2014 special issue of the *American Psychologist* featured articles summarizing select contributions from the field of psychology to the assessment and treatment of chronic pain. The articles examined a range of psychosocial and family factors that influence individual adjustment and contribute to disparities in pain care. The reviews also considered the psychological correlates and neurophysiological mechanisms of specific pain treatments, including cognitive–behavioral therapy, hypnosis, acceptance and commitment therapy, mindfulness, and meditation. Although a number of articles emphasized the role that negative states of mind play in pain outcomes, positive emotions were given only brief mention. Here, we provide a rationale for the inclusion of positive emotions in chronic pain research.

Why Positive Emotions Facilitate Adaptation to Chronic Pain

Part of the problem underlying the relative neglect of positive emotions in the papers that comprise the special issue is the narrow conceptualization of what constitutes a positive emotional state, and how such states help define psychological well-being. If one adopts a simple framework for understanding human emotion in which positive is the opposite of negative, then attention to the distress signaled by negative states is all one needs to attend to when designing and evaluating clinical interventions. Watson and Tellegen (1985), among others, have made it plain what clinicians have long known: There is tremendous variability in people's emotional lives. Though emotion researchers will disagree on what are the best ways to dimensionalize emotion categories, most would agree that emotions have more than one dimension.

Of interest to pain researchers, as well as those who study emotion, is why positive emotions are beneficial during difficult times. Davis, Zautra, and Smith (2004) have proposed the dynamic model of affect (DMA) to account for how positive states influence adaptation to stressors like chronic pain. In contrast to other models of stress and coping, which view emotional adaptation entirely in terms of regulating psychological distress, the DMA takes into account both negative and positive states in the stress process. The model predicts that under ordinary circumstances, positive and negative emotions are relatively independent, whereas under conditions characterized by uncertainty, including pain and stress, an inverse correlation between positive and negative emotions increases sharply. Applications of the DMA in chronic pain populations have demonstrated that the inability to sustain positive states during times of high pain increases vulnerability to negative affective states and future pain episodes (for a review, see Davis, Zautra, et al., 2004). By contrast, the experience of positive emotions appears to foster adaptive recovery from pain (Zautra, Smith, Affleck, & Tennen, 2001; Zautra, Johnson, & Davis, 2005).

How Positive Emotions Arise in the Context of Chronic Pain

What factors are implicated in the maintenance and recovery of positive emotions in the face of pain? Growing evidence suggests that certain psychological attributes that allow for differentiation of positive and negative affect may prove beneficial for those with chronic pain. In an early investigation, Zautra et al. (2001) followed a sample of 175 women with rheumatoid arthritis ($n = 81$) or osteoarthritis ($n = 94$) over a 20-week period. Women reporting greater *mood clarity*, an aspect of emotional intelligence that reflects the ability to identify and understand specific emotions, exhibited greater differentiation of positive and negative affect. Ong, Bergeman, Bisconti, and Wallace (2006) reported similar effects for *psychological resilience*, a stable trait characterized by the ability to overcome and bounce back from adversity. Specifically, higher levels of trait resilience predicted a weaker association between positive and negative emotions and were linked to faster negative emotional recovery from stress. Taken together, these data suggests that those with greater mood clarity and trait resilience have a tendency to (a) experience positive emotions even in the midst of significant challenge, such as daily episodes of severe pain, and (b) draw on such experiences to resourcefully rebound from stressful circumstances.

Intervention Implications for Chronic Pain

A focus on positive emotions has implications for existing psychological pain interventions, as described in the special issue on chronic pain and psychology. For example, Davis and colleagues (2004) suggested that stress reduction techniques, such as mindfulness training, may offer a means of broadening emotional awareness and, thus, help to preserve positive emotional engagement, especially during times of high pain, a prediction borne out in recent randomized controlled trials with pain patients (e.g., Davis & Zautra, 2013). Moreover, to the extent that positive emotions serve to counteract catastrophizing cognitions that are frequently triggered by pain episodes (Ong, Zautra, & Reid, 2010), there may be benefit from expanding standard cognitive–behavioral therapy interventions to include a focus on positive emotions. Indeed, such interventions may prove to be particularly important for patients with specific chronic pain conditions, such as fibromyalgia, who show a core affective disturbance that is characterized by an overall deficit in positive emotion (Finan, Zautra, & Davis, 2009). More generally, what the literature we review advocates are pain studies and interventions that hew to a *two-dimensional view* of pain patients' emotional well-being, one not defined solely by how much pain and distress they experience, but also by how well they attend to the personal goals and social relations that give meaning and value to their lives.

Concluding Remarks

More than 3 decades ago, Lazarus, Kanner, and Folkman (1980) suggested that under intensely stressful conditions, positive