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„Literaturverzeichnis und Anhang A“

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Appendix A

Research Methodology

Between 1992 and the present, my students and I have collected information on the life impacts of MCS from over 1400 people. Our methodology was primarily survey research, although some interviews and considerable phone discussion were involved. To maintain confidentiality identifying information was removed from surveys, each respondent was assigned a number, and both names and surveys were kept in a locked closet accessible only to me.

Phase I

In Phase I (1993), people provided demographic data, including age, gender, length of illness, level of perceived disability, the safety level of their workplace and home, their partner status, and their partner's opinion of their MCS. Respondents also completed three standardized instruments to measure quality of life—the Herth Hope Scale (HHS) (Herth 1991), the Personal Resource Questionnaire 85 (PRQ85) (Weinert 1987) to measure social support, and the Psychosocial Adjustment to Illness Scale Self-Report (PAIS-SR) [Derogatis 1986], a self-report scale measuring seven life domains including health care orientation, vocational environment, domestic environment, sexual relations, extended family relations, social environment, and psychological distress.

Open-ended questions requested that respondents explain the following: how limited they were as a result of MCS, what activities they wanted to engage in but couldn't, if they had a doctor who was knowledgeable about MCS, whether they believed they had ever been harmed by inappropriate medical treatment, whether they had ever received a psychiatric label for MCS, whether they had experienced any significant personal growth as a result of having MCS, and what they thought should be done to make life less difficult for those with MCS.

Demographics

A total of 305 people responded to Phase I—32 percent from the Chemical Injury Information Network (CIIN), 19 percent from an ad in the National Ecological and Environmental Delivery System (N.E.E.D.S.) newsletter, 16 percent from the ad in the Human Ecologist, 7 percent from the National Center for Environmental Health Strategies, 6 percent from support groups, and 2 percent from physicians' offices. Eighteen percent learned of the study from other sources (probably from others with MCS/CI), and 0.7 percent did not respond to the question that asked where they learned about the study. The final convenience sample of 305 self-identified people had a mean age of 46.8 years (ranging from age 23 to age 79).

Women comprised 80.3 percent of the sample (n=245). People reported having MCS for a mean of 15 years, but did not attribute their suffering to MCS for a mean of 7.5 years. Participants included 282 Caucasians, fifteen Native Americans, three Latina/Latinos, two Asian Americans, and two who identified themselves as "other."

Respondents reported experiencing varying levels of chemical sensitivities including mild (12.8%), moderate (31.1%), severe (39.3%), and totally disabled (15.7%). The average reported decline in annual income for participants after developing MCS was \$17,761 (from approximately \$27,000 to approximately \$9,000). Here is a profile of the total sample characteristics for 305 initial respondents and 209 continuing participants in the 1993 and 1995 studies, respectively:

Table 1: Participants with Self-Reported Sensitivity to Chemicals

	Initial	
	1993 Sample	1995 Sample
Gender (% women)	80.3	82.3
Mean age in 1993	46.8	45.0
% Caucasian	92.5*	91.9**
% Employed in 1993	31.5	34.4
% Employed in 1995		34.0
% In intimate relationship	61.3	51.7
Personal income in thousands	13.3	16.3
Household income in thousands	35.7	37.2
% Citing one sensitizing exposure	42.3	49.0
% Citing pesticide as sensitizer	27.1***	24.5***
Years with MCS (1993)	14.4	14.7
Age became ill	32.0	32.3
One-year medical costs in dollars	5,784	5,899
Total medical costs in dollars	34,783	35,258
Cost to make home safer in dollars	27,816	27,974
% Who had doctor educated re: MCS	72.1	73.7

* Other groups represented include Native Americans (4.9%), Latina/Latino (1.0%), Asian (.7%), and “other” (.7%).

** Other groups represented include Native American (4.8%), Latina/Latino 1.0%), Asian (1.0%), and other (1.0%).

*** Of those who had one identifiable exposure.

Hope

The Herth Hope Scale (HHS) (Herth 1991), a respected instrument used to measure hope as an index of well-being (Foote, Piazza, Holcombe, et al. 1990; Herth 1991; Raleigh 1992), consists of thirty items each scored from 0 (never applies to me) to 3 (often applies to me). The highest possible score is 90. Average level of hope in Phase I MCS respondents was 65.8. Below are the scores found with other populations by the author of the scale, Kay Herth. You can see that MCS respondents had low levels of hope compared with the adult well group and older adult populations.

Adult Well Group	80
Older Adult	72
Elderly Widowed	54

Social Support

The PRQ85 has two parts. In part 1, participants were asked to mark who they would turn to for help in ten life situations, and to mark their level of satisfaction with help received on a six-point scale ranging from “very dissatisfied” to “very satisfied.” This is what people said:

Table 2: Percent of Respondents Reporting Support Needs in the Last Six Months and Satisfaction Level with Help They Received

Situation	% Answering “Yes”	Satisfaction with help received
Had a crisis?	62.0	4.23
Needed help caring for an extended family member?	17.4	4.26
Had a concern about a relationship with spouse, partner, or intimate other?	40.3	4.01
Needed advice for a problem with a family member or friend?	52.1	4.49
Had financial problems?	53.8	3.76
Felt lonely?	77.0	4.43
Been sick and unable to carry out usual activities for a week at a time?	55.4	4.31
Been upset and frustrated with the conditions of your life?	80.3	3.96
Had problems with work in or out of the home?	54.4	3.77
Needed someone to talk to about day-to-day personal concerns?	87.5	4.59

- 6 = greater satisfaction, and 1 = lesser satisfaction.

For help with these situations, respondents reported turning to various support sources in this descending order: friends in 4.7 of the possible ten situations, spouses in 4.5, professionals in 2.9, children in 2.3, other kin in 2.9, spiritual advisors in 1.6, support groups in 1.2, neighbors in 1.0, and no one in 0.6.

Perceived support was measured by part 2 of the PRQ85. The instrument has twenty-five items rated on a seven-point scale with highest possible score being 175 and lowest 25. Respondents scored between 58 and 174 on perceived social support with an average of 125.9. This score is lower than scores of other groups measured with this scale, which

ranged from 139 to 149 in middle-aged and older adults. Foote, Piazza, Holcombe, et al. (1990) found PRQ means of 141.13 in forty people (32 women; 8 men) with multiple sclerosis (mean age = 48.2). White and Richter (1990) found a mean of 131 in a sample of 134 women with diabetes mellitus who were similar in age to the present sample.

Women reported higher levels of perceived social support than did men. Women's average score was 127.7 and men's was 118.6. People who were more fatigued reported lower levels of social support. Those whose health had improved in the last two years had higher levels of support than those who had worsened; those who said they had improved in their health had a mean of 131.18, and those who reported deterioration had a mean of 119.69. Neither severity nor length of illness was related to perceived social support.

Part of the problem with maintaining relationships had to do with barriers that were created due to the restricted number of safe locations for social interaction. Here are the limitations spontaneously mentioned when respondents were asked how limited they were:

Table 3: Limitations of People with MCS

		%
Item/Area	Limitation	(n=305)
Church	Can't attend church at all	11
Driving	Drive only in low traffic areas	14
	Drive only with air filter in car	17
	Drive only with mask or respirator	11
	Some days cannot drive at all	7
	Cannot drive at all	7
Malls	Malls only for a very limited time	21
	Malls only wearing a mask	2
	Cannot go to malls at all	25
Movies	No movies at all	8
Restaurants	Restaurants rarely	23
	No restaurants at all	19
Socializing	No one enters home with fragrance	5
	No one enters home at all	2
	Can socialize only outdoors	2
	Cannot socialize at all	4
General	Must carry oxygen at all times	10
	Cannot ever be around perfume	41
	Cannot walk outside freely	7
	Was housebound in past	4
	Totally housebound now	8

Note: These percentages were compiled from an open-ended question and represent bare minimums regarding how many people have this limitation. That is, people had to specifically mention the limitation to have it count.

Table 4: Thwarted Goals of People with MCS

Thwarted Goal	% of Respondents (n=305)
Want to work	56
Want to pursue education	25
Want to pursue hobby	33
Want to travel	22
Want to visit family	9
Want to attend church	8
Want to nurture others(e.g., attend children's activities)	4

Note: Again, these are activities specifically mentioned and represent minimums. Medical treatment is covered in chapter six, and personal growth in chapter ten.

Phase II

Of the 305 people in Phase I, 288 were willing to be involved in further research. Late in 1993, 268 of these 288 people returned surveys that explored how people had become sensitive, their occupation at the time, the consequences for their work, whether they had moved, how much money they spent on health care and cleaning up their residence, whether they had applied for workers' compensation or disability benefits and whether it was granted, how they were treated by family members, and whether or not they had children. Women without children were asked if MCS had anything to do with their decision not to have children. Respondents were also asked about the number of medical and psychological providers they had seen and how they had been treated. Final questions dealt with whether they had ever been housebound, if their health had improved, and the results of any treatments they had tried.

Of the 268 Phase II respondents, 135 believed they had been made sensitive by one identifiable exposure, 64 said that they had not, and 67 did not know. The most commonly cited exposure thought to initiate MCS was pesticide (n=35) followed by remodeling (n=13) and workplace renovations (n=8). Listed below are the chemical exposures thought by respondents to have caused their chemical sensitivity in the 135 people who blamed one exposure. Exposures are listed as respondents described them. If MCS was attributed to renovations without specifying chemicals, it is listed as such. If carpeting was specified, then the exposure is listed as carpet. An exposure was listed as remodeling even if it occurred in the workplace if it involved purchasing new items, such as furniture, carpet, and paint. If actual construction was involved, then it was listed as renovations. Many people felt that they had become ill from a long series of exposures rather than as a result of one identifiable occurrence, and they are not listed in this table.

**Table 5: Chemical Exposures Reported to Cause
Chemical Sensitivity in 209 People**

<i>Exposures in combination with poor ventilation (sick building)</i>	n
Remodeling	5
Trichlorethylene	5
Duplicating chemicals	2
Dust control product	1
Herbicide trifluralin for cotton	1
Photochemicals	1
Photochemicals and exhaust fumes	1
Photocopy, remodeling, and pesticides	1
 <i>Exposures alone</i>	
Pesticides	35
Remodeling, and/or new carpet	13
Workplace renovations	8
Formaldehyde	7
Anesthesia	4
Diesel fuel oil	3
Carbon monoxide	2
Natural gas	2
Paints, varnishes, turpentine	2
Poor ventilation (no specific chemicals mentioned)	2
Aerosol spray	1
Acrulein	1
Air freshener	1
Amalgam dental work	1
Antibiotic use	1
Boiler room spill (ethanol and glycol)	1
Bus fumes	1
Carpet cleaner with benzene butyl compound added	1
Carbonless paper	1
Carbon monoxide in auto (defective fresh air intake)	1
Chemicals used to clean chickens in poultry processing plant	1
Copy machine fumes	1
Electromagnetic fields	1

Fiberglass dust	1
Glutaraldehyde (used to disinfect surgical instruments)	1
Lacquer (industrial)	1
Manufacturing chemicals for prostheses/orthotics	1
Mercury from having all oral fillings removed	1
Methyl isoamyl ketone	1
MTBE gasoline additive	1
Perfumes	1
Petroleum distillate used to undercoat air conditioner in workplace	1
Petrochemicals coming through air-conditioning system	1
Rayon plant (near home)	1
Red dyes in work uniform and remodeling	1
Secondhand smoke in workplace	1
Silicone breast implants	1
Tile adhesive	1
Zinc chloride (water softener chemicals in heating ductwork)	1
Combinations, miscellaneous:	
Pesticide and formaldehyde	3
Books and formaldehyde	1
Formaldehyde and linoleum adhesive	1
House fire, ammonia/bleach combination, hair perms	1
Long-term Lysol use and fuel oil spill in basement	1
Newspaper ink and bleach	1
Passive smoke and workplace renovations	1
Pesticide leak and work construction	1
Toluene, xylene, acetone	1

**Table 6: Occupation at the Time of Developing MCS for 209
People with Self-Reported Sensitivity to Chemicals**

Occupation	
Homemaker	29
Secretary/clerical	24
Student	22
Teacher	17
Nurse	15
Social worker, psychologist, counselor	9
Sales, misc.	8
Owner of small retail business, misc.	7
Computer programmer/analyst/software designer	6
Health care worker (X-ray, cardiology, physical therapy, recreational therapy, independent living director)	6
Management (office, personnel)	6
Bookkeeper	5
Financial associate/planner	5
Retired	5
Restaurant worker	5
Chemist	4
Engineer (electrical, mechanical, process)	4
Factory worker	4
University professor	4
Banker or teller	3
Mechanic	3
Painter	3
Artist	2
Benefits worker	2
Budget analyst	2
Civil servant	2
Domestic	2
Farmer or rancher	2
Hairdresser	2
Journalist	2
Librarian	2
Museum worker (curator, editor)	2
Photo lab technician	2
Public relations	2
Tailor/Sewing machine operator	2
Typesetter	2
Accountant	1
Administrative assistant	1
Applications examiner for licensing land mobile radios	1
Auction clerk	1

Contractor, home renovations	1
Copy editor	1
Department store makeup artist, perfume promoter	1
Dental hygienist	1
Director of reading clinic	1
Educational curriculum developer	1
Eligibility worker, Dept. of Social Services	1
Health planner	1
Hotel clerk	1
Human resource worker	1
Injection mold worker	1
Insurance claims processor	1
Interior designer	1
Job service interviewer	1
Media instructional assistant	1
Memorial home employee	1
Minister	1
Navy program analyst	1
Office manager	1
Operation manager	1
Photographer	1
Piano teacher	1
Physician	1
Planning analyst	1
Police dispatcher	1
Private school director	1
Realtor	1
Research assistant	1
Service rep	1
Store clerk	1
Technical assistant	1
Trade organization administrator	1
Truck driver	1
YMCA desk employee	1

Of the 268 Phase II participants, 205 (76.5%) reported having lost or having had to quit a job because they were unable to tolerate the chemicals in the work environment. People spent an average of \$27,816 to redo their homes. Many had moved repeatedly in search of safe homes. When asked how safe their current home was, 5 percent of participants replied that their home was “very safe,” 36 percent said it was “mostly safe,” 44 percent said it “should be better,” 11 percent said it was “mostly unsafe,” and 5 percent said it was “not at all safe.”

Thirty-five of 64 women without children said that MCS had been a factor in this decision. Women had foregone childbearing because they felt that their health was too damaged to carry a child (n=10), for fear it would worsen their own health to carry a child (n=19), because medical offices were inaccessible (n=18), because of MCS-induced financial problems (n=18), and to avoid passing on chemical sensitivity to a child (n=24). Some women reported more than one reason.

The Disability Addendum

Of the 305 people in my initial study, 151 had applied for disability benefits or worker's compensation. In 1995, these respondents were mailed a short questionnaire asking them to detail their attempt to gain compensation.

Participants were asked several questions about the disability benefits application process, including what health labels were used on their applications, whether disability benefits were granted, under what label(s) disability benefits were granted, what medical evidence was used, whether they used legal representation, how long the process took, what evidence they thought was most helpful in court (if granted), and what obstacles they encountered in the process.

Questionnaires were returned by 104 respondents (75 women and 29 men) with a mean age of 45.5. Over half (n=66) reported developing MCS as a result of one identifiable chemical exposure, and 47 people reported that this occurred in the workplace. Most (n=97) reported having already lost or left their jobs because of their sensitivities.

The Filing and Granting Process

Of the 104 people who filed for disability benefits, 51 had filed once, 22 twice, 20 three times, 3 four times, 5 five or more times, 1 was not sure, and 2 did not answer this question. Appeals and hearings were counted as additional filings for the purposes of this study. Fifty-nine participants were awarded disability benefits, 13 were denied at the time of the study, cases for 31 individuals were still pending, and one response was unclear. Of the 59 people who received disability income, 29 were awarded on first petition. The average cost of obtaining disability benefits was \$2,060, it took an average of twenty-three months to obtain, and the average award was \$12,702.

People used a wide variety of labels in the application process: some used MCS-related conditions (48 people filed under labels such as multiple chemical sensitivity, environmental illness, toxic encephalopathy, and sick building syndrome); some filed under other diagnoses, even though MCS was their primary health problem (n=23); and 29 people used a combination of MCS and other labels. These additional labels included psychiatric problems (n=11), respiratory illness (n=10), musculoskeletal dysfunction (n=7), chronic fatigue immunodeficiency syndrome (CFIDS) (n=5), immune disorders (n=4), circulatory problems (n=3), gastrointestinal disorders (n=3), and others (n=17). Types of medical evidence provided by filers for disability benefits are presented below. Most commonly submitted test results were blood work (primarily immune panels and blood screen for chemicals) and brain scans.

Table 7: Medical Evidence Included in Application for Disability Compensation

Procedure

Any Type of Blood Work	55
Immune Panel	40
Blood Screen for Chemicals	27
Viral Tests	6
Chemical Antibodies	5
Autoimmune Antibodies	3
Activated Lymph Profile	2
Cholinesterase Level	1
Other Blood Work	7
Any Type of Brain Scan	22
MRI	10
SPECT Scan	8
PET Scan	2
CT Scan	1
Allergy Tests	11
Neuropsychological Examination	9
EEG	8
EEG with Evoked Potentials	7
Challenge/Provocation Neutralization Testing	6
Chemicals in Fat Tissue	3
Liver Profile	3
Pulmonary Function Tests	2
Thyroid Tests	2
Hepatitis	1
Double Blind Booth Test	1
Other	8

Attorneys represented 60 people in the filing process, and 44 people represented themselves. Of the 29 people who were granted disability benefits on their first petition, 10 used the aid of attorneys, and 19 did not. Those who did use attorneys had to search extensively for someone educated or experienced regarding MCS. One respondent said, “I approached over twenty lawyers—none which would accept my case, though most said I had a case and should keep trying!”

The labels under which disability compensation was granted are presented below. The primary category under which compensation was granted was MCS; psychiatric categories were second.

Table 8: Labels Under Which Disability Compensation Was Granted

Labels

MCS Related*	44
Psychiatric**	27
Chronic Fatigue Immunodeficiency Syndrome	7
Musculoskeletal	3
Circulatory	2
Immune Related	2
Respiratory	1
GI	0
Did Not Know	9
Other	10

* Includes labels such as multiple chemical sensitivity, environmental illness, toxic encephalopathy, sick building syndrome, sensitivity to fumes, multiple allergies, chemical allergy, multiple hypersensitivities, etc.

** Psychiatric labels include: depression (n=7), posttraumatic stress disorder (n=4), conversion disorder (n=2), schizophrenia (n=2), somatoform disorder (n=2), anxiety disorder (n=2), affective disorder (n=2), schizoid personality disorder (n=1), dementia (n=1), "emotional" (n = 1), global assessment of functioning scale = 50 (n=1), and unspecified psychiatric (n=2).

Phase III

In 1995, the two-year follow-up study (Phase III) collected information from the 209 people who could be contacted. Respondents were again asked about employment, partner status, and income, and asked to complete three instruments of measures of life satisfaction—the Satisfaction With Life Scale (SWLS) (Diener, Emmons, Larsen, et al. 1985), the Life Satisfaction Index Z (LSIZ) (adapted from Neugarten, Havighurst, and Tobin's 1961 Life Satisfaction Index A, as cited by Wood, Wylie, and Sheafor 1969), and the Congruity Life Satisfaction Measure (CLS) (Meadow, Mentzer, Rahtz, et al. 1992).

In addition, I designed a measure that looked at activism, and asked further questions about the accessibility of medical help. One open-ended Phase III question related to how the person's identity had been affected by having MCS. Demographics of this sample are included in Table 1 along with the Phase I sample. Satisfaction with life was generally low. Activism results were as follows:

Scores on the activism scale ranged from a low of 0 to the highest possible score of 18. When given 1 point for each item, the average activism score for this sample was 6.9 on the MCS Activism Scale, which means that people had been involved in an average of seven of the listed activities. Most people had done personal reading (n=207), and more than half had attended support groups (n=117). Table 9 lists the percentage of respondents who engaged in each activity. Level of activism was not significantly related to age, gender, income, length of illness, or course of illness. Activism was positively related to education (with more educated people being more involved in activism), severity of condition (with people more severely injured engaging in higher levels of activism), and with having lived in unusual circumstances, such as a tent, trailer, porch, or RV. Activism was negatively related to working outside of the home (with people able to work being less active than those unable to work), possibly because they had less available time for activism.

People's efforts were concentrated toward educating the public about chemicals in ambient air, helping to pass legislation to protect the public from the negative effects of

common chemicals, mandating education of medical personnel in regard to toxicology, improving health care service delivery for people with chemical sensitivities, and acquiring both recognition of the condition chemical sensitivity/ injury in the mainstream medical community and training physicians regarding treatment.

Table 9: MCS Activism Scale Results in a Sample of 209 People with Self-Reported MCS/CI

Sometimes having an illness or a disability leads to involvement with others around educational or advocacy issues. In response to your condition, have you:

	% answering yes
➤ Done personal reading of books, articles, newsletters, or other materials to educate yourself regarding MCS/CI?	99
➤ Joined an organization that published a newsletter that dealt with MCS/CI (e.g., CIIN, HEAL, NCEHS, NYCAP, etc.)?	84.2
➤ Supported other people with MCS/CI in a nonprofessional capacity?	89.5
4. Attended any meetings of a support group?	56
5. Taken an active role in a support group?	43.5
6. Written an article for a newsletter/publication?	36.8
7. Engaged in letter-writing campaigns in relation to MCS-related issues?	56
8. Organized other citizens to take a stand on an environmental issue that was related to MCS?	32.1
9. Been an officer of a support/advocacy group for those with MCS/CI?	23
10. Spoken publicly about MCS-related issues?	34.9
11. Done a media interview in relation to MCS?	28.7
12. Advocated for legislation beyond letter writing that would affect those with MCS?	22.5
13. Engaged in original research (data gathering and collating and reporting) in relation to environment or MCS?	32.5
14. Started/headed a local advocacy or support group for MCS?	18.2
15. Worked with others with MCS in a professional	

capacity (as a physician, consultant, counselor, etc.)?	15.3
16. Edited a newsletter or publication devoted to MCS/environmental issues?	12.9
17. Written a book/technical report on the topic of MCS/environment?	9.1
18. Started/headed a national advocacy/educational/ support group for MCS?	4.8

Phase IV

Some new people were added to the study in Phase IV and data were collected at this point from 254 people. Again, demographics were collected, but this survey dealt primarily with the types of chemicals people reacted to and the kinds of reactions they experienced. In addition, the Sickness Impact Profile (SIP) (Bergner, Bobbitt, Kressel, et al. 1976; Bergner, Bobbitt, Pollard, et al., 1976) was used to measure illness-engendered dysfunction in everyday life. The SIP looks at respondents' assessment of their limitations in functioning that are caused by illness.

Patrick and Deyo (1989) summarized the literature on the use of the SIP with a number of chronic illnesses.

Comparing my data with that of Patrick and Deyo, we found that MCS respondents demonstrated more dysfunction than patients with angina, Crohn's disease, rheumatoid arthritis, chronic lower back pain, and oxygen dependent chronic obstructive pulmonary disease. The only conditions in Patrick and Deyo's data bank showing more dysfunction than MCS on the SIP are non-responding chronic pain and amyotrophic lateral sclerosis.

The most serious problems for MCS respondents from my study were shown in the categories of work, alertness behavior, and recreation and pastimes. Considerable impairment was also shown on sleep and rest, social interaction, home management, emotional behavior, and mobility. (See Gibson, Rice, Dowling, et al. 1997 for more information.) The details of the Phase IV data collection are under submission for publication.

The Large Treatment Study

In 2001, with financial support and help from CIIN, my students and I conducted a large study of treatments tried by 917 people. See Appendix E for this article, published in Environmental Health Perspectives in September 2003.

The Work Accommodation Study

In the summer of 2003 I collected data from 100 people relating to their work, accommodations requested and received, and their experiences at the Centers for Independent Living and the Vocational Rehabilitation Centers. This study was presented at the Chemical Injury Information Network Chemical Injury Conference October 3-5, Fairfax, VA. You can get a photocopy from me of the conference paper. But some of it is summarized in chapter 13.

James Madison University MCS/CI Research Team Publications

Books

- Gibson, P.R. (2005). Multiple chemical sensitivity: A survival guide. Second Edition. Churchville, VA: Earthrise Publications.
- Gibson, P.R. (2002). Understanding and accommodating multiple chemical sensitivity in independent living. A 50-page guide published by IL NET, a cooperative National Training and Technical Assistance Project of the Independent Living Research Utilization (ILRU) Program and the National Council on Independent Living.
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Book Forward

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- Gibson, P.R. (2017). Living on the margins with access denied: Introduction to special issue on environmental sensitivities. *Ecopsychology*, June, 2017
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Conference Presentations

- Gibson, P.R., Kovach, S., & Lupfer, A. (2013). Unmet healthcare needs for persons with chemical sensitivity. Paper delivered at the Southwest Conference on Disability, October 8-11, Albuquerque, New Mexico.
- Gibson, P.R., Coronado, Y., & Cook-Smith, A. (2011). Access to community based advocacy services for persons with multiple chemical sensitivity. Poster to be delivered at the Festival of International Conferences on Caregiving, Disability, Aging, and Technology, June 5-8, Toronto, Canada.
- Gibson, P.R., Sledd, L.G., McEnroe, W.H., & Vos, A.P. (2009). Down the rabbit hole: The different world of chemical intolerance. Paper delivered at the Southwest Conference on Disability, September 30 – October 2, Albuquerque, New Mexico.
- Gibson, P.R., Lockaby, S.D., & Bryant, J.M. (2009). Experiences of persons with multiple chemical sensitivity with psychological providers. Paper delivered at the Southwest Conference on Disability, September 30 – October 2, Albuquerque, New Mexico.
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- Gibson, P.R. (1997). Multiple Chemical Sensitivity, Illness and Culture: On the Margins of Health Care. In P. Gibson, chair, Marginalized Health Problems and Women: Fibromyalgia, CFIDS, and Chemical Sensitivity. Symposium delivered at the 105th Annual Convention of the American Psychological Association, August 15-19, Chicago, IL.
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