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*"Building a Psychologically Healthy Society:
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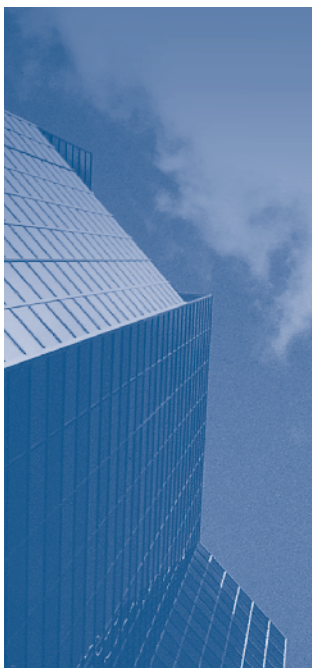
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From the Editor

This year, the theme for the *OP* is “Building a Psychologically Healthy Society: Theory, Research and Practice.” We are fortunate to have a variety of articles addressing this topic, ranging from personal accounts of inward journeys to research studies. In the first article, **Christine E. Agaibi, MA**, discusses the importance of bringing spirituality and religion into the practice of psychology and the roots of it in our profession. **Janette McDonald, PhD**, shares her personal experience in a Zen center while **Richard Sears, PsyD**, chronicles his six-week journey through India and Nepal.

Christopher Mruk, PhD, examines several important aspects in the positive psychology movement as well as provides examples of how this practice can be integrated clinically. **Sunwoong Park, Jack Bauer and Nicole Arbuckle** share research findings on how self-esteem and growth motivation to affect happiness. **Michelle Madore and Yvonne Roberts** provide a brief history of evidence-based practice (EBP), as well outline the criticisms and benefits of this practice. They conclude with ethical considerations for psychologists to think about when implementing EBP. **Craig S. Travis, PhD, and Mary Miller Lewis, PhD**, examine the costs and benefits of biologizing mental illness and call on the profession to examine their own beliefs about the biological basis for mental illness.

We have three articles from the winners of the OPA Convention Student Poster Session. In the undergraduate category, four students from John Carroll University, **Amanda Maggiotto, Martina Sheridan, Ashley Russo and Abby Coats**, won for their work in examining how the gender and attractiveness of the harasser impact perceptions of sexual harassment. **Veronika Karpenko, MS**, of Ohio University, captured the top prize in the graduate student empirical category. Her work examines the relationship between change

in symptoms of attention deficit/hyperactivity disorder (ADHD) and improvement in functional domains. This article is co-authored by **Julie Sarno Owens, PhD, and Margaret Mahoney, BA**, also from Ohio University. **Jessica Turchik, MS, and co-author Christine Gidycz, PhD**, also from Ohio University, received the top prize in the graduate student non-empirical category. Their article provides a literature review on the issue of the sexual assault of men.

The last article presents the Telepsychology Guidelines that were approved by the OPA Board of Directors in April. Many thanks go to **Kenneth Drude, PhD**, for his leadership and vision in developing these guidelines.

Don't forget you can earn credit for reading the *OP*. Simply complete the quiz for continuing education and send it to the OPA office with your payment.

I would like to extend my sincere appreciation to the peer reviewers who reviewed the manuscripts submitted for publication in this issue of the *OP*. They include **William Bauer, PhD, Milton Becknell, PhD, Charles Dolph, PhD, Michael Dwyer, PhD, Kathryn MacCluskie, EdD, Janette McDonald, PhD, Justin Perry, PhD, and Elizabeth Swenson, PhD, JD**.

This issue is my first issue as the editor of the *OP*. It has been a pleasure to work with so many dedicated and talented professionals.

Kathleen (Ky) Heinlen, PhD, LPCC-S



In Defense of Spirituality: A Return to a Forgotten Practice for Holistic Psychological Health

By: Christine E. Agaibi, MA, The University of Akron

Abstract

Religious and spiritual topics are typically omitted from the counseling process. While these topics were historically taboo for psychologists, recent research has championed the effort to address these issues in treatment. Additionally, research shows that clients who discuss religious/spiritual beliefs tend to engage less in psychologically damaging behaviors and are more positive and hopeful. Furthermore, these clients appear to contribute more to changing the world around them. This article discusses these issues and gives examples of ways to assess religion/spirituality in clients. Finally, examples are given of ways to encourage clients to become agents of change through exploration of religion/spirituality.

Since the inception of psychology, theorists, researchers, and clinicians alike have posed questions regarding ways to achieve human mental and psychological health. While in the general sense, psychological health is seen as the absence of mental illness, psychological well being in its most adaptive form is actually multifaceted. In fact, there is interconnectedness between mind, body, spirit, and even community which are all necessary for human well being (Witmer & Sweeney, 1992). It is also important to note that a psychologically healthy society begins with and is made up of psychologically healthy individuals.

Cowen (1991) stated that at one time or another we have all experienced a transient or chronic threat to our wellness. However, restoration to wellness can be achieved by maintaining control over our stressors. The question thus becomes how can individuals understand and achieve wellness so that similar vitality can be attained in the greater society. Witmer and Sweeney (1992) stated that spirituality, self-regulation, work, love, and friendship are five characteristics necessary for the attainment of wellness. Though the latter four are often the focus of research and practice, these researchers ascertain that spirituality is actually the core of wellness.

Historical Views of Religion/Spirituality in Psychology

Historical figures in psychology focused on non-spiritual elements of wellness. Early individuals like Freud, Breuer, and Charcot only saw a relationship between mental and physical health and argued that psychosomatic complaints such as hysteria had origins in mental disturbance.

Additionally, some psychologists like Freud and Skinner saw the subject of religion/spirituality negatively, stating respectively that religion is, “an illusion derived from unconscious wishes” and “a controlling agency” (Seybold, 2007, p. 304). Thus, the subject of religion/spirituality became taboo. Psychologists turned the focus from these issues, instead advising clients to change their thoughts, enjoy work and the environment, and engage in healthy physical behaviors and positive, self-disclosing, and trusting relationships (Witmer & Sweeney, 1992).

While many historical psychology figures deemed spirituality unnecessary for wellness, other psychology forefathers believed this topic to be essential. James and Hall pioneered the discussion about the significance of religious/spiritual dimensions to individual development (Hall, 1904; James, 1917; Johnson, 2003; and Kemp, 1992).

Jung also declared the importance of religious/spiritual exploration for ideal mental well being (Jung, 1933). The late 20th century brought a new wave of dialogue on religion/spirituality and its connection to mental and physical health (Seybold, 2007). Some of the first people to accept this as truth have been non-psychologists in the fields of medicine, education, and sociology. Today, more research is being dedicated to the benefits of spirituality and its centrality to the objective of well being.

Why is This Important for Psychologists?

A 2006 Gallup Poll revealed that 87% of Americans are convinced or have little doubt of the existence of God (Gallup Organization, 2006). A more recent poll found that 82% of Americans believe that religion is fairly or very important in their lives (Gallup Organization, 2007). Given these statistics, it is important to realize that religion and spirituality are a central tenet of meaning for many Americans (Silberman, 2005). Existential psychologists were among the first to establish the importance of meaning as a necessity for psychological health. Researchers such as Park (2007) reaffirm that meaning generally and religious/spiritual meaning specifically are important by stating, Meaning systems comprise the lenses through which individuals interpret, evaluate, and respond to their experiences and encounters. Individuals' meaning systems are therefore central to understand the influence of psychosocial processes on their psychological and physical health. For individuals for whom [religion/spirituality] is important, [religion/spirituality] forms a core part of their meaning system, influencing their global beliefs, goals, and sense of meaning in life. (p.320)

While not all Americans are religious, for those that are, religion seems to provide a set of guidelines for conduct, something to strive for, rules related to lawfulness, and motivation to endure despite difficulty. Religion also tends to give people a hope in the goodness of the world and other people as well as giving individuals a reason to achieve their goals (Park, 2007). Additionally, research has shown that there is a negative correlation between religion/spirituality and suicide, substance abuse, risky sexual behavior, and depression (Larson & Larson, 2003). Since research on religion and spirituality appears to confirm the connections between these elements and mental and physical health, the exploration of client beliefs are essential for psychologists. Psychologists need to understand what religion/spirituality means to clients, how clients practice these beliefs, and how beliefs manifest in client lives.

Definitions of Religion vs. Spirituality

While the majority of the literature uses religion and spirituality synonymously, Hill and Pargament (2003) distinguish between these terms stating that religion is,

“becoming reified into a fixed system of ideas or ideological commitments” while spirituality is, “increasingly used to refer to the personal, subjective side of religious experience” (p.64). Gallup polls described subjective religious/spiritual experiences based on gender and age. For example, Gallup polls stated women tend to have more spiritual beliefs than men and that spirituality increases with age (Gallup, 2002). Consequently, religion/spirituality appears to be a unique experience to each individual encountering those beliefs. For some, the experience may be more traditional and dogmatic, while for others, it may be more subjective and personal. Millions of Americans, despite age, gender, race or culture, have some belief system, which appears to be important for psychological growth, well being, and health. Therefore, psychologists have a responsibility to bring these issues to the forefront of assessment, goal setting, and therapeutic interventions alike.

Examining Spirituality in Clients

Silberman (2005) assists psychologists in meeting this responsibility by discussing several ways to examine spirituality in clients so that one can better understand oneself and gain optimal mental health. First, psychologists need to gain an understanding of the client's worldview and beliefs regarding himself/herself. This information guides the clinician's understanding of what the client holds sacred, his/her views about others, and his/her views about the nature of this world and what may lie beyond it.

Second, clinicians need to become aware of client contingencies and expectations that are often attached to religious/spiritual beliefs. For example, Silberman (2005) states that people may hold the expectation that those who live virtuously should receive reward while those who act immorally should be punished. However, distress and psychological symptoms may arise if a virtuous person is not rewarded as he/she expects. Such beliefs may then diminish the client's beliefs about his/her ability to change him/herself or the world. Being aware of such beliefs can assist psychologists in treatment by showing the client alternative ways to obtain reward and enhance self-efficacy.

Third, a clinician should assess the client's goals that are rooted in religion/spirituality. According to Silberman (2005), this evaluates the client's motivation for holding on to what he/she believes is sacred. Thus, does this client perceive that he/she will obtain a reward for his/her belief? Is the client's goal altruism, benevolence, forgiveness, or a desire to appease a supreme being? Gaining information about the client's goals assists tremendously in developing and manifesting therapy objectives.

Fourth, Silberman (2005) suggests that clinicians assess client actions. The client may experience some cognitive dissonance or incongruence between his/her subscribed

continued page 10

religious beliefs and his/her behavior. Relieving this distress will only come with in-depth examination of the religious principles and working with the client to find ways to reconcile that belief with actions.

Fifth is examining the client's emotions, which are sometimes influenced by religion/spirituality. For example, Silberman (2005) states that religion often encourages emotions such as forgiveness and joy and discourages emotions such as anger. So, using the client's religious beliefs therapists can introduce positive emotions to the client with greater ease.

Encouraging Clients to Become Agents of Change Through Spiritual Exploration

This article shows that examining religious/spiritual beliefs, though historically unpopular, is valuable to psychological treatment and is necessary for the development of psychologically healthy individuals. It is important to reiterate that psychologically healthy individuals create psychologically healthy societies. Many Americans have some religious or spiritual orientation, which allows them to view the world as generally good, just, and having potential for change. Counseling that focuses on religion/spirituality brings these beliefs to light, and assists client in developing positive emotions. In addition, a client that focuses on religion/spirituality tends to develop confidence in his/her own ability to create change in the world. Exploring and understanding the premises of religion/spirituality, irrespective of specific dogma, teaches clients about the importance of social justice and fairness. A client that becomes aware of his/her spiritual place in the world can then begin to explore and identify ways to become a social activist in his/her home, community, and the world. Encouraging these ideas in therapy can positively change one's worldview and interactions with others thus leading to a healthier society one client at a time. Thus, it seems that religious/spiritual discussions in therapy are beneficial, and lead to psychologically healthy individuals that proverbially light a candle rather than curse the darkness in their lives and the world around them.

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About the Author

Christine E. Agaibi, MA, is a doctoral candidate (ABD) at The University of Akron. She is an active member of the Ohio Psychological Association of Graduate Students (OPAGS) and served as diversity chair for the 2007-08 year. She was elected president-elect of the organization for the 2008-09 year. Christine also was recently elected to serve in the presidential role for Ohio Women in Psychology.

Additionally, while in graduate school, she served as philanthropy chair of the Counseling Psychology Graduate Student Organization (CPGSO). She also has been involved with the National Peer-Mentoring Program for Ethnic Minority Graduate Students where she mentored minority students in the beginning of their graduate career to assist them with questions about multicultural issues, education in psychology, and their future careers.

Christine is also an active graduate student affiliate of the American Psychological Association; APAGS; APA Divisions 2, 17, 24, 32, 35, 36, and 40; the Ohio Psychological Association; and the Cleveland Psychological Association.



An Ohio Psychologist in India and Nepal

By: Richard Sears, PsyD, MBA, ABPP



At the doctoral clinical psychology program where I teach, our mission is to focus clinicians on understanding and contributing to social justice issues. Fouad, Gerstein, and Toporek (2006) describe social justice as follows: “Related to the legal notion of equity for all within the law, social justice also connotes that the distribution of advantages be fair and equitable to all

individuals, regardless of race, gender, ability status, sexual orientation, physical makeup, or religious creed.” (p. 1)

In January and February of 2008, I journeyed through India and Nepal. This six-week trip truly changed my perspective on the world and my place in it. My eyes were opened to a completely new definition of social justice.

My trip began in New Delhi where I presented at the World Congress on Psychology and Spirituality. Representatives from over 40 countries participated in the conference. My presentation, “Psychological Obstacles on the Spiritual Path,” was well received. I also was invited to participate in the creation of a consortium of researchers for the empirical investigation of meditation techniques and chaired a panel that included a speaker named D.R. Kaarthikeyan. Kaarthikeyan is rather famous in India, as he is the president

of a number of magazines and other companies, the former director of the Central Bureau of Investigation, and the person who solved the Indira Gandhi murder case.

Interestingly, most Indian psychologists boycotted the conference. They felt that they should only be pursuing hard, empirically-based data, and any questions about spirituality (broadly defined as finding meaning in one’s life) was not worth investigating.

I took a day to visit the city of Agra, which contains the Red Fort and the Taj Mahal. It was amazing to learn of the unequal distribution of power in history. Despite the poverty of the general population, the rulers created architecture on a colossal scale, often made of marble, sometimes with gemstones embedded in the walls.

I then traveled to Bodhgaya, a city in the state of Bihar, the poorest state in India. Bodhgaya is the city where the historical Buddha (which means “the awakened one”) sat in



meditation and achieved his breakthroughs. The city was an amazing contrast of spiritual richness and abject poverty. It was most difficult to see the children, who somehow found happiness in their play, even when they were barely clothed and covered in dirt.

I later met my martial arts teacher and a psychology colleague, Dr. Brian Denton, in Kathmandu, Nepal. From there, we traveled to a teaching monastery in Pokhara, a city



on the edge of the Himalayan Mountains. I spent much time talking to the monks about life there, and about the field of psychology, which they knew little about. Most of the monks were children who were learning the old Tibetan ways (they are refugees living in Nepal because of the Chinese invasion of Tibet), as well as more modern subjects. I was also able to observe the Tibetan New Year celebrations, which included traditional dances as well as sack races and tug-of-war contests. My friends and I were asked to put on a martial arts demonstration, and I received my fifth degree black belt from my teacher. It was quite a meaningful moment, there by the mountains of the Himalayas.

Nepal has a serious gasoline shortage, and the electricity is shut off at least eight hours per day. I truly came to appreciate the luxury of having gasoline, electricity, and clean drinking water readily available in the United States. The Maoists, a growing presence in Nepal, are trying to recruit followers in their desperate attempt to make changes in their country, and we were caught in a rally march on the way to the airport. Though it was a bit anxiety provoking, no violence occurred, and it passed after about half an hour.

In my psychology career, I have learned much about the privileges of being a white male. In these travels, I learned about the privileges of my wealth, education, ability to choose, and being a native English speaker. English was considered the most common tongue for travelers. At one point, I was the only native English speaker attending a lecture that was being given in English to people from all over the world.

Throughout my travels, I attempted to speak to as many people as I could about mental health services. I discovered two common themes. One, there is a strong stigma about the use of mental health services, and secondly, they are not much valued by the society.

One Indian woman, who was completing her doctorate in the U.S., told me that agencies would not hire a doctoral-level clinician when they could pay less to someone who held a “certificate,” which one can obtain after a few months of training. There are currently no licensure laws. I also was told that people are so busy trying to earn a living to survive that psychotherapy is considered a luxury.

Interestingly, I also experienced a bit of culture shock when I came back to the abundance we have in the United States. I have come to appreciate the small things in my life so much more, and have expanded my perceptions of what constitutes the world around me.

I believe that if we are to build a psychologically healthy society, we must first become aware of the state of the rest of the world, and consider in our efforts the context of a global community.

About the Author



Richard Sears, PsyD, MBA, ABPP, is a core faculty member of the PsyD program at the Union Institute & University in Cincinnati, where he also runs a small private practice. He is lead author of the book “Consultation Skills for Mental Health Professionals.” He can be contacted at richard@psych-insights.com.

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Consciousness and Meditation: A Zen Experience

By: Janette E. McDonald, PhD, Capital University

Abstract

This article reflects on my three-month sabbatical experience at a Zen Center. While my intentions for such an experience were many, this paper focuses on only one topic—the potential impact that Zen meditation has on increasing levels of consciousness and awareness. Through formal sitting meditation, one learns to pay close attention to the thought processes, which potentially increase one’s mindfulness and levels of personal awareness. One may engage in meditation whenever one is fully present to the current moment. The following is a phenomenological rendering of my experience and was collected from personal journal entries, Buddhist literature, and field notes from individual conversations. I found that quieting the mind in any form, especially sitting meditation, was helpful in developing a heightened self-awareness and increasing one’s mindfulness.

Introduction

A year ago, I was accepted as a member of a Zen monastery’s Path of Service program, which allowed me to live and work in much the same way as the Zen monks. In this paper, I reflect on the subtle yet important experience of paying attention through meditation and its benefits. First is a short explanation of Zen Buddhism and how it connects with the concept of consciousness, followed by a discussion of the Zen community (sangha), as interpreted through my phenomenological lens. I conclude with some repeated themes of meaning as gathered in dialogue with members of the monastery.

Zen and Understanding Consciousness

Zen is a form of Buddhism that focuses on sitting meditation, but it also teaches that meditation can be any form of concerted attention directed in the present moment. Walking, gardening, playing musical instruments, preparing meals, sitting, and cleaning our living quarters were some of the daily activities performed at the monastery, and all of these actions could be quite meditative when addressed with concerted attention.

Some (Suzuki, 2006; Rosenberg, 2004; Kaplau, 2000) have said that Zen is first and foremost about training the mind to be centered, conscious, and focused. By sitting quietly, following the breath, one begins to notice one’s self in ways never before imagined. When you sit and pay close attention to your thoughts you notice their speed and scattered movement as they leap from topic to topic. You see your negative judgmental side; you feel anger and resentment that may have been buried for years, and you notice the tenderness and meaning that human experience offers.

Such clarity can be directed to any action. As you pit a bowl of cherries, you may experience hundreds of thoughts that have nothing to do with pitting cherries. Through meditation, your consciousness is heightened and you begin to notice different shades of reds, pinks, and purples in each cherry.

You see and appreciate their individual beauty and splendor in a refreshed way.

Consciousness: A Variety of Definitions

A term called skandhas (or heaps) is well known to Buddhists. The five skandhas, form, feeling, perception, thought, and consciousness, make us human and cause our suffering (Nhat Hanh, 1999). Some words in the Zen tradition, namely consciousness, mind, and self, have different meanings and interpretations when compared to how they are understood in psychology. For instance, some neuroscientists (Hamilton, 2005) have studied consciousness and meditation and argue that human consciousness is nothing more than brain functioning. Others maintain that the brain and mind are the same, and the self is simply a biological bundle of molecules (Hamilton, 2005). Consciousness viewed in this way does not and cannot extend beyond the physical body. It is certain to cease at death.

Consciousness, Karma, and Reincarnation—A Different Understanding

Buddhists however, view consciousness differently and understand that the brain and mind are not the same. Consciousness is viewed as a field of self-awareness, and for Buddhists, eight levels of consciousness exist. The first five register the mental association of the sense organs. The sixth is associated with what might be called mind. The seventh is known as afflicted consciousness, and the eighth, alaya, is “the ground basis of all” (Mipham, 2008). A detailed discussion of these exceed the purpose of this paper; however, the Zen sutras suggest this understanding is thousands of years old and has been passed down through the great sages.

Furthermore, the Buddhist concept of reincarnation explains how one’s consciousness may extend beyond one’s current physical body. The concept of karma helps clarify an understanding of reincarnation. The laws of cause and effect are often equated with karma. Simply stated, we will reap the benefits of this life in our next.

Consciousness at the Monastery

Setting and Population

Members of this Zen community came from every continent on the globe. Their socio-economic status was as varied as was their age, gender, levels of education, sexual orientation, and experience and devotion to Buddhism. They were Christian, Muslim, Jew, Sufi, Buddhist, atheist, agnostic, and several combinations thereof. The monastery also served as a retreat center with on-going educational seminars. The teachers and lecturers were renowned physicians, rabbis, Sufi masters, medical ethicists, Roshis, Zen masters, Dogan scholars, musicians, artists, and regular ordinary folk. Like many Zen monasteries and centers, its population was always in flux. Some people came for a three-year commitment while others like me were there for much shorter periods.

I experienced most of the monastery residents to be thoughtful and serious men and women who were committed to a Zen meditation practice. There were 21 residents; more women than men and most were between the ages of 20 and 50. During informal dialogue, I learned that many had come to the Center to do intense personal reflection and self-examination. Several had struggled with mental illness such as depression and addiction. Some were cancer survivors and some had attempted or seriously contemplated suicide.

Meaningful Dialogue—Themes Revealed

Findings

Deeply looking within ourselves takes patience and courage and many of the residents seemed to exhibit both of these qualities. Each evening after supper, residents could be seen reading classic Buddhist texts, practicing yoga, or sitting formal meditation in the temple. These were routine nightly activities. During casual conversations, I learned that most expressed physical benefits from their extended sitting practice. Many lost excess weight. They reported better concentration when reading and meditating, and several noticed improved physical health. One person in particular noted her complete lack of headaches since she had been to the monastery. Finally, several attributed sitting meditation to an overall improved attitude of well being. For example, little annoyances seemed less annoying after they meditated.

While residents did not make the same distinctions in consciousness, they clearly understood the differences. For many, meditation helped them increase their awareness and consciousness. Most acknowledged the biological factors in consciousness, but they also mentioned that biology is not the entire reason for it. Almost everyone discussed language and meaning differences when comparing Western science with Zen Buddhism. It was not unusual to hear people use the word conscience and soul interchangeably.

Summary

Walking a garden path, chopping vegetables for a meal, or methodically giving a lecture to a class of students can be an awakening experience—one where you see and understand ordinariness and simplicity in new and refreshed ways. During my time at a Zen monastery, I gained a greater personal insight into the ordinary and simple. I went to the monastery for many reasons and one was to learn about the influence meditation had on consciousness. After three months of living like the monks, e.g. cleaning, cooking, performing daily chores, and meditating, I witnessed many benefits of meditation. Increased levels of conscious and awareness were some of the self-reported findings for members of this Zen community and for myself. Learning to quiet the mind from racing thoughts was a significant benefit for all of us. I remain grateful to the members of this Zen community for the compassion and wisdom they extended to me.

About the Author



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Positive Psychology and Positive Therapy: Implications for Practitioners

By: Christopher Mruk, PhD

Abstract

By now, most psychologists have heard about positive psychology. However, what distinguishes this approach from others may not be clear to many of us. This article attempts to achieve some clarity by examining three important dimensions of positive psychology. The first involves taking a brief look at the origins of positive psychology in order to understand why it has emerged. The second is to consider the chief characteristics of positive psychology in order to appreciate its focus. The third is to consider two examples of positive therapy in order to show how positive psychology may be of practical value to the clinician.

By now, most psychologists have heard about something called positive psychology. However, many of us may not be quite sure what the term means or what implications it holds for clinical work. A brief look at the origins of positive psychology, its chief characteristics, and two examples of how positive therapy may be helpful to clinicians are presented in this paper.

Although the concept of positive psychology may be traced back to the late 19th Century (Taylor, 2001), the first major version of this approach occurred in humanistic psychology. Maslow (1970) outlined such a vision and identified its major topical areas in an appendix titled, "Problems Generated by a Positive Approach to Psychology" (p. 281). In one way or another, most clinicians are familiar with this type of psychology. Recently, Seligman and Csikszentmihalyi (2000) introduced a new form of positive psychology that is receiving more attention today. Stated most succinctly, this approach is a "science of positive subjective experience, positive individual traits, and positive institutions" (p. 5). Simply referred to as positive psychology, the topics and goals of this approach are similar to those of its humanistic counterpart. However, the two psychologies greatly differ in terms of the methods they employ. Humanistic psychology welcomes qualitative research and methodological diversity, while the new positive psychology relies on quantitative methods and resulting empirical knowledge.

In just a few years, positive psychology has made considerable progress. For example, it has already seen: (1) the creation of a center for positive psychology at the University of Pennsylvania; (2) large scale research projects on positive personal qualities, such as the Values in Action program; and, (3) the support of both public and private organizations. In addition to research, positive psychology also is concerned with practical applications in two areas. The first is prevention and specifically focuses on facilitating the development of positive human qualities as well as the social processes and institutions that foster them. The second application is often called positive therapy (Seligman, 2002; Linley & Joseph, 2004) and helps people deal with clinical issues and other problems of living. This approach involves using "deep strategies" (Seligman, 2002, p. 6). One

such strategy is to strengthen therapy by tying it to healthy experiences and behavior that occur naturally in a person's life. Helping individuals experience even brief moments of well-being has the therapeutic value of connecting them with positive states in spite of the difficulties they may be facing.

Fava's Well-Being Therapy (WBT: Ruini & Fava, 2004) was developed to address the problem of relapse in treating depression and is often presented as an example of positive therapy. WBT is a short-term, highly structured therapy that aims at increasing periods of well-being in those who are depressed. The treatment consists of eight 30- to 50-minute sessions offered either once a week or once every other week and involves keeping a journal. The program begins by helping clients appreciate the episodes of well-being they experience, identifying the circumstances that seem to generate these experiences, and recording this material in their journals. The next phase or the intermediate sessions of WBT focus on helping clients understand how they may be short-circuiting such experiences and how to avoid doing that through, for instance, the use of cognitive restructuring. The final part of the therapy concerns helping people identify specific problem areas that impair their ability to experience well-being. Once identified, individualized plans are developed to help clients remove impediments and thereby expand the frequency and duration of well-being.

Throughout treatment, the focus gradually shifts to positive tasks such as environmental mastery, personal growth, finding purpose in life, the development of autonomy, creating positive relations with others, and so forth, until relapse is less likely. Thus, WBT works from a strengths perspective. There appears to be a fair degree of empirical support for this form of positive therapy (Ruini & Fava, 2004). Most traditional therapies, by contrast, direct attention at treating illnesses or problems which are more negative in focus. Interestingly, however, WBT was developed before the new positive psychology was launched. Thus, positive therapy is defined more by its focus and techniques than by a practitioner's training or membership in an official organization.

What makes positive therapy positive centers around the goal

of expanding periods of well-being and using therapeutic strategies that place more emphasis on a person's strengths rather than weaknesses. Consequently, a therapeutic approach aimed at enhancing authentic or healthy self-esteem that is accompanied by empirical support would seem to meet the criteria for a positive therapy. One such program consists of five two-hour sessions offered at the rate of once per week (Mruk, 2006). This approach begins with defining self-esteem in terms of competence and worthiness rather than feelings of self-worth alone. Thus, it may be helpful to distinguish this therapy by referring to it as Competence and Worthiness Therapy (CWT).

CWT begins with a Focusing Phase that addresses the importance of defining self-esteem as a relationship between competence and worthiness. These two factors balance each other in a way that leads to authentic, healthy, and/or positive self-esteem. Competence without worthiness, for instance, places too high a priority on success (or failure) not to mention the problem of being competent at negative things, such as antisocial behavior. Similarly, a disproportionate or unearned feeling of worth may actually reflect narcissism rather than well-being. In this initial phase, participants record moments of competence and worthiness in their own lives in journals which are then actively used as living examples of well-being throughout the program.

Next, the Awareness Phase focuses on identifying the domains of life in which a person exhibits higher and lower levels of competence or worthiness based on the Multidimensional Self-Esteem Inventory (O'Brien & Epstein, 1988). Attention is given to identifying strengths rather than weaknesses.

The third period, the Worthiness Phase, involves increasing one's sense of worth through various standard techniques. One of them is correcting self-denigrating thoughts through cognitive restructuring. The subsequent Competence and Worthiness Phase does the same for this component of self-esteem through the use of problem solving skills, thereby addressing both factors.

The final, Maintenance Phase, involves helping participants develop an individualized action plan for managing their self-esteem in the future, thereby extending the program's benefits.

Like well-being therapy, CWT is a process that focuses on increasing periods of well-being, linking therapy to deep positive structures, using assessment to individualize the process, and employing standard psychotherapeutic techniques to reach its goals. Similarly, this form of positive treatment has been evaluated qualitatively and quantitatively with positive results (Hakim-Larson & Mruk, 1997; Bartoletti & O'Brien, 2003). In addition, CWT has the potential to be adapted in ways that could be used for prevention which is another goal of positive therapy. This therapy could be modified for those who are at-risk for problems commonly associated with a lack of self-esteem, such as depression. Since the program is concerned with healthy self-esteem,

it could also be used to foster psychosocial growth and development as a form of positive life-coaching.

About the Author

Christopher Mruk, PhD, attended Michigan State and Duquesne University. His clinical background includes working in crisis intervention, directing the counseling center at St. Francis University in Pennsylvania, and consulting with Firelands Regional Medical Center in Sandusky, Ohio. For over 20 years, Dr. Mruk has been a professor of psychology at Bowling Green State University Firelands College in Ohio where he has received the Distinguished Teaching and its Distinguished Scholarship Awards. His publications include a number of articles, chapters, and books on self-esteem, psychotherapy, and positive psychology. He may be contacted at cmruk@bgsu.edu or <http://www.firelands.bgsu.edu/~cmruk/index.html>.

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Growth Motivation: A Buffer Against Low Self-Esteem

By: Sunwoong Park, BA, Jack J. Bauer, PhD,
and Nicole B. Arbuckle, BA, University of Dayton

Abstract

This study investigated the effects of self-esteem and growth motivation on happiness. While both self-esteem and growth motivation have shown strong relations with well-being and life satisfaction, people with low self-esteem but high growth motivation expressed substantially more happiness, compared to those with low self-esteem and low growth motivation. This buffering role of growth motivation against the negative effects of low self-esteem is discussed.

In 1986, Assemblyman John Vasconcellos and California Governor George Deukmejian agreed to fund a Task Force on Self-Esteem and Personal and Social Responsibility with an annual budget of \$245,000 over a period of several years. They argued that raising self-esteem (SE) would reduce crime and delinquency, decrease teen pregnancy and underachievement, lower drug abuse and crime, and cut pollution. They also believed that this financial cost would be returned because people with high SE would make more money and thus pay more taxes.

The SE movement appears to have failed. Most of the good qualities purported to belong to high SE turned out to lack empirical support. Out of more than 15,000 journal articles on SE published over the past 30 years, Baumeister, Campbell, Krueger, and Vohs (2003) reviewed 200 scientifically meaningful studies and concluded that there is little evidence that high SE actually leads to more positive outcomes.

Despite this disappointment, Baumeister et al. (2003) pointed out that SE has a strong relation with happiness; people with high SE are substantially happier and less likely to be depressed. The so-called *buffer hypothesis* attempts to explain this relationship: High SE operates as a buffer against negative events (DeLongis, Folkman, & Lazarus, 1988). Although the validity of this hypothesis remains equivocal, studies testing this hypothesis confirmed a consistent relation between low SE and depression/unhappiness, especially when combined with self-blaming attribution styles (Baumeister et al., 2003).

In fact, low SE has been notorious for its negativity. Beck (1967) argued that low SE as well as negative self-views lead to depression. Tennen, Herzberger and Nelson (1987) found that low SE is the best predictor of the depressive attributional style formulated by the learned helplessness model (Abramson, Seligman, & Teasdale, 1978). People with low SE have been found to know less about themselves (Campbell & Lavelle, 1993), lack positive self-views (Blaine & Crocker, 1993), emotionally fluctuate at the mercy of situations (Harter, 1993), and try to protect their low self-worth from falling lower (De La Ronde & Swann, 1993).

Based on these studies, Baumeister (1993) summarized the characteristics of people with low SE as uncertain, fragile, protective, and conflicted. However, we think that this description misses one important aspect of low SE. Among people with low SE, some people believe that they can

improve their skills and abilities and vigorously put effort into it. We call this belief and effort *growth motivation* (GM; Bauer et al., 2008).

GM is defined as a motivation for psychosocial growth and self-improvement. Narrative studies on growth goals and growth memories revealed that people with growth motives expressed more maturity and well-being (Bauer & McAdams, 2004; Bauer, McAdams, & Sakaeda, 2005). This present study investigated how GM affects happiness in conjunction with SE. While we supposed that GM in general would have an effect on happiness, we expected this effect to be much stronger in people with low SE.

Since people with high SE must have achieved successes in life and probably are happy already, the possibility of growth would have a relatively small effect on happiness. In contrast, people with low SE must have experienced many failures, and these experiences might drag them down to depression. However, as long as they believe that they can perform better in the future and as long as they indeed work hard to improve themselves, this belief and effort will lighten the weight of failures. In other words, GM will operate as a buffer against the negative effects of low SE on happiness. Therefore, people with low SE but high GM were hypothesized to be happier than those with low SE and low GM.

Method

Participants and Procedures

Undergraduate students (N = 109, 62% women) participated in the online study (www.surveymonkey.com) in exchange for course credit. The mean age was 19.7 years (SD = 1.19).

Measures

Growth motivation. The 25-item Growth Motivation Index (Bauer et al., 2008) was used to measure motivation for personal growth ($\alpha = .85$). This measure is composed of experiential, cognitive, and extrinsic GM. Each category respectively includes items such as "I strive to improve my interpersonal relationships," "I actively seek new perspectives on how to live my life, even if these new perspectives mean I've been wrong," and "I read material that is entertaining rather than challenging." Participants rated how often they do each item on a scale from 1 (never) to 7 (always). Extrinsic motivation scores were reverse-coded.

Self-esteem. The 10-item Rosenberg Self-Esteem Scale (Rosenberg, 1965) was used to assess SE ($\alpha = .87$). Items were

Table 1
Hierarchical Regression of Life Satisfaction and Well-Being on Self-Esteem and Growth Motivation

D. V.	I. V.	β	p
Life Satisfaction	Self-Esteem	.30	.001
	Growth Motivation	.27	.003
	Interaction	-.21	.024
Well-Being	Self-Esteem	.25	.007
	Growth Motivation	.42	.000
	Interaction	-.08	.411

rated on a scale from 1 (strongly disagree) to 5 (strongly agree).

Well-being. The 54-item Psychological Well-Being Scale (Ryff, 1989) was used to measure well-being ($\alpha = .94$). Items were rated on a scale from 1 (strongly disagree) to 6 (strongly agree).

Life satisfaction. The 5-item Satisfaction With Life Scale (Diener, Emmons, Larsen, & Griffin, 1985) was used to measure life satisfaction ($\alpha = .85$). Items were rated on a scale from 1 (strongly disagree) to 7 (strongly agree).

Results

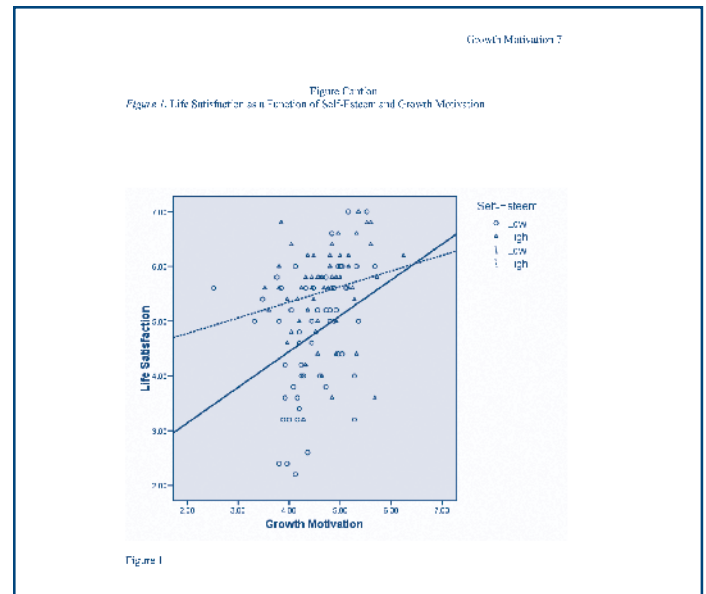
While SE and GM did not significantly correlate ($r = .18$, $p < .10$), each of them correlated significantly with well-being and life satisfaction. SE had significant relations with life satisfaction ($r = .35$, $p < .001$) and well-being ($r = .33$, $p = .001$); GM with life satisfaction ($r = .32$, $p = .001$) and well-being ($r = .47$, $p < .001$).

As Table 1 shows, SE and GM were main effects on life satisfaction and well-being, even after controlling for each other. The effect of SE and GM interacted on life satisfaction. Figure 1 visually presents the nature of this interaction; life satisfaction of people with low SE but high GM was substantially higher than that of people with low SE and low GM.

Discussion

This study confirms three points. First, SE has strong ties to happiness, which already has strong support. Second, GM has substantial ties to happiness. This finding is especially impressive in that GM is not significantly related to SE. Finally and most importantly, GM moderates the effect of SE on happiness. As long as they are oriented toward growth, people with low SE tend to be more resilient against unhappiness or depression.

We propose that this difference in low SE can be explained by the ways people respond to negative outcomes. The learned helplessness model (Abramson et al., 1978) suggested that people low in SE make internal, stable, and global attributions for failure, and this attributional style is an important feature of depression. In this model, making internal attributions is equivalent to blaming oneself.



However, we argue that there is a beneficial facet of making internal attributions: Struggling for growth and self-improvement. Since people learn and grow by correcting previous mistakes, accepting responsibility for failure indicates that they are willing to rectify their mistakes such that they can succeed next time. In fact, this idea was already confirmed. Park, Bauer, and Arbuckle (2008) found that people with high GM took responsibility for failure, regardless of levels of SE. Tice (1993) also reported that people low in SE seek information about their faults and flaws when they want to remedy deficiencies and shortcomings.

Another beneficial aspect of making internal attributions is having control. People cannot accept responsibility when they do not have control over situations, whether it is success or failure. In other words, accepting responsibility implies claiming control over outcomes. This perception of control in attributional style was found even in the eyes of others. When leaders made external attributions for negative outcomes, employees perceived them as powerless (Lee & Tiedens, 2001).

Positive aspects of having control have been well reported. For example, older people in nursing homes who had control over their environment such as picking movie days or growing a plant became happier, more active and even lived longer (Langer & Rodin, 1976; Rodin & Langer, 1977). Janoff-Bulman (1992) found that victims of tragedies, such as date rape or breast cancer, coped better if they blame themselves (especially behavioral self-blame) for the tragedy. By blaming their behaviors which caused the situation, the victims can believe that the tragedy will not happen again as long as they change those behaviors in the future.

Introducing the concept of GM to research on happiness and mental health is quite new. However, now that SE, which was regarded as the panacea for all the problems of mental health has been proven groundless, psychologists need a new paradigm. We hope that people's willingness to learn, grow, and improve themselves can be one of the answers.

About the Authors



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The Ethics of Evidence-Based Practice

By: Michelle Madore and Yvonne Humenay Roberts, University of Cincinnati

Abstract

Evidence-based practice (EBP) has received increased attention in the field of psychology over the past few decades. This article provides a brief history of EBP as it pertains to psychology, as well as a discussion of the benefits and criticism of the practice. It also highlights the ethical considerations psychologists must remain cognizant of when implementing EBP.

The past two decades have seen a growing divide within the mental health community over the advantages of using evidence-based practice. Evidence-based practice (EBP) is “the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients” (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996, p. 71). Practicing EBP can be difficult as it requires clinical expertise, the ability to retrieve current clinical research, an aptitude for interpreting and applying data, and skill at communicating the risks and benefits of specific courses of action to patients until appropriate techniques are established. Its complexity and newness make EBP a much-debated topic in psychology.

EBP Background

EBP emerged in the field of psychology in the early 1990s shortly after the development of stricter guidelines by health maintenance organizations (HMOs) for treatment accountability (Okamoto & LeCroy, 2004; Sanderson, 2003). HMOs realized that the extreme variability in treatment plans for illnesses decreased the number of persons receiving effective treatment (Sanderson, 2003). The original approach to increasing treatment effectiveness was to decrease the number of sessions covered for each client during the course of treatment. The current trend set by HMOs is to allow 10 sessions based on a national average of sessions per client, which includes individuals who attend only one session or who drop out (Areán & Vidrez, 2002). Unfortunately, once clients learned of this, they wanted to opt for more comprehensive coverage but were extremely limited in their options (Stricker, 2003). HMOs were left with the burden of finding a sufficient balance between cost effectiveness and client satisfaction. In other words, efforts were made to decrease expenses while providing sufficient coverage for needed services (Sanderson, 2003).

Many agencies responded by developing committees to establish the standard of empirically based treatments for mental health disorders. The goal for EBP was to improve the effectiveness of patient treatment by providing a treatment manual outlining specific methodologies that were shown to significantly reduce symptomatology. In particular, the

Society of Clinical Psychology, American Psychological Association Division 12, created a Task Force on the Promotion and Dissemination of Psychological Procedures. In October 1993, it adopted a report that focused their efforts on “identifying, supporting, and disseminating empirically supported treatments” (Sanderson, 2003, p. 294). The final product was a collection of volumes, still in the process of release, titled, “Advances in Psychotherapy – Evidence-Based Practice.” Each volume addresses current research regarding a specific disorder (Chambless et al., 1998).

Task force members asserted in a 1996 report that the goals they had established were being misrepresented (Chambless et al., 1998). This report clearly stated that the information collected about EBP is not an all-inclusive list of possible treatments for mental health disorders. Rather, it suggests that the treatments listed are those of particular interest and have been reviewed and voted by the committee members unanimously to be supported by evidence from the literature.

Benefits of EBP

Proponents of EBP have suggested that an empirically-based approach to practice, teaching, and research addresses some limitations of current practice (Sackett, et al., 1996; Straus & McAlister, 2000). First, new discoveries related to the treatment of clients with mental health disorders are happening all the time. Without incorporating the latest research findings, practice would quickly become outdated. Second, EBP enhances a psychologist’s ability to manage and evaluate data in a timely manner, which leads to less information overload and less delay in implementing research findings. Third, EBP may help to bridge the gap between the demand for health care and the resources available, especially in low income communities, by forcing clinicians to use established techniques. In such areas, which have a disproportionate number of clients per professional, EBP may help speed clinical decision-making and allow for more face-to-face contact between professional and client without sacrificing quality of care.

Criticisms of EBP

Opponents of EBP argue that an empirical approach suppresses clinical freedom resulting in a more constrained method of clinical practice that is insufficient in providing optimal levels of clinical care (Landry & Sibbald, 2001; Tonelli, 2001; Williams & Garner, 2002). Some suggest the emphasis in EBP on published research may interfere with the effective application of clinical skills to meet an individual client’s needs. Professionals implementing EBP must integrate the published evidence with their own personal clinical expertise to choose the best course of treatment.

Opponents of EBP further argue that providing a comprehensive guide to treat clients could prevent the progress of the scientific process, initially by discouraging the presentation of opposing theories for treatment of particular

disorders, and later by limiting research of different treatment modalities (Roberts & Yeager, 2004). They also point out that the peer review process has several restrictions. For example, research being published has high levels of internal validity (i.e., treatment efficacy) but fails to address issues of external validity (i.e., clinical utility). Additionally, studies that include non-significant results or negative trials go unpublished (Gupta, 2003). As a result, EBP is compromised by not representing all completed studies that may have an effect on treatment outcomes (Straus & McAlister, 2000). Further, most studies are conducted with a homogenous population of white males and under represent groups such as women, children and ethnic minorities (Harris, Tulskey, & Schultheis, 2003). Finally, because the random, double-blind placebo controlled study is expensive, funding sources ultimately decide what gets investigated, with much of the funding being donated by pharmaceutical companies whose agenda may be inconsistent with the needs of the practitioners of EBP (Williams & Garner, 2002).

Ethical Considerations with EBP

Based on the Ethical Principles of Psychologists and Code of Conduct, the potential for ethical violations in treatment using evidenced based practice is apparent. Several main issues that should be considered include: manualized care, change in the dynamics of the therapeutic relationship, negation of non-significant findings, and lack of empirical evidence justifying the use of EBP.

Manualized Care

Historically, psychological treatment has been a joint effort between the psychologist and the client. Through this relationship, an individual treatment plan is developed. EBP focuses on treatment outcomes for populations rather than the individual (Kirsner & Federman, 1998). This approach has been guiding the field to a more manualized form of care eliminating the client's contribution to the treatment plan. As a result, the potential for harm increases because the psychologist may no longer be taking into account the individual's needs, wants, and motivations. Further, it poses an ethical dilemma by restricting the range of treatment options and compromising the integrity of the treating psychologist by forcing him/her to possibly utilize a therapeutic technique that he/she is not as competent in.

Therapeutic Relationship

There are important aspects about research that are not addressed in the argument for EBP. First, there are a multitude of variables that can be contributed to the amelioration of a client's symptomatology. Research discussed in Roth and Fonagy (1996) has shown that there is a strong relationship between the effects of treatment and other variables beyond type of treatment used. These include therapist variables such as years of training and years of experience. The most commonly mentioned variable is the idea that regardless of what treatment method is used, a person's condition will improve when a strong therapeutic alliance is present (Roth & Fonagy, 1996). Due to the imprecise nature of how to measure the strength of the alliance, the influence of that relationship may always be a substantial point of debate. Ignoring the value of the therapeutic relationship simply because it may be difficult to

measure violates our duty to maintain competence.

Random Assignment

Similarly, forcing the field to use the purported "gold standard" methodology in research in itself is unethical, as it would require psychologists to randomly assign which clients would and would not receive treatment. Additionally, the idea of a "gold standard" creates a hierarchy within the field of published research, which devalues other methodologies (e.g. qualitative research) that can still contribute important findings (Slowther, Ford & Schofield, 2004).

Evidence for EBP

Lastly, there is debate in the literature as to the empirical basis of EBP (Goldenberg, 2005; Thyer, 2004). Support for the effectiveness of EBP in psychological research is lacking, yet the movement progresses as if the statistical evidence is in fact sufficient. Ethically, as researchers and clinicians it is our duty to consider what is best for our clients. This means that for the few areas where evidence is adequate, empirical data should be taken into consideration when therapeutic treatment plans are established. However, psychologists should be cognizant of all facets of the debate over empirically based practice.

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Michelle Madore is currently a third year graduate student in the psychology program at the University of Cincinnati.



She is working toward her doctoral degree with an emphasis in clinical psychology and a specialization in neuropsychology. She received her MA in psychology with a specialization in clinical psychology at the California State University, Northridge. Coming from a military family, Ms. Madore has already had the opportunity to live in a variety of locations such as Tennessee,

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“It May Be Descartes Fault, But Why Are We Still Doing It?”

The Pitfalls of Biological versus Psychological Explanations for Mental Illness

By: Craig S. Travis, PhD, Mount Carmel Family Medicine Residency, and Mary Miller Lewis, PhD, Senior Life Consultants, Inc.

Abstract

This article explores the danger underlying the opinions of healthcare and insurance industries that if a condition is physical (biological) it is valid and real, but if it is psychological (emotional), then it must not be real. Therefore, for psychological illnesses to receive the same validity, they must be biologized. Although biologizing mental illness may have some positive aspects (e.g., validating the existence of a disorder), overall it may actually have a detrimental effect on the profession of psychology and marginalized groups. The authors conclude with a call to the profession to examine their own beliefs about biologizing mental health.

“Is this a biologically based disorder?”

Oft heard remark from insurance companies

Healthcare and insurance industries hold the opinion that if a condition is physical (biological) it is valid and real; however, if it is psychological (emotional), then it must not be real (e.g., “in your head”). Why does this happen? Perhaps it is because of the stigma of mental illness that has been pervasive in society throughout time, or maybe it is because concrete, tangible things are easier to understand. The assumption that something must be seen to be “real” creates a failure to acknowledge the psychological as legitimate. Abstract ambiguous constructs are harder to explain, especially when they rely on subjective human experience, yet they’re probably equally, if not more important to validate as “real.”

Perhaps the lack of validation of the psychological as real is a possible explanation for the mass increase of DSM diagnoses that has occurred over the last 20 years. We need diagnostic labels to help target the problem; however, there are pitfalls in biologizing mental health disorders that could ultimately undermine psychologists and psychotherapy as a “valid” treatment for mental illnesses. This article explores the authors’ belief that we are dangerously medicalizing and biologizing both psychology and human nature, and how this subtly has a detrimental effect on the profession of psychology, marginalized groups, and subsequently on society as a whole.

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The Biologizing of Psychology

Although concern of overmedicalizing natural human experience has been a concern for some time, the impetus for this article came from viewing a webpage stating the following: “PTSD is a real illness.” Why do we have to make something an “illness” to make it real? Why does making it biological give it more validity? Ultimately, the medical model facilitates the attitude that organically based problems (e.g., heart attack) are “real” and therefore the sufferer is legitimately ill; therefore, an illness with no visible pathology (e.g., depression, PTSD) is not necessarily “real.” However, PTSD is ultimately a Post Traumatic Stress Response. The literature clearly notes that PTSD is a person’s psychophysiological response to an extreme situation; an event important enough that it precludes focus on everything else and becomes disruptive to the person’s life (Rosen & Frueh, 2007). Part of our response to the environment is biological, but does that alone make us ill? Are we sick because of it? We think not. It is a response to a stressor, where the attempts at coping in the primitive part of the brain become problematic. (See Travis 2006, 2007 for a model and explanation for anxiety and depression as natural but maladaptive reactions to stress).

Zinberg and Mineka (2007) remind us that “fear and anxiety learning in humans is not only normative and ubiquitous but also *adaptive* because they evolved as the core of the threat defense system (p.259, italics added).” These authors further differentiate when normal and otherwise adaptive fear and anxiety become abnormal and maladaptive. They suggest that one or more of three things happen to the resulting conditioned emotional stimulus, thus making fear and anxiety learning maladaptive. Those three responses are: (a) they are out of proportion to the degree of objective threat; and/or (b) they overgeneralize to cues that are not threatening; and/or (c) they outlast the contingencies that were critical for their development in the first place (Zinberg & Mineka, 2007). Nowhere is it stated that they are sick or have a real (versus not real) illness, yet the reaction is disruptive to the individual’s life. Anxiety reactions are the most common modes of faulty responses to the stresses of life, and especially to those inner tensions that come about from confused and unsatisfactory relationships with other people, or equally important, relationships with yourself.

Negatives to Biologizing Mental Illnesses

The profession is in danger of perpetuating this biologized thought conditioning—and not just for the diagnostic label of PTSD. “_____ is a real medical illness (insert the diagnosis of your choice)” can be seen in multiple venues. We have followed the pharmaceutical campaign rhetoric in order to be reimbursed for services. Rather than treating psychological disorders that have biological or medical implications, we treat biologically based mental illnesses. It is a means to an end; however, it may backfire in our efforts to treat our clients. We describe three major negative factors arising

from medicalizing mental illnesses: Ignoring environmental factors, disenfranchising oppressed groups, and reducing the power of individuals to change themselves.

Ignoring Environmental Factors

A 2007 study, using data from the National Comorbidity Survey, finds one out of every four people identified with depression could, in fact, be reacting normally to some of life’s more troubling times (Wakefield, Schmitz, First, & Horwitz, 2007). To adequately understand one’s “condition,” one needs to understand their environment. When an individual is put in a depressing environment, feeling depressed is a likely response. “The wealth of data collected during much of the last century gives strong support to the notion that behavior is largely determined by its environment. More specifically, it has become increasingly clear that the consequences of behavior are responsible in large part for what we do and why we do it. In other words, we act as we do because of what happens when we do it” (Cambridge Center for Behavioral Studies, 2008). Biologizing a mental health disorder may ignore the factors that triggered it in the first place. Further, it may miss the impact that culture, community, family, and social groups have on the environment. In addition, the impact of the mental illness on those factors may be missed as well as the resilience of individuals to adjust and adapt over time (e.g., social



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ecological models, risk and resilience models; see Boyer, 2008 for a review of integrative models).

Disenfranchising Oppressed Groups

Members of oppressed groups (e.g., racial/ethnic/cultural minorities, women, disabled, elderly, etc.) have a significant number of environmental factors that impact their emotional well-being. Medicalizing mental health care has not significantly improved the care for many of these groups in the U.S., and in fact, ignoring the impact of inequitable social realities for clients creates unethical care (Aldarondo, 2007; Hansen, 2006). Physicians often tend to overlook the social realities that may impact their patients' mood, focusing rather on biology and medication (Thomas-MacLean & Stoppard, 2004). However, pills will not cure the emotional effect of racism, sexism, ageism, poverty or oppression on individuals. Research demonstrates that when individuals fulfill their personal, relational, and collective needs, they experience wellness within their social context (Prilleltensky, Dokecki, Frieden, & Wang, 2007). This model is a better fit for individuals of diverse groups, is clearly broader than just biology or western medicine, and taps into the ability of individuals to overcome oppression and discrimination in an unjust society (Prilleltensky et al., 2007).

Reducing the Power to Change

It is likely that when an individual is told that their mental health is biologically based, it may disempower them to change their behaviors. Western medicine, focused on the illness-based model of treatment, advocates for a passive role for the patient (or client). In these models of treatment, the mind is separated from the body, and somatic symptoms (as well as somatic treatment) are seen as more valid or desirable because they are treatable within the medical context (Thomas-MacLean & Stoppard, 2004). Therefore, the patient can only take control of their "illness" by taking medication that changes internal biochemistry, rather than modifying unhealthy behaviors or changing negative beliefs that contribute to mental health problems.

When Biologizing Mental Illness is a Positive

There are positive aspects to medicalizing mental health problems and identifying the biological bases underlying certain disorders. Naming something can increase a client's power over the situation, as well as validate their experience. For example, research indicates that when depression and other mental illnesses are given a diagnosis, it validates the experience of the individual with depression and can be a source of relief that it is not "all in their head" (LaFrance, 2007). Further, some disorders have significant evidence of strong biological bases and respond well to medications—schizophrenia, for example. Ultimately, however, there are numerous mental health conditions such as PTSD, that, despite having biological and somatic symptoms, are psychologically-based disorders. Generally,

mental health and physical well-being are not exclusive, but rather intertwined domains, and the fields of positive and integrative psychology clearly demonstrate that the mind can impact the body, and vice versa (e.g., Seligman, Steen, Park, & Peterson, 2005; Surtees, Wainwright, Luben, Wareham, Bingham, & Khaw, 2008).

We should clarify that we are not against the use of medication when necessary. What we are against is the medical model of pill-pushing cure all. In general, it appears that medication treats symptoms and not the problem. "Biologizing" mental health assumes a pill will cure everything and that psychotherapy would not help. Unfortunately, psychologists are trying to get validation by the medical profession and insurance companies to be seen as "real" doctors, when our true agenda should be getting people to recognize that they do have the strength to overcome illness without always deferring to medical opinions. Take obesity, for example. Although genetics are linked with being overweight; if obesity were 100% heritable, bariatric surgery would not work. Taking a pill is easier/faster than exercising and eating healthy. In our McSociety, this "quick fix" is seen as more convenient and more useful than the alternative. There is little doubt that the pharmaceutical industry has had an influence on treatment philosophy, strategy and approach and emphasized the biologically based illness/disease model (Metzl, 2003; Moynihan, Heath, & Henry, 2002; Special Section, 2006). Medication sells by selling sickness. If it is a chemical imbalance, then what biochemical level of neurotransmitter is a normal level? The answer is that we do not know.

Critics may raise the gene issue as supporting the underlying cause of the imbalanced biology. Yet researchers describe this relationship as genes being the switch, and the environment and the response to it determines if the switch is turned on or off (Roizen, 2004). For example, one could make a rat either anxious or not anxious by whether or not we lick it when



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it's young. Research shows that maternal grooming of rat pups turns on the anxiety-reducing gene in their offspring; non-grooming behavior leads to stressed out anxious and aggressive rats (Weaver, et al., 2004). Attachment theory (Bowlby, 1973, 1980, 2005) suggests this to be true of human beings as well, in that secure attachments lead to impulse control, self-respect, adaptive peer relationship skills, and extremely low risk for maladaptive functioning.

A landmark study by Eisenberger, Leiberman & Williams (2003) lends empirically derived objective evidence to the credibility of emotional pain experienced as 'real' pain. This research discovered that emotional pain (social rejection) is experienced in the same area of the brain, the anterior cingulate cortex, as physical pain and is correlated positively with self-reported distress. In essence, the brain sees emotional pain as real pain.

The Eisenberger et al (2003) study, as well as other affective neuroscience and brain imaging research and the neural plasticity theory, clearly shows that what/how a person thinks, feels, and behaves has direct and indirect effects on biology. But how a person thinks and feels about their situation is not "real" enough. Society tells them they are sick and have a real illness. Additionally, the pharmacological industry pushes the message that the only way to manage depression or other "real" illnesses is through medication. The authors are afraid that this is subtly invalidating the importance (and necessity) of psychology! The conditioned heuristic here is that "If you have a real illness, then you need a real doctor." However, physicians are not well-trained to detect mental health concerns, and typical mental health discussions may last fewer than five minutes in a physician's office (Tai-Seale, McGuire, Colenda, Rosen & Cook, 2007).

Aldarando (2007) notes that "rather than risking to prepare clinicians to understand and transform social inequities inimical to wellness and mental health, our professional organizations and training programs choose to subordinate the effects of social realities to individual biology and psychology (p. 13)". We hope we are wrong about our concern, but that is up to the profession to ultimately decide. Will we stand in unison in the position that psychological phenomenon are real and have real impact on peoples' lives, or is the profession's need for validation by the "hard" sciences so great that we must blindly follow that biology is real sentiment? We understand the need to be validated, but how far will the profession go?

Let the debate begin.

About the Authors



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The Effect of Attractiveness and Gender on Perceptions of Sexual Harassment

By: Amanda L. Maggiotto, Martina Sheridan, Ashley Russo, & Abby Coats, John Carroll University, OPA 2008 Student Poster Session Undergraduate Winner

Abstract

Sexual harassment is a growing problem on many college campuses. This study examines the effect that attractiveness and gender of the harasser have on perceptions of sexual harassment. Sixty-five undergraduate students rated 20 scenarios on the level of sexual harassment with conditions varying in the actor's attractiveness and gender. There was no significant main effect for the actor's gender or level of attractiveness. There was no significant interaction between gender and attractiveness. Limitations of this study and the prevalence of the problem of sexual harassment demonstrate reason to continue the study of perceptions of sexual harassment on college campuses and beyond.

Sexual harassment has negative effects, (DeSouza & Fansler, 2003; Osman, 2004) but is often ambiguous (Golden, Johnson, & Lopez, 2001). If people are unaware of what actions are considered sexual harassment, it is hard to combat them. Previous studies show that the harasser's gender affects perceptions of sexual harassment. For example, incidents with a female perpetrator are rated as less harassing than the same incident with a male perpetrator (LaRocca & Kromrey, 1999). Male harassers also were more likely to receive all forms of punishment (except expulsion) from their college or university compared to female harassers (Cummings & Armenta, 2002). While there is evidence that men are more likely to sexually harass both men and women (Dyer, 2005), this does not give insight into why participants would rate scenarios in which woman acted as the harasser as less harassing.

Some researchers have found that in addition to the gender of the harasser, the attractiveness of the harasser may also affect perceptions. Golden, Johnson, & Lopez (2001) found that behaviors were more likely to be perceived as sexual harassment when the harasser was an unattractive man and the victim was an attractive woman. Physical attractiveness influences a harasser's likeability, but does not affect their believability and recommended punishment (Madera, Podratz, King & Hebi, 2007). Further evidence for "attractiveness-induced leniency" exists as noted in the LaRocca & Kromery (1999) study, which found that physical attractiveness negatively affected participants' view of harassers when the harasser and person judging were of the same sex.

The present study investigated how gender and attractiveness of the harasser affect perceptions of sexual harassment. First, it was hypothesized that participants would rate scenarios where the man is the actor as more sexually harassing than scenarios where a woman is the actor. Secondly, it was hypothesized that scenarios with unattractive actors would

have a higher rating of sexual harassment compared to their attractive counterparts. Specifically, it was expected that participants would rate unattractive males as the most sexually harassing and attractive females as the least sexually harassing.

Method

Participants

Sixty-five (35 female) undergraduate students (ages $M=19.25$, $SD=3.21$) were recruited through the introductory psychology class pool at a small, mostly caucasian private university in the midwest.

Materials

Participants viewed 20 scenarios and rated them on a 4-point Likert scale for sexual harassment, (1= definitely was not sexual harassment, 2= probably was not sexual harassment, 3= probably was sexual harassment, 4= definitely was sexual harassment). An example scenario is "Sarah and Mike were dating but recently broke up. Sarah broke up with Mike and Mike is really mad at her for it. Mike starts a Facebook group titled 'Sarah is a slut' and invites everyone in their class to join the group." Pictures from HotorNot.com were used for the scenarios because they were rated for their level of attractiveness by visitors to the Web site. The pictures included an attractive male, an unattractive male, an attractive female, and an unattractive female.

Procedure

Participants were tested individually and randomly assigned to view a picture of an attractive female, attractive male, unattractive female, or unattractive male. The picture was accompanied by 20 scenarios. The participants read the scenario and rated it on its level of sexual harassment. After completing rating for each scenario, participants rated the actor's attractiveness and reported their own age and gender.

Results

A 2 (attractiveness of harasser) x 2 (gender of harasser) ANOVA was performed. There was no significant main effect for the gender of the harasser, $F(1,64) = .490$, $p = .486$, $n_2 = .008$. Although it was not significant, scenarios with a male harasser ($M=55.03$, $SD=8.60$) were rated as more sexual harassing than scenarios with a female actor ($M=53.32$, $SD=9.34$). There was no significant main effect for the level of attractiveness of the harasser, $F(1,64) = 1.69$, $p = .199$, $n_2 = .027$. Although results were not significant, scenarios with an unattractive actor ($M=55.77$, $SD=9.39$) were rated as more sexually harassing than scenarios with an attractive actor ($M=52.79$, $SD=8.37$). There was no significant interaction between gender of harasser and level of attractiveness for the harasser, $F(1,64) = .000$, $p = .992$, $n_2 = .000$.

Discussion

Contrary to the hypothesis, attractiveness and gender of the actor had no significant impact on sexual harassment ratings. This finding is in contrast to past research demonstrating the importance of gender for perceptions of sexual harassment (Katz, Hannon & Whitten, 1996; Madera et al., 2007). Consistent with past research (Cummings & Armenta, 2002; Katz et al., 1996; Madera et al., 2007) and our prediction, unattractive men were rated as most sexually harassing and attractive females were rated as the least harassing; however, this data was not significant.

While many past studies have found attractiveness to play a role in perceptions of sexual harassment, these studies have limitations. For example, Madera et al. (2007) found that attractiveness influences likeability of harasser, but not believability and recommended punishment. LaRocca and Kromrey (1999) found that attractiveness only played a positive role in perception when the person judging the harasser was of the opposite sex, and that attractiveness played a negative role when the harasser and judge were the same sex. These two studies show that attractiveness affects perceptions of sexual harassment only under certain conditions. Future research is needed to determine these conditions.

There are several limitations to the present study. One limitation might be how attractive the participants found the pictures of the actors. Attractiveness is subjective, so a pilot study to determine attractiveness of the actors is needed. Additionally, multiple studies discuss the gender of the participant. LaRocca and Kromrey (1999) had a significant interaction between gender of the harasser and gender of the participant, which might prove to be an important variable to consider in future research.

Sexual harassment on college campuses is an increasing problem (Dyer, 2005), so it is important to continue researching it. Additionally, it would be helpful to study perceptions of sexual harassment in non-college settings, such as in the work place or at restaurants and bars. Studying this phenomenon in multiple settings may lead to a plan to combat sexual harassment on and off college campuses.

Studying the perceptions of sexual harassment sheds light on how people need to be educated in order to combat it. Whether it is attractiveness or gender, several factors affect how others perceive sexual harassment. It is important to find those factors in order to get to the root of the problem of sexual harassment and stop it.

About the Authors

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Relation Between Symptom and Functional Change in Children with ADHD Receiving School-Based Mental Health Services

By: Veronika Karpenko, MS, Julie Sarno Owens, PhD, & Margaret Mahoney, BA, 2008 OPA Student Poster Session, Graduate Empirical Winner

Abstract

The current study examined the relation between reliable change in symptoms of attention-deficit/hyperactivity disorder (ADHD) and improvement in functional domains of 84 children receiving evidence-based school mental health services. Results indicated that children who demonstrated reliable improvement in symptoms of ADHD had significant reduction in teacher-rated functional impairment over the course of nine months. Functional impairments of children classified as no-changers and deteriorators in ADHD symptoms did not change and remained in the impaired range. Implications of these findings are discussed.

Children with attention-deficit/hyperactivity disorder (ADHD) demonstrate challenges across multiple functional domains, including academic performance and social relationships with peers, parents, and teachers (Barkley, 2006). Pelham and Fabiano (2001) argue that impairment demonstrated by children with ADHD (rather than the presence of ADHD symptoms) is the primary reason for referral to treatment. Thus, parents and teachers may not consider change in therapy meaningful unless a child's functioning has improved. The importance of improvement in functional domains during the course of psychotherapy carries significant implications for the evaluation of treatment outcome of children with ADHD.

Traditionally, psychotherapy research has relied on measures of symptomatology to measure treatment outcome and has utilized inferential statistical analyses to make conclusions about an average client (Ogles, Lunnen, & Bonesteel, 2001). In order to make treatment findings more clinically relevant, researchers coined the term clinically significant (CS) change to describe the change in treatment that is meaningful and noticeable to the individual client or to significant people in the client's life (Kazdin, 1999). One of the most frequently used methodologies for defining CS change was proposed by Jacobson and Truax (1991) and includes two criteria: a) statistical reliability of change from pre- to post-treatment, and b) movement from clinical into normative distribution. Statistical reliability of change is measured by calculating Reliable Change Index (RCI), which classifies clients into three outcome categories based on the direction and the magnitude of change: improvers, no-changers, and deteriorators.

It is important to highlight that studies have mostly applied criteria of CS change to measures of symptoms. As such, research has assumed that a reduction in symptoms is a meaningful indicator of change to consumers (Jensen 2001; Kazdin, 1999, 2001). This assumption poses two problems. On one hand, treated children may show a reduction in the severity of symptoms, yet their functioning may continue to be impaired across a range of important domains. On the other hand, children may make improvements in functioning, but be deemed a "treatment failure" because they did not make reliable change in symptoms. To date, there is a lack of research examining the relation between

functional impairment and CS changes in symptoms (Kazdin, 2001). The purpose of the current study was to examine the relation between reliable change in symptoms and improvement in important functional domains for children with ADHD receiving school-based mental health services.

Method

Participants

Participants were 84 children (78% male) who were enrolled in the Youth Experiencing Success in School Program (Y.E.S.S. Program; www.yessprogram.com) across four years. The Y.E.S.S. Program is a multi-agency school mental health program designed to increase access to evidence-based services for children and families living in rural communities (Owens, Murphy, Richerson & Girio, 2008; Owens, Richerson, Crane, Beilstein, Crane, Murphy, & Vancouver, 2005). The data for this study were collected in six schools across the rural Appalachian region of Ohio. The Y.E.S.S. Program included three evidence-based interventions for ADHD and oppositional defiant disorder (ODD): a daily report card procedure (Kelley, 1990), year-long behavioral teacher consultation (Sheridan, Kratochwill, & Bergan, 1996), and behaviorally-based parenting sessions (Barkley, 1997). Most participants ($n = 62$, 74%) met the criteria for ADHD, according to the "Diagnostic and Statistical Manual, Fourth Edition, Text Revision" (DSM-IV-TR). The remainder presented with ODD or conduct disorder (CD) without ADHD ($n = 11$), or with subclinical levels of disruptive behavior ($n = 11$).

Measures

Disruptive Behavior Disorders (DBD) Rating Scale. The DBD, a psychometrically sound measure (Pelham, Gnagy, Greenslade & Milich, 1992), was completed by teachers. The DBD is a 45-item scale that assesses DSM-IV based symptoms of inattention, hyperactivity/impulsivity, ODD, and CD. Items are rated on a 4-point scale ranging from 0 ("not at all" present) to 3 ("very much" present).

Impairment Rating Scale (IRS). The IRS (Fabiano et al., 2006) assesses adult perceptions of child functioning in multiple domains. Teachers rated behavior on a seven-point scale, ranging from 0 (No problem) to 6 (Extreme problem), measuring the severity of the child's impairment in each domain. Scores of three

or higher represent clinically significant problems. IRS has solid psychometric properties and discriminates between children with and without ADHD (Fabiano et al., 2006).

Procedure

Teachers completed the DBD and IRS at the beginning (pre-treatment) and end of the school year (post-treatment). Jacobson and Truax's (1991) methodology was used to create reliable change groups based on the symptoms of ADHD (the average of the inattention and hyperactivity subscales of the DBD). If the Reliable Change Index (RCI) was greater or equal to 1.96, children were considered deteriorators; if it was less than or equal to -1.96, children were categorized as improvers; and, if the RCI fell between 1.96 and -1.96, children were considered no-changers. Based on these calculations 31% of children were classified as improvers, 58.3% as no-changers, and 10.7% as deteriorators in the

Table 1.
Symptom-Based Reliable Change Groups.

	<i>N</i>	<i>%</i>
Improvers	26	31.0
No-changers	49	58.3
Deteriorators	9	10.7

Table 2.
Descriptive Statistics for Impairment Ratings by Symptom-Based Reliable Change Groups.

	<i>M</i> Time 1	<i>SE</i> Time 1	<i>M</i> Time2	<i>SE</i> Time2
Improvers	4.65	.23	2.67	.33
No-changers	4.25	.17	4.15	.24
Deteriorators	3.92	.36	4.44	.52

Note: M = mean, SE = standard error.

symptoms of ADHD (see Table 1). Calculation of the RCI was based on the following formula, also presented in Jacobson and Truax's article (1991), where r_{xx} = test-retest reliability of the measure; S_{diff} = standard error of the difference between the two test scores; SD_1 = standard deviation of the sample at time one; SE = standard error of measurement. This formula calculates that RCI greater than 1.96 is unlikely due to chance ($p < .05$).

$$RCI = \frac{X_{post} - X_{pre}}{S_{diff}}; S_{diff} = \sqrt{2(S_E)^2}; S_E = SD_1 \sqrt{1 - r_{xx}}$$

Results

A 2 (time: pre-treatment, posttreatment) x 3 (Group: symptom improvers, symptom no-changers, and symptom deteriorators) repeated measures MANOVA examined differences between three reliable change groups on the six functional domains of the IRS (relationship with peers; relationship with teacher; academic progress; classroom functioning; self-esteem; and overall impairment).

The multivariate effect was significant for the main effect of time, Wilks' Lambda = .91, $F(1, 71) = 7.11, p < .01$, and for the group by time interaction, Wilks' Lambda = .68, $F(2, 71) = 16.83, p < .01$. There was no main effect of IRS item, indicating that the group by time interaction pattern was not significantly different across the six domains. Means and standard errors for the composite IRS score (collapsed across the six domains) by group can be found in Table 2.

Simple effects tests indicated that there were no significant differences between the reliable change groups on the IRS composite at pretreatment, $F(2, 71) = 1.72, p = .19$. Yet, the three groups differed significantly at post treatment, $F(2, 71) = 7.54, p < .01$, such that the improvers differed significantly from the

no-changers and deteriorators who did not differ from each other. Simple effects tests also indicated that the symptom no-changers and the symptom deteriorators did not change significantly over time in functioning, Wilks' Lambda = .10, $F(1, 71) = .21, p = .65$, and Wilks' Lambda = .98, $F(1, 71) = 1.27, p = .26$, respectively. In contrast, improvers demonstrated significant reductions in functional impairment across time, Wilks' Lambda = .61, $F(1, 71) = 45.35, p < .01$. This pattern is displayed in Figure 1. See next page.

Discussion

Children who were rated by teachers as demonstrating reliable improvement in their symptoms of ADHD demonstrated significant reductions in teacher-rated functional impairment over the course of nine months in the Y.E.S.S. Program. Children who were rated by teachers as no-changers and deteriorators in their symptoms of ADHD did not evidence significant change in their

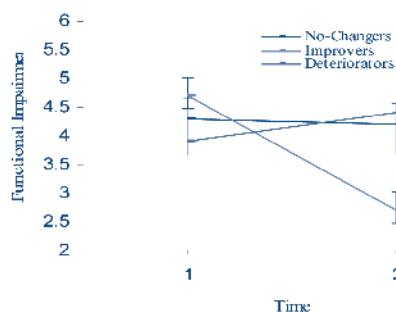
functioning and remained in the impaired range of functioning. Children classified as improvers in their symptoms of ADHD differed significantly from no-changers and deteriorators in functional change; no-changers and deteriorators did not differ from each other in the amount of functional change over the course of nine months.

Results demonstrated a relation between reliable improvement in symptoms, based on the Jacobson and Truax's (1991) Reliable Change Index, and reduction of functional impairment. This finding provides useful guidelines for treatment decision-making, such as termination decisions, modifications to treatment targets, and treatment intensity.

Current findings question the validity of separating no-changers from deteriorators. Treatment outcome studies usually report that 5% to 10% of clients deteriorate in treatment (Lambert & Ogles, 2004). In fact, some researchers (Lambert, Harmon, Slade, Whipple, & Hawkins, 2005) develop programs to provide feedback to clinicians when their clients deteriorate or do not show change in symptoms. There is an assumption in this line of research that deterioration in symptoms reflects negative outcome for clients. However, there has been no research comparing deterioration in symptoms against other important domains for clients.

Our knowledge about the nature and measurement of clinically significant change in treatment is in its infancy. Future studies need to continue comparing symptom-defined change against other measures, such as specific domains of functioning, improvement on specific presenting problems, or measures of client satisfaction with treatment.

Figure 1
Changes in Functional Impairment by Symptom-Based Reliable Change Group



About the Authors

Veronika Karpenko received her MS in clinical psychology from Ohio University in 2006. She is currently a doctoral candidate in the clinical psychology program at Ohio University. Her research interests are in measuring treatment outcome and examining clinical relevance of treatment outcome findings.



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the Youth Experiencing Success in School (Y.E.S.S.) Program (www.yessprogram.com). Dr. Owens' research examines the effectiveness of school-mental health programming that incorporates evidence-based services and the extent to which such services can be disseminated through university-community partnerships.



Margaret A. Mahoney is a first year clinical psychology (child track) student at Ohio University. Her research interests include working with children with disruptive behavior disorders, such as ADHD, and studying the effects of parental involvement on elementary school children.

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The Psychological Consequences of Sexual Assault on Adult Male Victims

By: Jessica A. Turchik, MS, and Christine A. Gidycz, PhD, Ohio University
2008 OPA Student Poster Session, Graduate Non-Empirical Winner

Abstract

Despite the fact that approximately 3-8% of American and British men have experienced an adulthood incident of sexual assault in their lifetime (Coxell, King, Mezey, & Gordon, 1999; Elliott, Mok, & Briere, 2004; U.S. Department of Justice, 2000), the sexual assault of men is rarely addressed. Although research has demonstrated that men can suffer adverse effects after a sexual assault, little empirical research has examined the psychological effects of assault experiences of men. This article reviews the literature on this topic as well as the implications of these findings on research and practice.

The sexual assault of men has largely been “overlooked, dismissed, or ignored” (Ratner et al., 2003; p. 73). It is estimated that between 3-8% of American and British men have experienced a sexual assault in their lifetime (Coxell, King, Mezey, & Gordon, 1999; U.S. Department of Justice, 2000) and that between 5-10% of rape victims are male (Coxell & King, 1996; U.S. Department of Justice, 2006). The greatest number of male rapes and sexual assaults likely occur in institutional settings such as prisons (Robertson, 2003; Struckman-Johnson, Struckman-Johnson, Rucker, Bumby, & Donaldson, 1996). Research also suggests that there is a greater percentage of reported sexual assaults among homosexual and bisexual men compared to men who identify as exclusively heterosexual (Balsam, Rothblum, & Beauchaine, 2005; Davies, 2002). Gay and bisexual men are thought to be at greater risk for assault because they are more likely to be assaulted by their dating and sexual partners and are more likely to be a target of anti-gay hate crimes (Davies, 2002; Mezey & King, 2000). Sexual assaults may also be more prevalent among men in the military (Krinsley, Gallagher, Weathers, Kutter, & Kaloupek, 2003; Murdoch, Polusny, Hodges, & O'Brien, 2004) and college (Larimer, Lydum, Anderson, & Turner, 1999; Tewksbury & Mustaine, 2001) compared to the general population.

Psychological Effects of Assault in Men

Research examining the psychological effects of sexual assault on men is not as well developed as research with women, with the majority of the investigations lacking comparison groups (Goyer & Eddleman, 1984; Huckle, 1995), using only descriptive analyses (Isely & Gehrenbeck-Shim, 1997; Walker, Archer, & Davies, 2005), examining case studies (Sarrel & Masters, 1982), and/or using small samples (Goyer & Eddleman, 1984; Huckle, 1995). Most research on male sexual assault has been largely atheoretical as most theories of sexual violence are based on male perpetrators and female victims, and these theories may not be applicable to male victims. Despite the above limitations, the literature has provided prevalence rates, rich descriptions of male sexual assault experiences, and direction for future research. For instance, in a sample of clinical records of 1,679 male sexual assault victims who presented to U.S. mental health agencies for services, 91.8% reported depression; 89.3% shame; 89.3% self-blame; 77.9% increased anger/rage; 68.4% increased use of alcohol or drugs; 46.3% suicidal ideation; 35.2% a suicide

attempt; 68.7% flashbacks; 60.6% fear of being perceived of being gay; 50.9% sexual dysfunctions; and, 63.3% reported increased interpersonal problems (Isely & Gehrenbeck-Shim, 1997).

In the last decade, research exploring the psychological effects of male sexual assault has increasingly begun to use control groups (Larimer et al., 1999; Pimlott-Kubiak & Cortina, 2003), compare male and female victims' responses (Stermac, Del Bove, & Addison, 2004; Struckman-Johnson & Struckman-Johnson, 2006), and use larger samples (Coxell et al., 1999; Pimlott-Kubiak & Cortina, 2003). These studies have shown that men who have had sexually coercive experiences as an adult are more likely to have a range of psychological problems such as lower self-esteem (Busby & Compton, 1997), increased depressive symptoms (Larimer et al., 1999; Ratner et al., 2003), and increased substance abuse problems (Burnam et al., 1988) than those without a history of nonconsensual sexual experiences. One especially concerning finding is that men who are victimized in adulthood are almost three times more likely to report suicidal ideation and deliberately harm themselves than those without nonconsensual sexual experiences in adulthood (Ratner et al., 2003).

These studies also have demonstrated that male victims of adult sexual assault can experience similar levels, or in some cases, more distress and psychological symptoms compared to female victims (Elliott, Mok, & Briere, 2004; Pimlott-Kubiak & Cortina, 2003; Struckman-Johnson & Struckman-Johnson, 2006). For instance, one group of researchers found that in a stratified random sample of 469 community men, those with a history of adulthood sexual assault reported more symptoms on nine of the 10 scales of the Trauma Symptom Inventory Scale than women with a history of adulthood sexual assault (Elliot et al., 2004). In another study that compared male and female rape victims (oral, anal, or vaginal penetration) over the age of 16 seen at the same medical center, it was found that male victims were more likely to be rated as more depressed and hostile following the assault than female victims (Frazier, 1993).

One problem that may be unique for men is confusion concerning sexual identity and orientation after an assault. Although sexual identity and sexual dysfunction issues are

thought to be “among the most severe and longest lasting consequences for victimized men,” these problems are often overlooked (Tewksbury, 2007, p. 31). No studies have examined sexual identity problems with a control or comparison group, yet almost every study that has examined case studies or men’s comments concerning sexual assault experiences have described sexual identity and orientation confusion in men following sexual assault experiences. For example, in a community sample of 40 British men who were sexually assaulted, 70% reported long-term sexual identity problems and 68% a “damaged masculine identity” (Walker et al., 2005). Homosexual victims may experience internalized homophobia and feel that the assault was a punishment for being gay (Garnets, Herek, & Levy, 1990), while heterosexual victims may feel confused about their sexuality and masculinity, especially if their body sexually responded during the assault (Mezey & King, 1992; Scarce, 1997).

Predictors of Psychological Symptoms from Sexual Trauma

A few studies have examined predictors or correlates of psychological symptoms and functioning in men after a sexual assault experience. A past history of childhood sexual abuse has been shown to be related to experiencing a sexual assault as an adult (Coxell et al., 1999; Elliott, Mok, & Briere, 2004). One study examined several demographic factors and found that being male, younger, and experiencing an incident of adult sexual assault in the last year increased the likelihood of reporting trauma symptoms (Elliott et al., 2004). Burnam et al. (1988) found that younger male victims were more likely to report subsequent drug abuse than older victims, whereas older victims were more likely to report obsessive-compulsive symptoms. Experimental studies also suggest that men find unwanted sexual contact from men more negative than unwanted sexual contact from women (Lev-Wiesel & Besser, 2006; Struckman-Johnson & Struckman-Johnson, 1993), and have more negative reactions as the level of coercion increases (Struckman-Johnson & Struckman-Johnson, 1994).

Implications for Help-Seeking, Practice & Research

Male rape victims often remain silent, do not report their assault to police, family, or friends (Coxell et al., 1999; Hillman, O’Mara, Tomlinson, & Harris, 1991) and are reluctant to seek counseling or medical services (Hillman et al., 1991; Ratner et al., 2003). Male victims who decide to disclose their assault may have to endure unsympathetic and unsupportive statements from law enforcement, friends, crisis centers, counselors, co-workers, and family members (Brochman, 1991; Donnelly & Kenyon, 1996; Sarrel & Masters, 1982; Kassing & Prieto, 2003). These responses seem to be influenced by homophobia, gender stereotypes, and rape myths and can be detrimental to the service provision and support available for male victims (Donnelly & Kenyon, 1996). In a survey conducted with representatives of 30 rape crisis agencies, many representatives voiced a lack of sympathy for male victims, traditional gender role stereotypes, and a general lack of responsiveness to male victims (Donnelly & Kenyon, 1996). Another survey of counselors-in-training found that trainees, especially those who were inexperienced, show some degree of acceptance of rape myths and believe that a man who does not physically resist his attacker should have done so (Prieto, 2003).

Davies and Rogers (2006) concluded that counselors and other professionals need to be aware of negative attributional biases and judgments of male sexual assault victims and possible

negative reactions of those to whom the victim disclosed their assault experiences, and more information and publicity is needed to encourage male victims to come forward and to dispel male sexual assault myths.

Whereas research has demonstrated that male sexual assault does occur and can have long-term detrimental effects, the vast majority of studies investigating sexual assault and rape only assess the experiences of female victims. Although the majority of adult sexual crimes are committed by men against women, sexual assault can be perpetrated by or against members of both sexes. More research is clearly needed concerning the psychological effects as well as predictors of psychological functioning in men after an assault, especially among high risk populations such as gay, bisexual, and transgendered individuals. Moreover, it has also been noted by researchers (King, Coxell, & Mezey, 2000; Larimer et al., 1999) that there has been almost no psychometric evaluation of the measures used to assess male sexual assault, and that this is needed to advance research in this area. Efforts must also be made to educate counselors, law enforcement, support service providers, and the general public. Until male sexual assault is publicly acknowledged and accepted, male victims will be isolated and marginalized, leading to unnecessary secondary victimization of these men.

About the Author



Jessica A. Turchik, MS, is currently a fourth year clinical psychology doctoral student at Ohio University. Her research interests include sexual risk taking, sexual assault, scale development and validation, and assessment.

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The Ohio Psychological Association . . . Leading the Way in Technology

By: Ky Heinlen, PhD, PCC-S, Chair,
OPA Communications & Technology Committee

In 2005, under the leadership of Ken Drude, PhD, the OPA Communications and Technology Committee (CTC) began the process of developing guidelines for the use of technology in the practice of psychology. This endeavor was significant because no other state or national psychological association had developed guidelines or standards about practicing psychology electronically. While the American Psychological Association (APA) has a statement about electronic communication, which includes the use of the telephone, psychologists have heretofore had little direction about how to approach working in the online environment. It is important to understand that these are, in fact, guidelines and as such they are meant as suggestions and are aspirational in intent. To view the entire telepsychology guidelines document, visit the OPA Web site at www.ohpsych.org.

If you have comments or questions about the guidelines, or if you are interested in being a part of this committee and participating in our mission to inform the practice of psychology about technology, contact HEI001@aol.com.

Telepsychology Guidelines

The APA and other professional organizations have previously identified many of the issues addressed in these guidelines. These issues are identified in the endnotes and the documents listed in the references section. It is suggested that these telepsychology guidelines be read in conjunction with the APA Code of Ethics. There is some intentional redundancy between the guidelines and the APA Code of Ethics standards to emphasize the application of those standards when practicing telepsychology.

1. *The Appropriate Use of Telepsychology*

Psychologists recognize that telepsychology is not appropriate for all problems and that the specific process of providing professional services varies across situation, setting, and time, and decisions regarding the appropriate delivery of telepsychology services are made on a case-by-case basis.

Psychologists have the necessary training, experience, and skills to provide the type of telepsychology that they provide. They also can adequately assess whether involved participants have the necessary knowledge and skills to benefit from those services. If the psychologist determines that telepsychology is not appropriate, they inform those involved of appropriate alternatives.

2. *Legal and Ethical Requirements*

Psychologists assure that the provision of telepsychology is not legally prohibited by local or state laws and regulations (supplements APA Ethics Code Sec. 1.02). Psychologists are aware of and in compliance with the Ohio psychology licensure law (Ohio Revised Code Chapter 4732) and the Ohio State Board of Psychology "Rules Governing Psychologists and School Psychologists" promulgated in the Ohio Administrative Code.

Psychologists are aware of and in compliance with the laws and standards of the particular state or country in which the client resides, including requirements for reporting individuals at risk to themselves or others (supplements APA Ethics Code Sec. 2.01). This step includes compliance with Section 508 of the Rehabilitation Act to make technology accessible to people with disabilities, as well as assuring that any advertising related to telepsychology services is non-deceptive (supplements APA Ethics Code Sec. 5.01).

3. *Informed Consent and Disclosure*

Psychologists using telepsychology provide information about their use of electronic communication technology and obtain the informed consent of the involved individual using language that is likely to be understood and consistent with accepted professional and legal requirements. In the event that a psychologist is providing services for someone who is unable to provide consent for him or herself (including minors), additional measures are taken to ensure that appropriate consent (and assent where applicable) are obtained as needed. Levels of

experience and training in telepsychology, if any, are explained (though few opportunities for such training exist at this time) and the client's informed consent is secured (supplements APA Ethics Code Sec.3.10).

As part of an informed consent process, clients are provided sufficient information about the limitations of using technology, including potential risks to confidentiality of information due to technology, as well as any legally required reporting, such as reporting clinical clients who may be suicidal or homicidal. This disclosure includes information identifying telepsychology as innovative treatment (supplements APA Ethical Principles 10.01b). Clients are expected to provide written acknowledgement of their awareness of these limitations. Psychologists do not provide telepsychology services without written client consent. Psychologists make reasonable attempts to verify the identity of clients and to help assure that the clients are capable of providing informed consent (supplements APA Ethics Code Sec. 3.10).

When providing clinical services, psychologists make reasonable attempts to obtain information about alternative means of contacting clients and provide clients with an alternative means of contacting them in emergencies or when telepsychology is not available.

Psychologists inform clients about potential risks of disruption in the use telepsychology, clearly state their policies as to when they will respond to routine electronic messages, and in what circumstances they will use alternative communications for emergencies. Given the 24-hour, seven day-a-week availability of an online environment, as well as the inclination of increased disclosure online, clinical clients may be more likely to disclose suicidal intentions and assume that the psychologist will respond quickly (supplements APA Ethics Code Sec. 4.05).

4. Secure Communications/Electronic Transfer of Client Information
Psychologists, whenever feasible, use secure communications with clinical clients, such as encrypted text messages via e-mail or secure Web sites and obtain consent for use of non-secured communications.

Non-secure communications, avoid giving personal identifying information. Considering the available technology, psychologists make reasonable efforts to ensure the confidentiality of information electronically transmitted to other parties.

5. Access to and Storage of Communications
Psychologists inform clients about who else may have access to communications with the psychologist, how communications can be directed to a specific psychologist, and if and how psychologists store information. Psychologists take steps to ensure that confidential information obtained and or stored electronically cannot be recovered and accessed by unauthorized persons when they dispose of computers and other information storage devices. Clinical clients are informed of the types of information that will be maintained as part of the client's record.

6. Fees and Financial Arrangements
As with other professional services, psychologists and clients reach an agreement specifying compensation, billing, and payment arrangements prior to providing telepsychology services (supplements APA Ethics Code Sec. 6.01).

7. Expiration and Review Date
These guidelines will expire in five years after their formal adoption unless reauthorized or replaced prior to that date. Expiration Date: (April, 2013)

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Ohio Students Honored at Science Day 2008

By: Megan Swart, OPA Intern

At the 2008 State Science Fair, Ohio Psychological Association members continued to uphold a 14-year-old tradition by judging the behavioral science projects. Fourteen Ohio students, grades 7-12, were awarded for their remarkable projects on May 12, 2008 at The Ohio State University.

Science Day judges were broken into five different teams, corresponding with each different grade level. Together, these 13 judges reviewed 122 projects. Cash prizes, made possible by the Central Ohio Psychological Association (COPA) and Dayton Area Psychological Association (DAPA) and the Foundation for Psychology in Ohio. Prizes were awarded to the top finishers in each grade.

First place won \$75, second place took home \$50, and third place received \$25. In addition to those winning an award, there were many students in attendance who had presented in the preceding years.

Judges were Rose Mary Shaw, PsyD; Pam Deuser, PhD; Linda Sirokey-Sabdo, MA; Cathy McDaniels Wilson, PhD; John McCue, PsyD; Christopher Fiumera, PhD; Mary Mills, MA; James Sunbury, PhD; William Schonberg, PhD; Mary Miller Lewis, PhD; Michele Evans, PhD; Michael Ranney, MPA; and John Marazita, PhD. A special thank you to the judges for donating their time to judge and for the donors for contributing award money!

2008 Science Day Winners

Grade 7

1st Place: William Barton, Bellbrook, "Testing the hot hand phenomenon: Probability vs. perception."

2nd Place: Steven Pfaffinger, Cincinnati, "Does exercise affect short term memory?"

3rd Place: Claire Pappa, Columbus, "Messages and meanings: The effect of facial features and voice intonation on the perception rating of a neutral story."

Grade 8

1st Place: Mark Wright, Westerville, "Eyeballs and basketballs: Does depth perception improve free throw shooting percentage?"

2nd Place: Kateri Dillon, Kettering, "At what age can children see from another's perspective?"

3rd Place: Mary Switala, Centerville, "Does multitasking impact the quality and quantity of work being done?"

Grade 9

1st Place: Jeremiah Shaw, Kettering, "Are auditory stimuli better retained than tactile stimuli?"

2nd Place: Amanda Smith, Dayton, "Social contract: Ethical theory."

Grade 10:

1st Place: Shaadee Samimy, Worthington, "The effects of socio-cultural factors on listeners' perception of the accentedness of non-native speakers of English."

2nd Place: Alec Stansbery, Upper Sandusky, "Harmony: a soul element of music."

Grade 11

1st Place: Sushil Sudershan, Sylvania, "The effect of a computer taught lesson plan versus a book taught lesson plan on long term memory."

2nd Place: Cynthia Molnar, Mentor, "An examination of the effects of birth order on one's intelligence level."

Grade 12

1st Place: Brian Hedges, Carroll, "Predicting substance abuse in adolescents."

2nd Place: Alice Sleeth, Carroll, "Do teenagers stereotype their peers? Take two."

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Welcome to the following new OPA members!

Approved by vote of the OPA Board of Directors on June 7, 2008:

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Elizabeth H. Bing, PhD (reinstatement)
Ann K. Burlew, PhD (reinstatement)
John C. Jorden, MEd, DMin (reinstatement)
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The OP Quiz for Continuing Education

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In Defense of Spirituality: A Return to a Forgotten Practice for Holistic Psychological Health

1. The central thesis of this article is to examine how individuals can understand and achieve wellness so that similar vitality can be attained in the greater society.

True False

2. The author identifies which of the following as pioneers in discussing the importance of religious/spiritual dimensions:

- a. Freud and Charcot
- b. James and Hall
- c. Jung and Adler

3. Psychologists have a responsibility to bring religious and spiritual issues to the forefront because:

- a. They are important issues that are essential to the human psyche.
- b. Millions of Americans, despite age, gender, race or culture, have some belief system which appears to be important for psychological growth, well being and health.
- c. Clients need to work toward self-actualization and religious and spiritual issues are an important part of that.

An Ohio Psychologist in India and Nepal

1. Many Indian psychologists boycotted the conference because.

- a. They felt they should only be pursuing hard empirically based data.
- b. They thought questions about spirituality were not worth investigating.
- c. Neither of the above.
- d. Both of the above.

2. One thing the author discovered in his travels was that there is a strong stigma in using mental health services.

True False

3. The author concluded that in order to promote a psychologically healthy society it is important to:

- a. Consider our efforts in the context of a global community.
- b. Travel and talk to people from around the world.
- c. Practice daily meditation.

Consciousness and Meditation: A Zen Experience

1. Buddhism is a form of Zen and focuses on meditation.

True False

2. Buddhists view consciousness as separate from the brain and identify eight levels of consciousness including:

- a. Eternal judgment.
- b. Enlightenment.
- c. Afflicted consciousness.

3. The author identifies several potential benefits of Zen meditation, including:

- a. Weight loss.
- b. Increased focus and concentration.
- c. Quieting the mind.
- d. All of the above.

Positive Psychology and Positive Therapy: Implications for Practitioners

1. According to the author, what makes positive therapy positive is:

- a. Positive behavioral reinforcements.
- b. Being confident that it is the right therapeutic approach.
- c. Expanding periods of well-being.
- d. Ignoring the negatives in the client's life.

2. Competence and Worthiness Therapy (CWT) is a process that focuses on increasing periods of well-being and linking therapy to deep positive structures.

True False

3. The first phase in CWT is;

- a. Focusing
- b. Awareness
- c. Worthiness

Growth Motivation: A Buffer Against Low Self-Esteem

1. This study examined

- a. how growth motivation affects happiness in conjunction with self-esteem.
- b. a program that increases participants motivation to grow when buffered with low self-esteem.
- c. what motivates individuals to improve their self-esteem.

2. The participants in this study were.

- a. A diverse group of varying ages, races and gender.
- b. Responding to an invitation on a listserv.
- c. Undergraduate students.

3. Which of the following was NOT a finding of this research:

- a. Self-esteem has strong ties to happiness.
- b. Growth motivation does not have strong ties to happiness.
- c. Growth motivation moderates the effect of self-esteem on happiness.

The Ethics of Evidence-Based Practice

1. The author suggests that one of the reasons EBP developed was

- a. To provide an all-inclusive list of possible treatments for mental health disorders.
- b. To decrease the number of sessions covered for each client during the course of treatment.
- c. To provide clear practice guidelines so that clients would receive the same care regardless of what agency they received services from.

Continued on page 42

The OP Quiz for Continuing Education continued

2. Which of the following is NOT identified as an ethical concern with EBP
- manualized care.
 - change in the dynamics of the therapeutic relationship.
 - negation of non-significant findings.
 - empirical evidence justifying the use of EBP.

3. The authors suggest that forcing the field to use the purported “gold standard” methodology in research in itself is unethical.
- True False

“It May Be Descartes Fault, But Why Are We Still Doing It?” The Pitfalls of Biological versus Psychological Explanations for Mental Illness

1. The authors identify which of the following as negative consequences for biologizing mental illness:
- Ignoring environmental factors.
 - Disenfranchising oppressed groups.
 - Reducing the power to change.
 - All of the above.
2. One of the positive aspects identified in medicalizing mental health problems was:
- Accurately prescribing medication to ameliorate the symptoms.
 - Naming it to increase a client’s sense of power over the situation.
 - Balancing the biochemical level of neurotransmitters.

3. The position of the authors is that psychological phenomena are more real when they are validated from a biological perspective.
- True False

The Effect of Attractiveness and Gender on Perceptions of Sexual Harassment

1. In this research, participants viewed movie clips and rated how harassing they found various scenes.
- True False
2. This study found:
- No significant interaction between gender of harasser and level of attractiveness.
 - A significant interaction with regard to the gender of the harasser but not with level of attractiveness.
 - A significant interaction between gender of harasser and level of attractiveness.
3. Consistent with previous research and the hypothesis, the study found:
- Attractive men were perceived as the most harassing.
 - Unattractive men were perceived as the most harassing.
 - Attractive females were perceived as the most harassing.
 - Unattractive females were perceived as the most harassing.

The Psychological Consequences of Sexual Assault on Adult Male Victims

1. What percentage of men are likely to experience sexual assault in their lifetime?
- 3 - 8%
 - 10 - 15%
 - Less than 3%

2. The most severe and longest lasting consequence of sexual assault on males is:
- Depression and anxiety.
 - Sexual dysfunction and sexual identity issues.
 - Minimal.

3. The author identifies several psychometric evaluations of measures used to assess male sexual assault.
- True False

Relation Between Symptom and Functional Change in Children with ADHD Receiving School-Based Mental Health Services

1. In this article, CS refers to.
- Conditioned stimulus.
 - Cognitive structure.
 - Clinically significant.
2. The participants for this study were.
- Students from suburban middle schools.
 - Students from urban inner city schools.
 - Students in schools from the rural Appalachian region of Ohio.
3. The study divided the participants up into three groups, including:
- Positive, negative and no effect.
 - Improvers, no changers and deteriorators.
 - Gainers, losers and status quo.

The Ohio Psychological Association. . . Leading the Way in Technology

1. The guidelines developed by the OPA are consistent with the technology guidelines developed by APA.
- True False
2. Guidelines are:
- Meant to provide clear practice standards for practitioners.
 - Meant to be aspirational in intent.
 - Irrelevant when making ethical decisions.
3. The guidelines suggest that as part of the informed consent process, clients are provided with
- Instructions on how to use electronic communication.
 - Personal contact information for the psychologist so they can be reached in an emergency.
 - Sufficient information about the limits of technology.

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Classified Ads

OFFICE SPACE FOR LEASE

Dr. Pamela Deuser (614-481-2101) has two private practice offices available at her Grandview/Marble Cliff area location; a former residence commercially upgraded, wheelchair accessible and on a bus line. One office (132 sq. ft. plus closet) leases for \$340.00/month. The second (162 sq. ft. plus closet) leases for \$425.00/month. Includes utilities, use of waiting room and kitchen area.

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Coleman Professional Services is seeking a child therapist responsible for the assessment and treatment of children and adolescents. Opportunity to work closely with other professionals, develop evidence-based treatments, and make a difference in the lives of our youth. MA with independent licensure, ability to work some evening hours and experience providing services to children and/or families required. Experience in providing services for anger and sexual offending issues a plus. Excellent benefit package. Please send resume to CPS-OHPSY-CHILDT, 5982 Rhodes Rd., Kent, OH 44240 or visit www.coleman-professional.com. E.O.E.

PSYCHOLOGIST

The RIVER CENTRE CLINIC is seeking a psychologist interested in a full or part-time opportunity for our Eating Disorder Program. River Centre Clinic follows a treatment philosophy designed to provide eating disorder sufferers of all ages an affordable treatment alternative to inpatient care. The qualified candidate must have strong therapeutic skills in individual, family, outpatient and group therapy. Experience working with adult and adolescent eating disorder populations is preferred; but not required. Additional information about our clinic is available at www.river-centre.org. If you are interested please fax, mail, or e-mail a letter of interest with salary requirements and three references to: River Centre Clinic, 5465 Main Street, Sylvania, OH 43560, Attn: Human Resources; Fax: 419-885-8600; e-mail: hiring@river-centre.org.



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