“Psychology: Science, Practice and Advocacy in the Decade Ahead”
CPH & Associates is delighted to announce that Rockport Insurance Associates has joined our team.

- Expect the same superior personal service and pricing.
- Expect the same commitment to bringing you the best in professional liability coverage.
- Expect more programs and more resources.

SERVICES INCLUDE:
- Instant online quotes for individual policy holders.
- Real time online application forms for individual policy holders with proof of coverage on the confirmation page. Saves time and paper.
- 3/4 discount on your professional liability premium just for completing the application online.
- Optional CPH TOP® enhancement to add general liability and personal property coverage to your policy for an additional $332 per year.
- Automatic $50,000 limit for State Licensing Board investigation coverage and options to increase coverage up to $100,000 for an additional premium.

CPH & ASSOCIATES specializes in Professional Liability Insurance for Mental Health Professionals. Our goal is to make understanding and purchasing coverage easy. With us you get the resources of a big company, and the individual attention of a boutique.

Call 1-800-875-1911 or visit our website at www.cphins.com
FEEL SAFE TO DO YOUR BEST

with American Professional Agency’s Psychologists Professional Liability Insurance Plan.

Your clients depend on your years of experience to assist them.

Let our staff protect your future.

We are committed to quality and excellent customer service.

Visit our website or call for a free quote today!
800-421-6694
Ohio Psychological Association

James R. Raia, PhD
Alice H. Randolph, EdD
Mary M. Rath, RN, MED
Linda D. Rhyne, PhD
Lyne C. Rustad, PhD
Diana S. Santantonio, EdD
Lou Sauer, PhD
Jennifer R. Schantz, PhD
Terry R. Schwartz, PsyD
Faye D. Schwelitz, PsyD
Richard E. Sexton, PhD
Ammon Shai, PhD
Joseph W. Shannon III, PhD
Bethany A. Shaw, PsyD
Joan Simon, PhD
Joan E. Simpson, PsyD
Barbara Sinclair, PhD
Gary J. Sipps, PhD
Carole P. Smith, PhD
Robert L. Smith, PhD
Joel A. Smith, PhD
Robert L. Smith, PhD
Randall J. Snyder, PhD
Lee A. Snyder, PhD
Janet B. Stedman, PhD
Val V. Steigelmann, PhD
Karen Stailey Steiger, PhD
Jennifer J. Stoeckel, PhD
Gerald J. Strauss, PhD
Glen F. Strobel, PhD
Karl W. Stuckenberg, PhD
Terry R. Tobias, PhD
Fiona H. Travis, PhD
David F. Turner, PhD
Janice M. Vidic, PhD
Robert L. Smith, PhD
Robert L. Smith, PhD
Randy R. Snyder, PhD
Mitchell L. Wax, PhD
Susan Steinberg, PhD
Michael S. Witter, PsyD
Sally Wilson, PhD
Richard M. Wax, PhD
Erica S. White, PhD
Faye D. Schwelitz, PsyD
Christine E. Agabi, MA
Carol Bline, PhD
Akemi Brewer, PsyD
Christine Charyton, PhD
Faye D. Schwelitz, PsyD
Erica S. White, PhD
Other gifts
Bonnie Benson, MEd
Wendy M. Kellon

Ohio Psychological Association
395 East Broad Street, Suite 310
Columbus, OH  43215
(614) 224-0034
(800) 783-1983
(614) 224-2059 fax

Staff
Michael O. Ranney, MPA, Executive Director
Katie Crabtree Thomas, BA, Managing Editor
Audrey E. Ellenwood, PhD, Editor

Articles in The Ohio Psychologist represent the opinions of the writers and do not necessarily represent the opinion of governance, member or the staff of OPA. Acceptance of advertising does not imply endorsement by OPA.
Table of Contents

The Ohio Psychologist:
“Psychology: Science, Practice and Advocacy in the Decade Ahead”

7 From the Editor, Audrey E. Ellenwood, PhD

8 Mindfulness-based interventions with adults with mental retardation and their care staff: A review of the literature, Shaznin Daruwalla and Laura Solomon, OPA Poster Session Non-Empirical Winners

11 Athletes and problematic eating: A meta-analysis, Lauren M. Metzger, Sarah K. Murnen and Linda Smolak, OPA Poster Session Honorable Mention Winner

16 Mindfulness-based relapse prevention: An introduction, Richard Sears, PsyD, ABPP

18 Clinical issues among immigrant women: risk and resiliency, Marina Prado-Steiman, Irene Lopez, PhD

21 Advocacy in the professional practice of psychology: The critical role of graduate students, Katie Edwards, MS, Jessica Luzier, PhD, OPA Poster Session Empirical Winners

24 Marijuana: National epidemic or national treasure?, Michael Schilling, BA

27 Working with children of chronic illness using a non-traditional family therapy, Audrey E. Ellenwood, PhD, Jeannie E. Jenkins, PhD

33 2010 Ohio Science Day Winners

35 OP CE Quiz for Continuing Education Credit
From the Editor
Audrey E. Ellenwood, PhD

“Psychology: Science, Practice and Advocacy in the Decade Ahead” is the focus and theme of The Ohio Psychologist and 2010 OPA Convention. This theme helps direct the OPA as the organization ventures past its 60th year of existence. It also provides hope, as well as highlights best practice approaches for psychologists that can lead to the strengthening and shaping the profession for years to come.

I hope that as you absorb the content within the Ohio Psychologist, you will find a written text that will (a) inspire you to use new therapeutic approaches within your practice, (b) teach you about the most recent science of the profession and (c) show you how to advocate for issues that are important to you.

With that thought in mind, may you be challenged to engage at some level in the OPA to share your expertise, experience and knowledge with those that will carry on and secure the future of psychology.

As you dive into this year’s publication, you will find that many of the enclosed articles extrapolate OPA’s 2010 theme.

Science
OPA Non-Empirical Poster Session Winners Shaznin Daruwalla and Laura Solomon provide an overview and critique research related to the use of mindfulness techniques with maladaptive behavior in individuals with mental retardation in their article, “Mindfulness-based interventions with adults with mental retardation and their care staff: A review of the literature.” This article helps shift one’s perspective to thinking about developing techniques that would be successful with this population. OPA Poster Session Honorable Mention Winners Lauren M. Metzger, Sarah K. Murnen and Linda Smolak talk about the relationship between athletic participation and eating disordered attitudes in their article, “Athletes and problematic eating: A meta-analysis.” Richard Sears, PsyD, builds upon cognitive-behavioral principles to help prevent relapse for clients struggling with chemical dependency in his article “Mindfulness-based relapse prevention: An introduction.” Dr. Sears shares that even though mindfulness is not a panacea, it appears to hold promise as an additional tool for working with the challenges of addiction.

Advocacy
When it comes to advocating for psychology, Katie Edwards, MS, 2009 OPA Poster Session Empirical Winner, and Jessica Luzier, PhD, are no strangers. Ms. Edwards has testified in front of the legislature for two bills; a sexual assault bill and one for dating violence education, and Dr. Luzier received an American Psychological Association Heiser Award for advocating for the sequence of training bill. In their article, “Advocacy in the professional practice of psychology: The critical role of graduate students,” they review the importance of advocacy for the profession of psychology and provide suggestions for making advocacy a more central role in the professional development of future psychologists.

As far as advocating for a specific issue, marijuana is becoming a national epidemic, with many people experimenting and using the drug. Many are advocating for its use, especially in the medical realm, and there is a national debate about whether or not marijuana should be legalized. Michael Shilling, BA, talks about these issues and more in his article, “Marijuana: National epidemic or national treasure?”

Practice
Audrey E. Ellenwood, PhD, and Jeannie E. Jenkins, PhD, advocate that the profession may need to rethink how psychotherapy services can be offered to families of children who have chronic illness. In their article, “Working with children of chronic illness using a non-traditional family therapy,” they identify issues surrounding traditional family therapy approaches for families with a chronically ill child and present a non-traditional settings for therapy.

As many of you know, the Ohio Psychologist is a peer-reviewed publication. Each article submitted has been carefully reviewed by three peer reviewers, their feedback have been provided to every author and changes to each manuscript has been made before the acceptance was official. OPA is fortunate to have a core set of peer reviewers with a high level of expertise. I would like to extend my appreciation and thank-you to the following who reviewed manuscripts for this issue of the Ohio Psychologist: Kerm Almos, PhD, William Bauer, PhD, Milton Becknell, PhD, Charles Dolph, PhD, Andrea Karkowski, PhD, Kathryn MacCluskie, PhD, Justin Perry, PhD, Sherry Simon, PhD, Elizabeth Swenson, PhD, JD, and Michael Torrello, PhD.

Also, Katie Crabtree Thomas, OPA’s managing editor, was highly instrumental in helping to publish the Ohio Psychologist. Her level of commitment to this publication cannot be understated.

Audrey E. Ellenwood, PhD
Editor, Ohio Psychologist
Mindfulness-based interventions: Adults with mental retardation and their care staff
By Shaznin Daruwalla and Laura Solomon, Wright State University School of Professional Psychology, OPA Poster Session Winners, Empirical Category

Abstract
Mindfulness has been defined as a holistic, sensory awareness of one’s environment without evaluation of the immediate experience. Recently, research and utilization of mindfulness-based interventions has increased dramatically (Allen, Chambers, & Knight, 2006). Interventions for decreasing maladaptive behavior in individuals with mental retardation have had limited effectiveness (Singh, Lancioni, Winton, Adkins, Singh, & Singh, 2007). Due to these limitations, researchers have adapted and investigated the effect of mindfulness-based interventions with this population and their care staff. This project serves to review and critique extant research related to the use of mindfulness techniques with this population, and provide recommendations for future research.

Background
The proliferation of interventions based on the ancient Buddhist concept of mindfulness has been exponential and dynamic over the past two decades (Brown, Ryan, & Creswell, 2007; Kabat-Zinn, 2003). Researchers and clinicians alike have gravitated toward investigating and incorporating techniques grounded in mindfulness. Further, the concept has been recently popularized by the general media, with the term “mindful” becoming a part of daily vocabulary. Kabat-Zinn (2003), one of the pivotal figures in introducing mindfulness to Western culture, operationalizes mindfulness as an “awareness that emerges through paying attention on purpose, in the present moment, and nonjudgmentally to the unfolding of experience moment by moment” (p. 145). However, even with the growing abundance of mindfulness-based interventions in research and clinical practice, there is a lack of consensus over the definition of mindfulness (Hayes & Shenk, 2004). In spite of the lack of agreement on the definition, the use of mindfulness has expanded in diverse ways to serve client groups with different health disorders. For instance, Mindfulness-Based Stress Reduction (MBSR) is used extensively with various clinical (e.g., cancer, HIV, rheumatoid arthritis, depression) and non-clinical (health care professionals, students, novice meditators) populations.

Several factors encouraged a group of researchers with special interest in working with persons with developmental disabilities to adapt the use of mindfulness techniques for this population. First, the researchers noted the disempowering nature of interventions employed in working with persons with intellectual disabilities (Singh, Wahler, Adkins, & Myers, 2003). Singh et al. (2003) further noted the limited effectiveness of psychotropic medications and techniques based on behavioral contingencies in extinguishing maladaptive behaviors. The authors aimed to create treatment alternatives through developing a mindfulness meditation practice, “Soles of the Feet,” for use with persons with intellectual disabilities. This review paper highlights and comments on the research efforts of studies investigating the use of meditation practice with this specific clinical population. Recommendations for future research are also discussed.

Method
Singh et al. began studying the use of mindfulness with persons with mental retardation in 2002 with a single case study on an individual with dual diagnoses of mild mental retardation and a psychotic disorder. Following the collection of baseline data, the researchers engaged the participant in treatment for one year, and continued collecting data for one-year following the termination of treatment. During the treatment phase, the participant was taught a simple meditation called “Soles of the Feet,” designed to increase his awareness of internal and external stimuli and events. This meditation taught the participant to control his aggressive behavior by shifting his attention from emotionally arousing events and onto a neutral part of his body (i.e. the soles of his feet). This shift in attention allowed the individual to calm down, make a choice about how to respond, and recognize situations that triggered verbal or physical aggression.

Results
Results of this study showed that the participant demonstrated a significant decrease in the frequency of his aggressive behaviors during the treatment and follow-up phases. Further, the frequency of administration of PRN medications, the number of times physical restraints were used, and the number of staff and resident injuries resulting from his aggression decreased significantly, while he demonstrated an increase in self-control and positive engagement in community activities. Finally, the participant’s psychotropic medication was tapered off and...
eventually discontinued, and, because of the significant improvements in his behavior, he was able to re-engage in and maintain a community placement. Additionally, the researchers noted that after learning the mindfulness procedure, the participant’s relationships with both staff and peers improved, which further reduced the number of situations that triggered aggression (Singh et al, 2003).

In 2004, Singh et al. published an additional study on the use of mindfulness by care staff working with group home residents with profound mental retardation and physical disabilities. A baseline of resident behaviors indicating happiness (i.e. grinning, clapping, humming, etc) was obtained, followed by an eight-week course in mindfulness for care staff. The happiness of the residents was measured during interactions with the participating staff members for 16 weeks following the termination of the mindfulness-training program. Results of this study showed that the residents’ behavioral demonstrations of happiness increased significantly when engaging with care staff trained in mindfulness. The researchers speculate that, through learning mindfulness, the caregivers may have been more focused in their interactions with residents and engaged them with a “beginner’s mind,” a tenet inherent in mindfulness (Singh et al, 2004).

A 2006 article published by Singh et al. discussed the applicability of mindfulness training for staff persons caring for individuals diagnosed with severe or profound mental retardation and a comorbid Axis I disorder. In this study, care staff received training in behavior management techniques, followed by training in mindfulness. The residents’ aggressive behaviors, the number of learning objectives they mastered, and the number of observed pro-social behaviors were measured following each training session. Results showed that after the behavior management training, the frequency of staff interventions decreased only slightly; however, after mindfulness training, staff interventions for managing aggression decreased significantly, particularly in medium to low staff-to-resident ratios. Further analysis of the results indicated that, after mindfulness training, staff was more involved and patient with residents, more responsive to resident needs, and more creative and adaptable in their work with residents.

The success of the initial study on the “Soles of the Feet” meditation (Singh et al., 2003) prompted the researchers to investigate the utility of this practice with persons with moderate mental retardation. In 2007, Singh, Lancioni, Winton, Adkins, Singh, and Singh taught the meditation practice to three individuals with dual diagnoses of moderate mental retardation and mental illness. However, the participants initially found it difficult to practice the meditation procedure due to their inability to recall an aggressive episode in their immediate past. This led the authors to modify the meditation by introducing a discriminative stimulus (i.e. a dot on the top of their foot) to assist in focusing their attention. Researchers concluded that the modified meditation procedure helped to reduce participants’ aggressive behavior and increase their self-management skills. Follow-up data was collected for a period of two years and participants were successful at retaining their community placements throughout this time.

The final study conducted by this research group in 2009 included group home residents with varying degrees of mental retardation (mild to profound) and their care staff. Staff and residents were trained in mindfulness techniques for 12 weeks, and then engaged in mindfulness practice for an additional 28 weeks. Regardless of the frequency of aggressive behavior prior to the mindfulness intervention, incidents of verbal redirection and staff and peer injuries decreased during mindfulness training and practice phases. Further, the frequency of staff interventions to curb aggressive behaviors decreased, as did the use of restraints and stat medications. Finally, the researchers concluded that the mindfulness training enabled staff to break the cycle of negative staff-resident interactions and opened the potential for a positive interaction cycle.

Conclusion
In conclusion, these studies showed that regardless of who received the mindfulness training, staff-resident interactions were enhanced because of mindfulness. Further, mindfulness allowed the care staff–resident dyad to develop other relationship patterns that afforded residents more control over their own behavior. Finally, mindfulness not only allowed the residents to apply their newfound self-management skills to maintain community living placements, but also gave them the opportunity to actively participate in the complex process of social interaction.
Limitations
In conducting a review of these articles, several limitations became apparent. First, most of the studies were either single-case studies or had a small number of participants, thus making it difficult to generalize the results. Second, the researchers used convenience samples in all of the studies, thereby limiting the generalizability of the results. Researcher bias is also a significant concern throughout all of the studies conducted due to the fact that the studies were performed by the same research group, and in particular, shared the same lead author. While this is indicative of the researchers’ positive interest and passion about the topic, it also presents a risk of unchecked bias or overinterpretation of positive results. Additional significant limitations include systemic barriers that may limit the efficacy of the use of mindfulness techniques both among individuals with intellectual disabilities and their care staff. Examples of these barriers include the time required by the care staff to remind and assist the residents with mindfulness practice, as well as care staffs’ interest and motivation. Finally, mindfulness requires diligent practice which may place unreasonable demands on care staff.

Recommendations
Because this research is still in its initial stages, most of the research has been based in qualitative methods (i.e. case studies) or has small sample sizes. The primary recommendations for future research, therefore, surround improvements in research design, including expanding to quantitative methods and more tightly controlled studies. Specifically, it is recommended that future studies use larger sample sizes to expand on the utility and generalizability of mindfulness with individuals with varying levels of mental retardation. Further, studies using a control group would be beneficial in supporting the ecological validity of mindfulness-based interventions with this population. Additionally, long-term studies and follow-up research would be valuable in determining the efficacy of mindfulness over time with this population. The extended duration of the studies would provide crucial information for how care staff can help individuals with mental retardation maintain their mindfulness practice.

References


About the Authors:

Shaznin Daruwalla, MA, is currently a doctoral candidate in clinical psychology at Wright State University’s School of Professional Psychology. Prior to entering the graduate program, she received her master of arts at S.N.D.T. Women’s University in Mumbai, India. She has research and practice interests in mindfulness-based interventions and its application to diverse populations. Ms. Daruwalla can be contacted via email: daruwalla.2@wright.edu.

Laura Solomon is a doctoral candidate in clinical psychology at Wright State University’s School of Professional Psychology. She is currently a third year student completing her clinical training at Wright State University’s Office of Disability Services. Her professional interests include working with children, adolescents, and families affected by disabilities, with a particular focus on developmental disabilities and autism spectrum disorders. Ms. Solomon can be contacted at solomon.17@wright.edu.
Athletes and Problematic Eating: A Meta-Analysis
By Lauren M. Metzger, Sarah K. Murnen, and Linda Smolak, Kenyon College, OPA Poster Session Honorable Mention

Abstract
The relationship between athletic participation and eating disordered attitudes was examined using meta-analysis. The analysis focused on athletic participation for both females and males within different classifications of sports, including aesthetic, endurance, ball game, and weight-class. A total of 120 studies were examined, yielding 137 effect sizes. Overall, female aesthetic sport athletes were found to have the greatest risk for eating disorders with \( d = 0.32 \), while female ball-game athletes were shown to have the least risk with \( d = -0.20 \). Follow up analyses showed that nationality, age, and elite status account for significant variation within some of the samples. It appears that athletics is not a protective source for all female athletes. The increasing pressure on men to conform to society's body standards was also discussed.

Since eating disorders, including anorexia nervosa and bulimia nervosa, have the highest mortality rate of any mental illness (Birmingham, Su, Hlynysky, Goldner, & Gao, 2005), it is not surprising that much research has been invested into identifying “at risk” populations. Athletes have been a source of focus given the idea that sports participation might play a conflicting role in either shaping or preventing the development of disordered eating. Athletics could serve a protective role in that it has been found to promote confidence, leadership, and other positive values (Erkut & Tracey, 2002; Frost & McKelvie, 2005; Wilkins, Boland, & Albinson, 1991), and it should lead participants to feel that their bodies are empowered (Blinde, Taub, & Han, 1993). However, numerous studies, including meta-analyses, have shown that some athletes, both male and female, are at a slightly increased risk for disordered eating (Hausenblas & Carron, 1999; Hausenblas & Downs, 2001; Smolak et al., 2000), especially in sports that emphasize thinness and aesthetic qualities (Hausenblas & Carron, 1999; Smolak et al., 2000). Some sports environments might promote a focus on weight and appearance, and there is increased objectification of women athletes in the media (Cagan, 2000). It is possible that female athletes might emulate a thin ideal body given femininity concerns that can develop for women participating in a masculine-stereotyped activity such as sports (Krane et al., 2004).

Despite the concentration of research examining the connection between disordered eating and female athletes, there has been considerably less research on male athletes and disordered eating. The factors that have been proposed to contribute to this phenomenon include some of the same ones that appear to be putting girls and women at an increased risk including media images (Petré & McFarland, 2009). Some male athletes may try to reinforce their masculinity by having the “ideal” male body type, which may lead them to excessive exercise and/or extreme low-fat diets (see Petré & McFarland, 2009).

The present study was an update of a meta-analysis conducted by Smolak, Murnen, and Ruble (2000). Much data has been published since that analysis was conducted, including research on boys and men. Further, we now know more about the importance of classifying sports by types, which might influence risk of eating disordered attitudes. Based on the recommendations by Hausenblas and Carron (2002), studies were separated based on sport type (aesthetic, endurance, weight-class/weight-dependent, ball-game), which is thought to cause less ambiguity than classification based “lean” versus “nonlean.” It was hypothesized that male and female aesthetic, endurance, and weight-class athletes would have higher rates of disordered eating than nonathletes. Female aesthetic athletes were predicted to have the most risk of all athletes.

Method
Overall, 120 studies were selected to be used in the analysis and some studies included more than one usable sample (each sport has its own control group), so there were a total of 137 effect sizes in the meta-analysis. Sundgot-Borgen and Larsen (1993) classified 41 sports into six categories, in which four were used in the current study: aesthetic – “outcome is based on the subjective evaluation of the competitive performance,” endurance – “main training requirement is aerobic,” weight-dependent – “a specific weight is required to compete,” and ball game – “a ball is exchanged among teammates.” Elite status was defined as those competing successfully at the national or international level, professional competitors, or in a school setting that prepares them for professional level. Once the overall effect size, \( d \), was computed the heterogeneity in \( d \) was further analyzed with respect to various study characteristics.

Results
Female Athletes vs. Female Nonathletes
Aesthetic. For female aesthetic sports the effect size was \( d = 0.32 \), which is small, but significant, \( z = 15.48, p < .001 \). Results also showed significant heterogeneity, \( X^2 (43) = 506.60, p < .001 \). This overall \( d \) was based on 3,540 female aesthetic sport athletes and 11,311 female control participants, based on 51 effect sizes. See Table 1 for follow-up analyses.
**Endurance.** For females participating in endurance sports, \( d = 0.03 \), and was not statistically significant. This overall \( d \) was based on 2,037 female endurance athletes and 5,182 female nonathletes. However, there was significant heterogeneity in the sample, \( X^2(21) = 285.47, p < .001 \) (see Table 2).

**Weight-Class.** As hypothesized, female athletes participating in sports that required weight classes were found to be at a small, but significant risk for problematic eating compared to nonathletes, \( d = .14, z = 2.83, p < .05 \). This overall \( d \) was based on 595 athletes and 3,318 nonathletes. This sample was also marked by substantial heterogeneity, \( X^2(14) = 31.49, p < .01 \).

**Ball Game.** It was predicted that female ball game sport athletes would not be at a greater risk for disordered eating compared to nonathletes. This hypothesis was supported with an overall \( d \) value of \(-0.20, z = -5.84, p < .001 \). This was based off eight studies with a total of 1,661 athletes and 2,279 nonathletes. Similar to the other sport types, there was significant heterogeneity in the sample, \( X^2(7) = 240.83, p < .001 \).

### Male Athletes vs. Male Nonathletes

**Aesthetic.** It was hypothesized that male, aesthetic athletes would show more problematic eating than nonathletes would. Results did not support this with a \( d \) value of \( .07, z = 0.89 \).

**Endurance.** Male endurance athletes were found to have significantly more disordered eating patterns compared to controls with an overall \( d = .19, z = 4.72, p < .001 \). Interestingly, this was a higher effect size than the one found for the female endurance athlete sample. Of the 13 effect sizes found, the range was \(-.41 \) to \( 1.65 \) with a total of 955 athletes and 3,499 nonathletes. There was a substantial amount of heterogeneity, \( X^2(12) = 208.14, p < .001 \).

**Weight-Class.** It was thought that male weight-class athletes would have more disordered eating problems and this hypothesis was supported with an overall effect size of \( d = .20, z = 9.33, p < .001 \). These results were based on 18 effect sizes with a total of 3,395 athletes and 7,277 nonathletes. Significant heterogeneity was also found, \( X^2(17) = 220.89, p < .001 \).

**Ball Game.** Although only four studies were used, male ball game athletes were predicted to have less disordered eating compared to nonathletes. This hypothesis was not supported with \( d = .21, z = 5.12, p < .001 \). These findings were based on 1,462 athletes and 1,268 nonathletes. There was not significant heterogeneity.

### Discussion

The present meta-analysis was an update to the Smolak, Murnen, and Ruble (2000) analysis. It included 86 additional studies, including data on boys and men. Unlike some previous meta-analyses, classification of sports was based on four categories. Female aesthetic athletes were found to have the most pathology, regardless of gender and sport type. Female weight-class athletes also appeared at risk, though both effect sizes were small, but nonetheless significant. Female endurance athletes were found to not have significantly more risk compared to nonathletes, although, there was significant heterogeneity in all three sport groups. Even though aesthetic sports (e.g. gymnastics, dance, cheerleading) and endurance sports (e.g. running, swimming, cycling) are usually both put in the lean classification group, it would appear that there are underlying differences between the two types of sports. The perceived importance placed on appearance may be greater in aesthetics sports compared to endurance and ball game sports. However, when nationality was taken into account, American endurance athletes were also at a small, but significant risk compared to nonathletes, while non-American endurance athletes were actually slightly, but significantly protected. This would appear to support the theory that America’s thin ideal culture does have an influence on female athletes.

Based on the results from the male athletes, it would appear that some hypotheses were also supported in that both endurance and weight-class athletes were at more risk than nonathletes. However, fewer conclusions may be made from the aesthetic and ball game sport results due to the limited number of studies found; more studies need to be conducted in this area. Because the types of sports for which male and female athletes were at risk differed, it suggests the agent behind male disordered eating may be more related to competitiveness, while for female it is more appearance and aesthetically driven.

As predicted, elite status was found to be associated with more risk in athletes, especially for female aesthetic athletes and male endurance and weight-class athletes. In relationship to the findings about age, it appeared that, at least for aesthetic and endurance sports, females of college and high school age where at more risk than younger and older females. The results for male athletes did not show as clear a pattern.

Some athletes participating in certain types of sports do appear to be at an increased risk for problematic eating, however, this varies by gender and other factors such as age, nationality, and elite status. Female ball game athletes seem to be the one source of possible protection, possibly because strength, power, and teamwork are emphasized more than appearance and the thin ideal. Yet, this group of athletes (male and female) is still underrepresented in research concerning eating disorders and body image. By taking a closer look at these and other lesser studied sport types (i.e. technical and power sports) a better understanding of the etiology behind athletes and problematic eating and eating disorders in general can be evaluated.
References

* Studies used in meta-analysis.


About the Author:
Lauren Metzger is native to Ann Arbor, Michigan and attends Kenyon College. She is a member of both the cross-country and track teams and was named to the NCAA Division III Coaches Association All-Academic Team for her 2009 cross-country season. Her research interests include eating disorders, body image, the Superwoman Ideal, and women’s mental health. Currently, she is doing a study looking at the relationship between the Superwoman Ideal and disordered eating in adolescents.
Mindfulness-Based Relapse Prevention: An Introduction
By Richard W. Sears, PsyD, MBA, ABPP Union Institute & University

Abstract
Relapse is a significant problem for clients struggling with chemical dependency. Mindfulness-Based Relapse Prevention is an eight-week group therapy intervention, based upon Mindfulness-Based Stress Reduction and Mindfulness-Based Cognitive Therapy for the prevention of depressive relapse. Mindfulness is a metacognitive skill used to work directly with sensations, emotions, and thoughts. Clients are taught the nature of cravings and urges, and learn to interpret and relate to them in a more adaptive way. Clients are also taught to recognize the early warning signs of relapse and to be proactive in prevention. Though research to date has been limited, mindfulness appears to hold promise as an additional tool for working with the challenges of addiction.

About Mindfulness
Mindfulness-based interventions have received a lot of attention in the recent literature (Baer, 2006; Didonna, 2009; Denton & Sears, 2009; Sears, 2009). Workshops commonly add the word “mindfulness” to a variety of topics, though there is great variation in the depth in which the topic is covered. Recently, the Society for Clinical Mindfulness & Meditation (www.clinical-mindfulness.org) has been formed, which will publish the “Journal of Clinical Mindfulness & Meditation” (ISSN 2153-4047).

One of the reasons for the recent popularity of mindfulness-based interventions is the growing empirical support. The Division 12 website of the American Psychological Association lists three mindfulness-based approaches on their list of evidence-based treatments: Acceptance and Commitment Therapy, Dialectical Behavior Therapy, and Mindfulness-Based Cognitive Therapy (www.PsychologicalTreatments.org).

Jon Kabat-Zinn (2003) defines mindfulness as: “the awareness that emerges through paying attention on purpose, in the present moment, and nonjudgmentally to the unfolding of experience moment to moment” (p. 145). The word mindfulness is common in the English language, and is often equated with “awareness.” However, in the clinical literature, it refers to a structured discipline which systematically develops this awareness in a way that fosters openness to present moment experience. As an analogy, we could all say that we do “weight lifting” any time we pick up a heavy object. However, the discipline of weight lifting involves systematically developing strength and endurance in various muscle groups to foster better physical health. Likewise, mindfulness training systematically enhances one’s ability to direct and sustain attention and work with difficult emotions in the service of psychological health.

One of the mechanisms of mindfulness is believed to be exposure. Worry and ruminations can be seen as a sort of negative reinforcement – if a client is worrying, there is a sense of trying to fix the problem, so anxiety is slightly reduced. By turning toward and sitting with one’s current experience, even if that experience includes anxiety, the client can observe the process of the anxiety initially increasing, then gradually decreasing, following the behavioral principle of extinction.

Jon Kabat-Zinn (1990) developed one of the first intervention models using mindfulness, which is called Mindfulness-Based Stress Reduction (MBSR). The eight-week program meets once per week, with about one hour of homework each night designed to help integrate the concepts of mindfulness into daily life. Segal, Williams, & Teasdale (2002) built upon the work of Kabat-Zinn and developed Mindfulness-Based Cognitive Therapy (MBCT). This program has demonstrated marked success in preventing relapses of depression, and has recently been applied to the treatment of other disorders, such as anxiety, posttraumatic stress disorders (PTSD), and eating disorders (Baer, 2006; Didonna, 2009).

Mindfulness-Based Relapse Prevention
Those who have done work in the field know that chemical dependency counseling is very challenging work, with significantly high relapse and failure rates. Relapse prevention is much more challenging than initial abstinence from the substance. As Mark Twain said, “It’s easy to quit smoking. I’ve done it hundreds of times.” Of course, the problem with alcohol, tobacco, marijuana, and other drugs is that they actually do work to reduce anxiety, at least in the short-term, and hence are strong negative reinforcers. Mindfulness appears to help clients tolerate the negative affect associated with urges and withdrawal symptoms.

Alan Marlatt has made significant contributions to the field of psychological treatment of chemical dependency and relapse prevention (eg, Marlatt & Gordon, 1985). In more recent years, he has incorporated mindfulness into his work (Witkiewitz & Marlatt, 2007; Witkiewitz, Walker, & Marlatt, 2005). Borrowing from the work of Kabat-Zinn (1990) and Segal, Williams, and Teasdale (2002), Marlatt has been instrumental in the development and study of Mindfulness-Based Relapse Prevention (MBRP).

MBRP incorporates training in mindfulness as presented in MBSR and MBCT, as well as standard cognitive-behavioral therapy. However, it also includes several unique aspects, such as bringing mindfulness to urges, behavior chains, and relapse prevention.

Marlatt has long used the term “urge surfing” to refer to the ability to stay with the strong urges to use, and to “ride them,” waiting for the urges to build, crest, and subside (Marlatt & Gordon, 1985). Mindfulness appears to enhance this ability – maintaining awareness of one’s thoughts related to the urges, one’s emotional state related to the urges, and the physical sensations that accompany the urges. By learning to be present and stay with the urges, the behavior of using can be decoupled from the thoughts, feelings, and sensations.

Another common strategy in chemical dependency work is tracing back the chain of events that led to a slip or relapse. For instance, a client may say that harsh words from a partner created so much anxiety that she had to take a drink. However, tracing back the situation may reveal that the client was feeling particularly lonely.
and vulnerable, and she made choices that may have contributed to escalating an argument with the partner. Mindfulness can help a client to be more conscious of sensations, thoughts, and feelings moment to moment, so that adaptive behavioral choices can be made before such choices become too difficult.

Marlatt also talks about the “abstinence violation effect” (Marlatt & Gordon, 1985). Basically, once a client relapses, they are tempted to just give up and go back to regular use. MBRP incorporates the use of mindfulness in one’s strategies to recover from slips to help the client continue to make progress toward recovery.

Because MBRP is relatively new, much more research needs to be done to determine its effectiveness, and to determine more precisely which aspects of the program are most important in achieving positive results. However, preliminary research looks promising (Witkiewitz & Marlatt, 2007; Witkiewitz, Walker, & Marlatt, 2005).

**MBRP and Smoking Cessation**

Even more recently, MBRP and mindfulness principles have been applied to tobacco cessation. In my experience with chemical dependency work, clients have told me that it is harder to quit smoking than it is to quit crack cocaine. Cigarettes are freely available everywhere, clients may have family members who continue to smoke around them, and actors are often portrayed smoking in film and television. This creates continual triggers for cravings.

Also, the immediate physiological benefit of nicotine, with the immediate negative reinforcement of the reduction of anxiety, make the behavior of smoking one more cigarette difficult to stop when contrasted with the remote possibility of contracting lung cancer years down the road.

For her doctoral dissertation, Sarah Bowen (2008) and her chair Alan Marlatt studied the effects of mindfulness-based instructions on negative affect, urges, and smoking. This study introduced mindfulness-based training using the urge-surfing technique to a group of undergraduate smokers. Interestingly, the experimental group and the control group did not differ significantly on measures of urges to smoke and negative affect. However, there was a stronger relationship between those urges and negative affect in the control group. That is, in the control group, negative affect was more likely to lead to stronger urges, and urges were more likely to lead to negative affect. Those using the mindful urge-surfing technique actually smoked fewer cigarettes in a one-week follow-up, suggesting that they learned to experience the urges in a new way.

**Summary**

The concept of mindfulness as used within MBRP appears to hold promise as an effective intervention for working with individuals suffering from substance abuse disorders. The techniques are founded on solid behavioral principles, and use methods that have been shown to be effective for the prevention of depression. While receiving formal training in MBRP would be ideal, some of the ideas, such as urge-surfing, can be easily incorporated into existing treatment models. Psychologists can talk to clients about the nature of urges, anxiety, and negative reinforcement, and help them to develop the ability to wait out the waves of craving. Psychologists can also ask clients to be more mindful of their emotional state throughout the day, so that they can take conscious action to prevent high-risk relapse scenarios.

Although mindfulness-based treatments have been shown to be effective for a variety of presenting issues, continued research is important to verify the effectiveness of mindfulness for addictions in comparison with treatment as usual.

**References**


**About the Author:**

Richard W. Sears, PsyD, MBA, ABPP, is a core faculty member of the PsyD program and director of the Center for Clinical Mindfulness & Meditation at the Union Institute & University in Cincinnati, where he also runs a small private practice and conducts mindfulness groups. He is the lead author of *Mindfulness in Clinical Practice*, forthcoming from Professional Resource Press. He can be contacted at richard@psych-insights.com.
Clinical Issues Among Immigrant Women: Risk and Resiliency

By Marina Prado-Steiman and Irene Lopez, PhD, Kenyon College, OPA
Poster Session Honorable Mention

Abstract

Immigrant women are a heterogeneous group of sojourners that migrate for various reasons. In this article, we will review some of the reasons for their migration, and note how various historical policies and structural forces have exacerbated their sometimes perilous status. The article concludes with a brief discussion of how epidemiological and clinical research should be combined to highlight the clinical issues involved in treating immigrant women.

Profile of the Incoming Immigrant

According to the U.S. Census Bureau, in 2003, foreign born U.S. residents totaled 33.5 million or about 11.7 percent of the U.S. population, and over half of these individuals came from Latin America, including the Caribbean, South America, and Central America, with 25 percent and 13 percent coming from Asian and European countries, respectively (U.S. Census Bureau, 2009). According to the Pew Hispanic Center (2006), roughly 12 million of the immigrants living in the U.S. immigrated in some unauthorized form and are undocumented residents. In short, despite the recent decline in incoming immigrants due to the economic downturn, current projections are that by 2042 minorities will be 54 percent of the population (U.S. Census, 2008).

With regards to immigrant women, data based on the decennial census since 1980, as well as the 2004 American Community Survey, indicate that while women worldwide are a substantial share of migration, there is a marked gender imbalance in the U.S. Specifically, there has been a decline in the percentage of women legally migrating to the U.S., in part, because of an increase in illegal male migration (Fry, 2006).

Unlike earlier groups of female migrants, current profiles indicate that those who arrive are typically older, better educated, have never been married, and are less likely to have children than earlier streams (Fry, 2006), although the majority of immigrant women still come to the U.S. previously married and caring for children. Additionally, while the overall rate of education has increased, there may still be problems with literacy with some groups. For example, some immigrants may suffer from a “double illiteracy” whereby they may be illiterate in English and in their own native language and are therefore “pre-literate” (Miller, 2007). Even among those who are fluent, there may still be issues related to language anxiety in one or another language. These issues may become particularly salient when caregivers have to interact with the school system on behalf of their children.

Such issues underscore the importance of understanding the role of socio-demographic factors, such as socioeconomic status, in the lives of immigrants. While there is great heterogeneity in life experiences within different groups, past research has shown the general feminization of poverty (Brady & Kall, 2007). These “push factors,” defined as conditions that drive people to leave their homes, can consequently affect whether a woman immigates to the U.S. and what types of jobs she acquires or is forced into. Additionally, “pull factors,” which are factors that attract individuals to another country, can also be a driving force for immigration.

Risk Among Immigrant Women

In addition to push and pull factors, U.S. historical policies have differentially encouraged or discouraged the immigration of various groups. For example, while Chinese women were once excluded from immigration because they were thought to be prostitutes, Japanese women were imported as “picture brides” (Lee, 2003). Since then, other contemporary venues for sexual exploitation in the U.S. have created a class of “forced immigrants” which entail forced work in massage parlors and the mail order bride business (Ehrenreich, 2003; Miller, 2007; Morash et al, 2007; Scholes & Phataralaoha, 2002).

Even for those who have not entered the country in this fashion, the threat of sexual harassment may still be salient, particularly for those who are either unsure of their status or are undocumented (Miller, 2007). For example, the non-profit group Civil Society, which serves immigrants in the state of Minnesota, has documented cases of property owners or workers who purposely “feel free to barge into an apartment when they hear the shower running without fear of repercussions, e.g., calls to the police” (Miller, 2007, p. 15-16). As a result, some women may be forced to flee their homes, which according to some immigration lawyers, may prospectively prove to be a better option than staying in the home and contesting the issue. To do so would run the risk of acquiring an “unlawful detainment” on their record, which in many cases could potentially prevent them from obtaining future housing (see Miller, 2007 for other examples of the difficulties faced by immigrants).

Abuse in Relationships

When compared to non-immigrant women, some have debated whether immigrants are either at higher risk for abuse or if immigrant-specific factors, such as language difficulties, isolation, discrimination, restriction to resources, and issues related to legal status, exacerbate an already elevated problem in a vulnerable population (Menjivar & Salcido, 2002). In addition, immigrant status can interact with other identities to further disempower women (Erez, Adelman & Gregory, 2009). Recent studies, such as Hass, Dutton, and Orloff (2000) have found lifetime prevalence rates of domestic violence to be as high as 49.8 percent among immigrant women, and more recent research with 78 Pakistani
and Indian women found the prevalence rate to be an astounding 77 percent (Najma & Schewe, 2007).

One factor that has been linked with increased abuse is the laws that were associated with the immigration of women. With the passage of the Immigration and Marriage Fraud Amendment in 1986, women who migrated were subject to a two-year conditional resident status before they could become citizens (Bhuyan, 2008). During this two year period, her U.S. husband, a citizen or a legal resident, was a woman’s legal guardian and responsible for her acculturation. The reasoning was that a woman could be introduced to American culture, and through a man’s assistance, learn all the appropriate skills to become a knowledgeable citizen. This “legal dependence” created situations of abuse and control where immigrant women, fearing deportation, sustained physical and psychological abuse at the hands of their spouses because they were unaware of, or afraid, to seek civil protection (Bhuyan, 2008; Conyers, J., 2007). Apart from physical abuse, immigrant women in abusive relationships also face other stressors. For example, often times women may be pressed into these decisions, like relinquishing custodial rights, as the result of numerous court actions brought upon by male-dominated clan members, such as among some Hmong and African immigrants, who rally to raise funds for private lawyers (Miller, 2007).

In recognition of these abuses, a series of Violence Against Women and Department of Justice Reauthorization Acts were passed (e.g., VAWA, 2000, 2004, 2005). Specifically, abused women could now formally identify as “battered immigrants” and self-petition for their legal status, without the fear of deportation (Conyers, Jr, 2007). While these laws have increased the protection afforded, recent research based on community samples, with different immigrant groups, using a variety of methodologies, suggest abuse is still occurring (Erez et al., 2009; Lee, 2007; Rianon & Shelton, 2003; Salcido & Adelman, 2004). Clinical observations, as well as interviews with treatment providers, also document the difficulties of service delivery for this population (Gupta, 2005; Keller & Brennan, 2007; Latta & Goodman, 2005; Liao, 2006; Nicolas et al., 2007).

Resiliency Among Immigrant Women

Despite the many obstacles that immigrants face, a new body of research indicates that generally immigrant groups, or more specifically first generation immigrants, have overall better mental health outcomes than those who are born in the U.S. (Alegria et al., 2008; Takeuchi et al, 2007). While findings do vary with respect to particular disorders, overall similar associations are found between immigrant status and health outcomes. The “immigrant paradox” seemingly contradicts the growing body of research that documented the numerous psychological difficulties faced by immigrants in the community and in clinical practice. Furthermore, there appears to be a discrepancy between the findings of epidemiological research, which focuses on assessing rates of disorder in a population, and more clinically related research that focuses on symptomatology in a specific sample.

As such, we must understand that patients who come to clinical practices don’t always represent the population at large. Because of issues surrounding stigma, (Nadeem et al; Abu–Ras, 2003), differences in self-perceived need (Nadeem et al, 2008), and difficulties in resource allocation, immigrants who come to therapy vary substantially from those who do not, and from immigrants in general. Additionally, consistent in the epidemiological research is the finding that the longer an immigrant stays in the U.S., or perhaps acculturates, or the later an immigrant migrates (particularly if they migrate before the age of 13), the worse the mental health outcomes are. In conjunction, in clinically based research, lack of social support and isolation are other key variables that are associated with poorer mental health. Thus, findings from epidemiological research, along with more clinically based studies, should be used to help identify and treat the risk factors that are associated with distress. These joint findings can also help highlight the protective factors associated with resiliency.
Conclusion
In conclusion, immigrant women present with a portrait of risk and resiliency. For many, immigration may provide an opportunity to improve their socioeconomic status and educational opportunities ("pull factors") and yet for others, the benefits promised by the process of immigration may be undermined by laws that entrap them. Driven by push factors, the ensuing acculturation that comes from immigration may further serve to marginalize them. In working with immigrant women, clinicians need to be aware of these vulnerabilities, as well as the recent epidemiological research that notes the many strengths of immigrant women.

About the Authors:
Marina Prado-Steiman is an English and psychology double major at Kenyon College. Her interests lie in cross-cultural and abnormal psychology, as well as the interplay of reality and magical realism in Latino literature. This past year she helped co-author a textbook chapter on acculturation and the immigrant experience with her adviser, Dr. López. Marina has attended several conferences in Ohio, including the Ohio Psychological Association’s, to present her research on Latinos and hopes to use the information she’s learned to provide culturally appropriate services to immigrant populations in the future.

Irene López (PhD, Kent State University, BA Vassar College) is cross-cultural and feminist psychologist with interests in the intersection between psychology and anthropology. She is interested in understanding the impact of phenotype on socioeconomic status and psychological adjustment as well as understanding the phenomenology and measurement of cross-cultural psychopathology. She has received a number of awards for her work and teaching, and recently returned from teaching on Semester at Sea (2010). In addition, she has published in a number of journals, and has presented her work both locally, nationally and internationally. Currently, she is an assistant professor in the department of psychology at Kenyon College in Gambier (www.kenyon.edu), and a task force member of the American Psychological Association Committee on Socioeconomic Status.

References

Advocacy has led to numerous successes for the field of psychology. Examples of these successes over the past several decades include parity legislation, modifying social security law to include psychologists, and acquiring funding for training, research, and treatment centers (Fox, 2008). Future advocacy ventures include prescriptive privileges, provider restraints (predominantly by managed care systems), and caring for diverse patients (Fox, 2008).

There are many important reasons for graduate students to become involved in current and future advocacy ventures. First, graduate students are “in the trenches” so to speak when it comes to the latest research. They are immersed in the literature about human behavior, and students (now more than ever) understand the importance of ensuring scientific support for interventions and outcome monitoring (Newnham & Page, 2009). This knowledge of solid research methods and critical thinking skills that is fostered in graduate school set the stage for students to reflect on ways to connect research with practice and policy.

Second, advocacy initiatives may directly impact students. For instance, the recent passing of the Sequence of Training Bill (House Bill 503) in Ohio will allow new graduates to become licensed more quickly after completing their doctorate, provided they have achieved a sufficient number of clinical experiences. Graduate students (including the second author of this paper) were directly involved in the passage of this legislation, from drafting testimony to working with the OPA’s Advocacy Committee and lobbyist to “behind the scenes” discussions.
with policy makers. Finally, advocacy is an important piece of a graduate students’ developing identity as a professional psychologist (Lating et al., 2010). Lating and colleagues (2010) suggested advocacy improves graduate students’ understanding of their positions not just as therapists who work with individuals, but also as professionals who are highly equipped at effecting social change. For example, the first author was involved with the passing of House Bill 19 in Ohio, which requires school districts to implement dating violence education within the health education curriculum. In fact, the first author had the opportunity to provide testimony to the Ohio Legislature that included data from her own research, which underscores the integration of research and practice. The advocacy mentoring and hands-on experiences provided to the authors by the OPA have been invaluable contributions to their professional development, fostering a life-long commitment to advocacy to promote the practice of psychology, and the greater good of humankind.

Despite the importance of advocacy for the profession, graduate students and psychologists are generally reluctant to participate in these efforts. Psychologists are less involved in advocacy and political giving than most other health providers (e.g., physicians, nurses, social workers; Fox, 2008; Pfeiffer, 2002). Lating et al. (2010) suggests that this is likely the case because the profession of psychology “was [largely] developed and socialized in academic departments largely isolated from the practice issues of psychology” (p. 202). Universities often place much greater focus on research and intervention than practice issues in psychology, which arguably leads to an underdeveloped professional identity that fails to incorporate advocacy, political processes, and legislation as important components (Lating et al., 2010). Thus, barriers to engaging in advocacy efforts are often the results of lack of awareness of advocacy issues and opportunities, disinterest in advocacy, and a sole focus on intrapsychic and interpersonal issues as opposed to larger sociopolitical and socioeconomic factors informing practice (Gronholt, 2009; Lating et al., 2010).

Given the barriers to engaging in advocacy efforts, several solutions have been suggested to increase psychologists’ participation in these professional activities. Specifically, Lating and colleagues (2010) suggested greater exposure and modeling of advocacy ventures, especially those beginning early in professional training. For instance, advocacy training and activities could be integrated into graduate training at all levels; every class could have an opportunity to incorporate training in broader advocacy initiatives, including psychological assessment, ethics, diversity, and psychotherapy. Furthermore, psychology department and training programs could encourage broader professional development for their students by entertaining colloquia focused on advocacy topics, discussing involvement in advocacy at faculty meetings, and encouraging and highlighting service learning projects completed by students. Additionally, faculty and students in psychology training programs may become involved in political ventures supporting positive changes, including fundraising and lobbying. An overarching theme of all of these suggestions is the importance of mentoring – that includes instructing, coaching, modeling, and advising – as a key to fostering the importance of advocacy in graduate students (Burney et al., 2009). It will be important for future research to evaluate the effectiveness of these various mentoring processes in fostering students’ interest and engagement in advocacy efforts.

In addition to academic departments, there are other ways in which graduate students’ interest in advocacy can be fostered. First, state, provincial, and territorial psychological association (SPTAs) are an excellent resource for students. For example, in Ohio, both undergraduate and graduate students have the opportunity to join the Ohio Psychological Association of
Graduate Students (OPAGS) and become members of the OPA Advocacy Committee where they can better understand current legislative initiatives. Additionally, the OPA’s Annual Legislative Day provides training opportunities and information about current legislation as well as a chance to meet with local state Senators and Representatives to discuss pertinent issues. Second, the American Psychological Association and American Psychological Association of Graduate Students (APAGS) have federal committees that function on behalf of psychologists and monitor legislative and advocacy initiatives on the national level. In fact, the APAGS Advocacy Coordinating Team is an excellent way for students to become involved early in their careers (Burney et al., 2009; Lating et al., 2010). Third, through involvement with either SPTAs or through APA and APAGS, students may attend and receive advocacy mentoring at the annual APA State Leadership Conference (Burney et al., 2009). Conducted by the APA Practice Directorate, this conference is an excellent experience for students to learn about psychologists’ roles in legislative and legal initiatives (Sullivan, Newman, & Abrahamson, 2007). Specifically, at the APA State Leadership Conference, there are opportunities to learn about political processes, network with state representatives, educate legislators and policy makers, and submit information to the media (Burney et al., 2009). Taken together, the advocacy mentoring provided through SPTAs and national organizations provides students with a strong foundation in the skills to be effective advocates throughout their professional careers.

Importantly, involvement in advocacy may at times be controversial and divisive for organizations such as the APA and OPA. For instance, psychologists often have divergent opinions on prescription privileges. Other social issues that have led to both strong support and opposition include abortion rights and same-sex marriages. Furthermore, when working with legislators to encourage different changes for the profession, organizations inevitably must endorse certain candidates over others. Thus, when students and early career psychologists first begin to immerse themselves in advocacy ventures, it is important to work closely with experienced mentors in the field who have developed the ability to model politically strategic ways of working in this complex system.

In conclusion, advocacy is a critical component of the professional development for psychologists in training. Psychologists have the opportunity to advocate on behalf of the profession and for the greater good of our communities, society, and world through multiple venues. The future of these advocacy efforts rests with psychologists in training, which underscores the importance of mentoring efforts of training programs, SPTAs, and national organizations. Margaret Mead said, “a small group of thoughtful, committed people can change the world.” Just think of what a large group of thoughtful psychologists committed to advocacy efforts could do.

References


About the Authors:

**Katie Edwards** is a fifth year doctoral student in clinical psychology at Ohio University. She will complete her predoctoral internship during the next academic year at the Vanderbilt University—Department of Veterans Affairs Consortium in Tennessee. Her area of programmatic research focuses on understanding women’s leaving processes in abusive relationships, ethics of interpersonal trauma research, and interpersonal trauma recovery. The ultimate goal of her work is to use research data to design efficacious programming and treatment efforts at the individual level and advocate for legislative policy and social change at the institutional and societal levels. Katie hopes to secure a faculty position at a university where she can continue to integrate her interests in research, clinical work, advocacy, teaching, and mentorship.

**Jess Luzier** is a fifth year doctoral student at Ohio University studying clinical psychology. She just finished her predoctoral internship at the West Virginia University School of Medicine (WVUSOM), Department of Behavioral Medicine and Psychiatry in Charleston, West Virginia. Her research interests include risky behaviors in adolescents and effective therapy practice with treatment-resistant youth. She has also been involved in leadership during her graduate tenure, including serving as OPAGS Chair, regularly attending the Ohio Psychological Association’s Legislative Day, and attending the APA State Leadership Conference twice as a representative of OPAGS. She was awarded the Karl Heiser Award for Advocacy at the 2009 APA Convention in Toronto, Canada, for her work lobbying for HB 503 (Sequence of Training). After graduating in June, she accepted a position as assistant professor in the department of behavioral medicine and psychiatry at the WVUSOM. She hopes to continue to pursue advocacy efforts throughout her career.

Correspondence concerning this article should be addressed to Katie M. Edwards, MS, 200 Porter Hall, Department of Psychology, Ohio University, Athens, OH 45701. Phone: (740) 274-1057. E-mail: ke264505@ohio.edu
Marijuana: a review of the literature
By Michael J. Schilling, BA, Capital University

Abstract
Marijuana is becoming a national epidemic, with many people first experimenting with marijuana during adolescence (SAMHSA, 2003). Some research suggests that marijuana can help improve the quality of life in some patients who are diagnosed with a terminal illness. The four main medicinal uses of marijuana are: anti-inflammatory effects, anesthetic action, antiemetic effects and anti-glaucoma effects. The purpose of this paper is to give a review of the literature on marijuana. This paper looks at marijuana for its medicinal use only, not for recreational use.

Marijuana is becoming a national epidemic, with many people first experimenting with marijuana during adolescence (SAMHSA, 2003). Marijuana is the most commonly used illicit substance among teenagers with nearly half of 12th graders having tried marijuana, and six percent disclosing daily use (Johnston, O’Malley, Bachman, & Schulenberg, 2005). Among more than two million Americans who used marijuana for the first time in 1999, two-thirds of them were between the ages of 12 and 17 (Department of Health and Human Services, 2002). Marijuana is typically smoked, resulting in subjective effects that may include euphoria, depersonalization, altered time sense, lethargy, drowsiness, confusion, and anxiety (Solowij, 1998). This paper will review the literature on marijuana. This paper is only looking at marijuana for its medicinal use, not for recreational use.

In order to understand why marijuana is such a controversial drug, there needs to be a better understanding on how it works. Marijuana comes from the plant cannabis sativa and because it is a naturally occurring plant, purity and potency of the drug cannot be adequately controlled (Barnes, 2000). Marijuana contains molecules known as cannabinoids (CBD) and cannabinol (CBN) (Nahas, Harvey, Sutin, Turchendorf, & Cancro, 2002). There are over 60 different cannabinoids that have been identified in the plant cannabis sativa (Harvey, 1999). However, the two main categories for cannabinoids are: psychoactive and nonpsychoactive. ∆9-tetrahydrocannabinol (THC) is the main psychoactive component. Cannabinoid-1 (CB-1) receptors are distributed throughout the brain with the highest concentrations in the frontal lobe, medial temporal of the cerebral cortex, globus pallidus, substantia nigra, striatum and the molecular layers of the cerebellum, amygdala, and the hippocampus (Nahas, Harvey, Sutin, Turchendorf, & Cancro, 2002). When THC binds to CB-1 and CB-2 receptors, there are changes in the brain, immune system, and the reproductive organs. Persistent THC binding to the CB receptors is associated in a time and dose related fashion with alterations in the cerebellum, impairing visual, auditory, somatosensory perceptions, coordination, memory, and consciousness (Nahas, Harvey, Sutin, Turchendorf, & Cancro, 2002). These cognitive deficits parallel those found in various forms of dementia that are characterized by hippocampal degeneration (e.g. Alzheimer’s Disease), and, therefore, marijuana-induced memory deficits have been attributed to hippocampal malfunction (Davies, Pertwee, & Riedel, 2002).

THC binding to CB-1 receptors in hippocampal neurons leads to neuronal death (Chan, Hinds, Impey, & Storm, 1998). THC is neurotoxic at concentrations as low as 0.5-1.0 μM, which are comparable to THC levels measured in human plasma after consumption of marijuana cigarettes (Chan, Hinds, Impey, &
verbal learning (Pope & Yurgelun-Todd, 1996). Also, with heavy
impairment of the attentional/executive system and reduced
brain (Loeber & Yurgelun-Todd, 1999). With heavy use, there
may persist after a period of abstinence (Tapert, et al., 2007).

Lewis, 2007) and the effects of marijuana use on brain function
development, including frontal lobe myelination and synaptic
(Wilson, & Swartzwelder, 2006). According to Gogtay et al,
rats indicate that acute THC exposure impairs learning more
(Ehrenreich, et al., 1999). Furthermore, behavioral studies in
been correlated with specific attentional dysfunction in adults
particular importance during adolescence given the academic
and social demands experienced during that developmental
period. Regular use of marijuana before the age of 16 has
been correlated with specific attentional dysfunction in adults
(Ehrenreich, et al., 1999). Furthermore, behavioral studies in
rats indicate that acute THC exposure impairs learning more
powerfully in adolescents than in adults (Cha, White, Kuhn,
Wilson, & Swartzwelder, 2006). According to Gogtay et al,
during adolescence there is a period of continued neuro-
development, including frontal lobe myelination and synaptic
pruning that subserves improved executive functioning,
including abilities such as decision making, inhibitory processing
and impulse control. Repeated cannabinoid use may alter
neuromaturation in regions with high CB-1 densities (Eggan &
Lewis, 2007) and the effects of marijuana use on brain function
may persist after a period of abstinence (Tapert, et al., 2007).
The minimum washout period for marijuana to leave the brain
is three days, although normally it can last about 30 days in the
brain (Loeb et al., 1999). With heavy use, there
impairment of the attentional/executive system and reduced
verbal learning (Pope & Yurgelun-Todd, 1996). Also, with heavy
marijuana use there is decreased firing of the ventral tegmental
area neurons that project into the nucleus accumbens, which
lowers dopamine metabolism in the medial prefrontal cortex
(Loeb & Yurgelun-Todd, 1999).

Ilan, Smith and Gevins (2004) found that marijuana also affects
the working memory that controls attention when faced with
distracting surroundings. This is why there are consistent findings
of impaired performance on difficult tests of memory over a
period of a few seconds to several minutes. When Ilan, Smith and
Gevins (2004) looked at subjects who reported being intoxicated
and experienced enhanced sensations, their conclusion was that
the subjects had more difficulty staying focused on the memory
task because they were having more compelling sensations,
perceptions, thoughts, and feelings that were competing for their
attention.

Even when there is no difference in performance of memory or
attention tasks between marijuana users and control subjects,
there was still a difference in brain activity (Kanayama,
Rogowska, Pope, Gruber, & Yurgelun-Todd, 2004). Marijuana
users recruited more brain regions compared to control subjects
in order to perform similar tasks (Jager, Kahn, Van Den Brink,
Van Ree, & Ramsey, 2006). This suggests that those subtle
attentional cognitive deficits may exist but are overcome by increasing
brain activity (Senn, Keren, Hefetz, & Sarne, 2008). According
to Gruber and Yurgelun-Todd (2001), marijuana smokers have
more trouble inhibiting inappropriate responses and appear to
produce more impulsive responses than control subjects. They
also found that impulsivity related to initial substance use and
the inability to discontinue marijuana use even after being told
of its potential physical and emotional ramifications may reflect
a primary dysfunction in the frontal neural circuit underlying
decision making.

Since marijuana use impairs decision making, it should come
to no surprise that THC is related to a higher risk of car crashes
(Ramaekers, Berghaus, Van Laar, & OH, 2004). THC may increase
body sway and imbalance without affecting braking speed
(Liguori, Gatto, & Jarrett, 2002). Weinstein et al. (2008) found
that the increase in glucose in the anterior cingulate gyrus
resulting from the effects of THC during maze performance
could be due to enhanced “attention for action.” This is because
of extensive motor and attention demand of maze performance
that exceeded routine function and required readjustment when
on THC. They state that “attention for action” is engaged when
routine functions are insufficient or ongoing behavior must be
adjusted to meet environmental demands. Weinstein et al. (2008)
found that in order for the subjects to perform optimally on the
maze task, regular marijuana users experiencing effects of THC
used the motor and attention areas in the brain extensively.
Without marijuana, it was sufficient to use lower visuo-spatial
mechanisms. Lastly, they found that there is faulty perception of
memory ability in users on THC. Most of the participants were
not aware of any impairment in the maze performance, and this
could serve as a warning sign for drivers and anyone engaged in
motor activity on THC.

There is no doubt that marijuana can be harmful on the brain
and lead people to make bad decisions they normally wouldn’t
make. There are people who believe marijuana has no medical
use at all and that it is just a harmful gateway drug. However,
patients who have been diagnosed with a terminal illness like
cancer and AIDS go through excruciating pain every day. Marijuana
is a drug that helps AIDS patients with wasting
syndrome eat more food. Marijuana also helps with nausea
in cancer patients going through chemotherapy. While many
doctors may not like the idea of using marijuana as medicine for
anti-inflammatory pain or anti-glaucoma effects, there are still a
number of doctors who prescribe marijuana for AIDS and cancer patients. When faced with a terminal illness, you have to look at the pros and cons for marijuana use and usually, when faced with death, people would like to be as comfortable as they can. Marijuana is a drug that can achieve that for them.

References


SAMHSA. (2003). Results from the 2002 national survey on drug use and health: national findings. 1018-1023.


About the Author:

Michael J. Schilling is a graduate of Capital University. After graduating, Michael started his own company, called Schilling Community Consultants. His company provides workshops for local communities to learn about drugs, and how to prevent gang violence. Michael can be reached by e-mail at mschilling@scc-llc.org or by phone at 614-753-7256. Michael would like to thank Dr. Michael Torello, Dr. Jody Fournier, Dr. Janette McDonald and his wife, Jazmin Schilling, for helping and giving loving support throughout college. Without the help of these people, Michael would not have been able to graduate.

THE OHIO PSYCHOLOGIST AUGUST 2010 26
Chronic illness is a major life altering experience which induces stress among family members (McCabe & Sharf, C., 2007). Psychologists can be in a key position to work with families who have children with chronic illness, but may need to rethink how services can be offered. Chronic illness differs from acute physical conditions in several important respects. A chronic illness is usually treatable but not curable. The daily burden of care is high and can be extremely distressing to the relatives. Many family members are open to help, but are unable to participate in traditional outpatient therapeutic sessions. The purpose of this article is to (1) identify issues surrounding traditional family therapy approaches for families with a chronically ill child; (2) present non-traditional settings for therapy; (3) discuss family stressors related to raising a child with chronic illness; and, (4) to present an Intervention-Based Family Assessment (IBFA) procedure that can be used by psychologists to better understand and create an emotionally supportive environment that can lead to change within families.

**Abstract**

Psychologists are in a key position to work with families who have children with chronic illness, but the profession may need to rethink how psychotherapy services can be offered to these families. The daily burden of care is high and can be extremely distressing to the relatives. Many family members are open to help, but are unable to participate in traditional outpatient therapeutic sessions. The purpose of this article is to (1) identify issues surrounding traditional family therapy approaches for families with a chronically ill child; (2) present non-traditional settings for therapy; (3) discuss family stressors related to raising a child with chronic illness; and, (4) to present an Intervention-Based Family Assessment (IBFA) procedure that can be used by psychologists to better understand and create an emotionally supportive environment that can lead to change within families.
Specialized Role and Function of a Home-Based Psychologist

Doing therapy within a home environment allows psychologists to work from an ecological and holistic perspective in analyzing the needs of families with a chronically ill child. Specifically, relevant skills that psychologists can use to help families with chronically ill children include:

- Conducting systematic behavioral observations of a child within the classroom or home environment;
- Conducting a setting analysis of the classroom and home environment;
- Performing ecological assessments of the instructional and home environments;
- Collaborating with families, teachers, and other school personnel in developing research-based interventions for the chronically ill child;
- Gathering baseline, intervention phase, and effectiveness data;
- Assisting the family by making needed intervention modifications based on formative evaluation derived from weekly progress monitoring;
- Providing on-going weekly individual or family therapy to enhance family functioning;
- Serving as a liaison to outside agencies that can help connect the family to needed resources, and;
- Offering assessment services to better design the appropriate alignment of interventions with the child’s diagnosed needs.

Family Stressors Related To Raising a Child

When a family member is diagnosed with a chronic illness, the quality of life for the family, regardless of culture or religion, is substantially altered. The presence of a chronic illness condition within a family creates an atmosphere of unrelenting daily stress among its members (Boice, 1998). The family's stressors can frequently range from financial to physical burdens. Often there are changes in parenting roles and sibling interaction. Inner resentment toward the chronically ill child and problems between parents are not uncommon. These issues can place the entire family at high risk for psychosocial adjustment difficulties. Child caretaking is so demanding that often the family is confined to their home, hospital, or doctor offices. The family's social network is often limited and social or extended family interaction becomes infrequent.

Reactions of Families to the Diagnosis of Chronic Illness

Families of all cultures experience overwhelming intense emotions when a family member is diagnosed as having a chronic illness. Both extended and immediate family members, particularly the parents, often experience the following emotional reactions: shock, confusion, numbness, denial, anger, anxiety, guilt, self-blame, fear, helplessness, depression, and inner resentment toward the sick person, spouse, and other children (Rao, Pradhan, & Shah, 2004). Individuals often become traumatized and report becoming confused, which can lead to estrangement from themselves as well as their family members. Within families, members often experience role reversals and a shift in balance of power among family members (particularly between children and parents) can create further family duress. The stickiness and rigidity of assigned roles among family members repeatedly result in on-going conflicts and arguments. Seeing that, members may experience depression, somatic illnesses, and acting-out behaviors (Schor, 1999). Therefore, it is important that a psychologist try to balance and unbalance a very rigid family structure while understanding the reality of the impact of the chronic illness. Often the structure of the family is in a “frozen” state, which is hyperfocused on the chronic family member’s dysfunction.

An Ecological Approach to Assessing Needs of Families

When interviewing families with chronically ill members, Shea’s (1998) five phases of a diagnostic interview (introduction, opening, body, closing, and termination) can be a good process to follow. Psychologists can expand upon this traditional interview process by incorporating a culturally-responsive, ecosystemic, and medically targeted interview. In this way, the needs of the family are comprehensively reviewed and defined. A structured interview with families of chronically ill children can yield information regarding (1) the onset of the chronic illness, (2) information related to how the chronic illness care has impacted the family’s current living conditions compared to past conditions, and (3) how successful the family has become in adjusting to the demands of caring for a chronically ill member.

In order for psychologists to provide effective home-based mental health services for families with a chronically ill member, they need to have an awareness and understanding of the child’s special needs and how these affect the family’s daily functioning. Families with chronically ill members are often not aware of the trauma and post-traumatic stress symptoms that have developed through their experiences with the onset of chronic illness (McCabe & Sharf, 2007; Ellenwood & Jenkins, 2007a; 2007b). To respond to the need for a culturally-sensitive measure for assessing family functioning with families experiencing the management and daily care of a chronically ill family member, the Intervention-Based Family Assessment (IBFA) was developed (Ellenwood & Jenkins, 2007a; 2007b). The IBFA is an ecological and holistic interview tool that helps identify physical and psychological care needs, explores sources of stress among and between family members, assesses coping strategies for the entire family, and determines how extended families and support systems are activated to help the family with the care of a chronically ill family member.

The IBFA is an effective intervention because the gentle questioning process serves to create structural and functional changes in the family. Through the process, families acquire hope for change and develop new ways of looking at their situation (Ellenwood & Jenkins, 2007b). The purpose of the IBFA process is to: (a) help the family restore their family roots and make sense of who they have been in a larger context; (b) uncover the family structures so that competency and respect are restored within the family system; (c) help the family understand how their own unique struggles with chronic illness are creating their presenting problems (e.g., confusing, depression); (d) help the family begin to identify their short-term and long-term goals so that an appropriate level of life-long care can be established; (e) identify
the fears, worries, and concerns of each member so that these concerns can be freely discussed; (f) promote a re-establishment and activation of core cultural and religious values, traditions and beliefs; (g) engage extended families and health care agencies/personnel to aid in the care of the chronically ill member; (h) inform the psychologist on ways to capitalize on the strengths of each family member so that appropriate interventions and networking with community agencies can be developed; and, (i) educate the psychologist on the family’s knowledge of the chronic illness.

Implementing the IBFA Approach

With the IBFA approach, the psychologist meets with the family in either their home or the school environment to assess the family’s emotional needs that stem from the chronically ill family member’s neurological or physical functioning. When beginning the initial stage of the IBFA procedure, it is important that rapport be established and a relaxed climate be created so that the family acclimates to sharing personal information. As the interview progresses into the body phase (Shea, 1998), the content solicited by the IBFA questions increases in intensity (Ellenwood & Jenkins, 2007b). Inquiry about family members’ knowledge of the illness produces information regarding the (1) medical diagnosis; (2) inferences made regarding this diagnosis; (3) expectations for recovery; and, (4) sources of the information. This helps the psychologist determine the extent to which family members have a common understanding of the medical condition that is impacting their family.

The next phase of the IBFA process transitions to a more personal level of disclosure. At this juncture, the psychologist guides the family into consideration of how their cultural and religious morals influence their receptivity to medical interventions and assistance from extended family members or outside community agencies. As the family shares their cultural and religious beliefs, the family members begin to inwardly negotiate their willingness to consider disclosing more personal information. If a resistant cultural block is encountered at this point in the process, the psychologist needs to communicate respect for the family member’s beliefs. However, it is important for the psychologist to encourage continued participation in the IBFA process so that a healthier family support structure can be established.

The body of the IBFA process commences with perceptions of the impact of the illness on each family member, concerns for other family members, and the family members’ mental health. During this phase, family members often share undisclosed personal information (e.g., fears, worries, concerns, etc.) about their perceptions of how the chronic illness is impacting other family members and themselves. The transactional dynamic resulting from this process provides the psychologist with diagnostic information for later therapeutic purposes. During this phase, self-protective, closed intrapersonal cognitive structures are replaced and a deeper level of inter- and intra-personal sharing occurs among family members. The exposure of this content alters the family dynamic to one of openness which will enhance the family’s receptivity to consider mobilizing available family resources in a healthier manner.

The final phase of the IBFA process begins to shift to a more cognitive level as information is sought regarding the level of support for the care of the chronically ill member and the family’s future plan for life-long care. The family’s ability and willingness to access both internal and external support is exposed through this process. Furthermore, the caretaking role, as well as the expectations for each family member, is revealed. This process allows the psychologist to identify stuck coping patterns. It also allows the family to begin to fantasize and hope about the possibility of family pattern changes in the care of the chronically ill person. The encouragement of fantasy is important with families of chronically ill members as it is a safe outlet for the expression of their wishes, hopes, and desires. In this way, they do not have to commit prematurely to initiating fantasized changes, which could overwhelm and destabilize the family. During this phase, the psychologist encourages the family to think about change but not initiate changes until further therapy occurs, as structured guidance with this change process will be needed. As the psychologist proceeds through the interview, it is important to remain cognizant of the family’s emotional state. The psychologist has the ability to increase or decrease the intensity of the questions to safely guide the family through the developmental, staged process of (1) content awareness, (2) introspection, and (3) interfamilial awareness.
Phases of the Intervention-Based Family Assessment

This six phase ecological approach specifically gathers relevant information regarding the understanding and impact of the chronic illness through assessing: (1) family constellation; (2) individual family member characteristics; (3) family participation in activities; (4) the illness; (5) cultural/religious beliefs and practices related to illness concerns; (6) perceptions of the impact of the illness on each family member; (7) concerns for other family members; (8) family members’ mental health; (9) level of support for care of the of chronically-ill member; (10) family’s future plan for life-long care; and, (11) other concerns. The following structured interview can be used by psychologists to gather pertinent information about the impact of the chronic illness on families.

Phase I: The first phase of the assessment deals with the family constellation, characteristics, and family activities. This phase is significant because it is important to identify who lives in the home, outside of the home, how family members perceive each other’s strengths and weaknesses, as well as their social involvements. A framework from which to understand the immediate family membership and interfamily perceptions can be mapped. To assess the family constellation, questions to ask are:

A. Who currently resides within your home?
B. Is there any member living outside of the home?
C. How many children do you have and what are their ages?
D. Share about how you parent the other children.

Even though parents of chronically ill children are often extremely concerned about the impact of the child’s illness on their other children, little time is often available to “parent” the healthy children and assumptions are frequently made that they will survive without much guidance. It is important for the psychologist to recognize this assumption because when healthy siblings lack parental guidance, they are more likely to score high on measures of fighting with family members and peers as well as participating in delinquency acts (Bouma and Schweitzer, 1990).

The second part of phase one addresses individual family member’s characteristics and the following questions are asked:

• How would you describe each individual’s strengths?
• How would you describe each individual’s weaknesses?

These questions clarify perceptions as family members are asked to describe each person’s characteristics to raise awareness of how individual assets contribute to or negatively impact family functioning. Key information can be gleaned by the psychologist that can help unlock family myths about who can and cannot competently manage the chronically ill child. In addition, the psychologist can assess the extent to which the family is willing to discuss personal characteristics and the family’s openness to acknowledging personal weaknesses, which can be a difficult task due to the fragile nature and protective posturing of the family.

The final part of phase one addresses the family’s participation in activities with the following questions:

• What type of hobbies or activities do you as a family participate in together or independently?
• What type of hobbies or activities do you participate in with friends?
• How frequently do you engage in these hobbies and/or activities?

This information helps the psychologist assess how much interaction exists between the family members and various types of emotional “outlets” that are used by the family. Mapping out family activities can assist with developing appropriate and effective interventions or recommendations that can be used to lessen the stressors impacting the family (Perrin, 1996). This portion of the interview helps the psychologist identify if the family members feel “trapped” due to care-taking obligations, and how much family interaction is occurring on a daily basis.

Phase II: In the second phase of the structured interview, the psychologist assesses the impact that the chronic illness has on the family. The extent to which the family understands the specifics and extent of the medical condition they are experiencing provides important information as to how well the family is working together. The psychologist can determine if family members have a common understanding of the medical condition and perceptions regarding recovery. Questions germane to this line of inquiry include the following:

A. Describe the medical diagnosis.
B. How do you see this diagnosis impacting your chronically-ill family member?
C. What is your understanding of the prognosis?
D. How did you acquire your knowledge of the medical condition?
E. How did the onset of the chronic illness impact each family member?

Through this questioning, the psychologist can become cognizant of family adjustment issues which are still unresolved and serve to compartmentalize the family. This phase of the interview assessment and intervention allows family members to speak openly about their personal reactions and emotions regarding the impact of the chronic illness on themselves and each family member. Family members begin to tune in to the pain they each are experiencing.

Phase III: During Phase III, the psychologist begins to intensify
the level of personal disclosure related to culturally- and religiously-based practices that would impact the care of the chronically ill member. Specific questions that can yield this information are as follows:

A. What is your ethnicity?
B. What religion do you practice and how does this bear on your willingness to seek medical or psychological treatment?
C. What are your family’s cultural beliefs that would influence the care of the chronically ill person?

A family’s cultural background is imperative to understand so the psychologist can determine if their beliefs might impede their openness to receive medical treatment or work on developing school-based interventions. This process also allows the psychologist to identify resources outside the school that could help the family gain normalcy and allow a healing process to begin.

Phase IV. During this phase, perceptions regarding the impact of care on each family member transitions the focus of the session to one characterized as more intense and emotionally based. Over time, families with chronically ill members are often unwilling to discuss concerns and their issues often become unspoken (Ellenwood and Jenkins, 2007a). Family members may carry silent worries that lead to additional stress or feelings of alienation. Family members try to protect each other by remaining silent. By inquiring about family concerns and their mental health needs, the deepest level of intensity for sharing is often initiated in this phase. As a result, an interfamilial awareness emerges as the silent suffering within each member becomes spoken and open to renegotiation. Specifically, the psychologist addresses the following:

A. How does each member take care of his/herself in the areas of:
   • stress management (e.g., relaxation activities, exercising).
   • Recreation (e.g., playing a sport)
   • Pursuing personal interests (e.g., hobbies)
   • Establishing support networks (e.g., seeking and responding to social invitations)
   • Reserving family time (e.g., activities with spouse and children)
   • Providing time for themselves
B. How does each family member express anger, pain, happiness, joy, and grief?
C. How do the members perceive the impact of the illness on the family?
D. What concerns do family members have for each other?

During this process, it may be difficult for family members to verbalize their concerns about each other. For the first time, the family’s myopic focus on the chronically ill child may broaden to include the other children in the family. Silent worries, unspoken myths, and beliefs of the parents are often revealed and discussed.

As the psychologist explores the family’s mental health, the adverse effects of the chronic illness on parental and spousal functioning may become apparent. During this phase it is important for the family’s mental health status to be addressed.

Research has indicated that families with chronically ill members are at risk for experiencing marital distress and face significant stressors for the duration of the illness (Walker, et al., 1996; Eiser, 1993). Key relational issues may surface as the psychologist identifies the functional or dysfunctional coping patterns of the family.

Family members responsible for caretaking rarely attend to their own personal needs. In particular, couples overwhelmed with responsibility begin to become overly focused on one area in their life (e.g., work, child, etc.). This alienation overwhelmed by couples often leads to anger, resentment, and withdrawn behaviors. Johnson and Greenberg (1985) found that couples with chronically ill family members often have difficulties with communication and intimacy.

Phase V. As the psychologist begins to shift the family back to a less emotionally intense cognitive position, information is gathered about the level of support and future care for the chronically ill member. The emotional stability of the family is highly dependent on the level of support that is provided within the immediate family as well as extended family members, friends, school personnel, and community agencies. Extended family members, teachers, and other significant adults can provide a valuable base from which the family of a chronically ill member can obtain optimal development (Perrin, 1996). By investigating the various resources available to the family, a psychologist can begin to think of how to connect the family with outside agencies if necessary. Further, the psychologist can help to identify and reactivate lost or inactive support mechanisms which will be most effective in fortifying the family’s emotional stability. In addition, future plans for life-long care need to be outlined. Questions used to elicit this content are as follows:

A. Do you have support from your extended family (and friends and community agencies)?
B. If yes, describe how they support you.
C. Do you feel comfortable seeking this support?
D. What are your long-term plans for the care of your chronically-ill family member?

This process also yields information as to how the family functioned prior to the chronic illness and what happened to the family support system after the onset of the illness. During this stage of the IBFA procedure, the psychologist needs to look at the family’s plans for long-term care. This is significant because some families become stationed at the daily care phase and fail to prepare for the future caretaking needs of the chronically ill member for when they will no longer be able to provide this care (Berger & Fowlkes, 1980). By identifying the family’s support structure and future plans for care of the chronically ill member, psychologists can accurately assess and develop properly aligned interventions for the family. From this information, a psychologist can determine if the family can think beyond the immediacy of their situation and develop realistic thoughts about how future caretaking needs would be met for all children.

Phase VI. During the termination phase, the psychologist brings closure to the session. Questions asked include:

A. When would be a good time to schedule another session?
B. What location would be most convenient for you?
This phase of questioning helps the psychologist identify the on-going care needs of the family so their situation is better understood. It also allows for the development of a process that will allow the family flexibility so they can partake in school-based mental health services. The session should conclude by reviewing the progress made that day.

Discussion

The IBFA procedure allows the psychologist to identify the family's spoken and unspoken suffering, the established symbiotic relationships, sources for hope, unhealthy belief systems, myths, and sources to help reconnect the family to the outside world. The gathering of the chronic illness story serves as a backdrop that can help psychologists collaborate with others to provide appropriate interventions which likely will include networking with agencies. A family with a chronically ill child needs to be encouraged to take risks and look for or engage the resources that were present in their life prior to the child's illness. The IBFA procedure provides the psychologist with an assessment tool that can be used in both a home and school setting. This process is an avenue through which families can change routines and habits, which will allow them to learn to enjoy life, reestablish lost contacts, and activate available community resources (e.g., respite care services). Through this assessment and intervention process, a crystallized, isolated family can begin to shift into a more open, connected, and flexible family structure. The process allows the psychologist to move from a position of abstract talking to concrete action within a natural environment that will allow the family to fantasize about change, play with change, attempt change, and make new situations and contacts possible. The psychologist will know about the success of the IBFA intervention through progress monitoring of the family's contacts with the outside world, the development of a healthier interfamilial, and the bidirectional dynamics that allow for flexibility of role and caretaking responsibility toward the child with a chronic illness.

References


American Journal of Family Therapy, 35, 403-415.


About the Authors:

Dr. Audrey Ellenwood is a licensed psychologist and founder of Assessment and Family Therapy of NW Ohio. Dr. Ellenwood is an associate professor at Youngstown State University and coordinator of the proposed school psychology program. Dr. Ellenwood was instrumental in the development of the children’s chronic illness clinics at St. Vincent Hospital, Toledo. She has extensive involvement with families with chronically-ill children. Dr. Ellenwood is currently the chair of OPA’s Communication and Technology Committee. She has presented on and is published in many topics related to family therapy and chronic illness at the local, state, and international level.

Dr. Jeanne E. Jenkins is an associate professor and coordinator of the school psychology program at John Carroll University. She received her undergraduate and specialist level education from Edinboro University of Pennsylvania. She has a second master’s degree and PhD in educational psychology from Cornell University. Dr. Jenkins has worked extensively with children and adolescents in both public and private schools. She has numerous publications and state and national presentations in areas related to the academic, social-emotional, and physical health needs of children. She is also serving a second appointed term on the Ohio Board of Psychology School Psychology Examination Committee.

C. Was this setting adaptable for your family?

D. Knowing the needs of your chronically-ill member, was this setting appropriate?

E. Are there changes or suggestions that could make the next session more amenable to your family needs?
Future scientists brought their outstanding research to Ohio Science Day on Saturday, May 8, 2010, where Ohio Psychological Association members judged their research. This is the 17th year the OPA has participated in Science Day, held at The Ohio State University.

Science Day judges were broken into five different teams, corresponding with each different grade level. Seventeen judges reviewed more than 130 projects. Cash prizes, made possible by the Central Ohio Psychological Association (COPA), Cleveland Psychological Association (CPA) and the Dayton Area Psychological Association (DAPA), were awarded to the top finishers in each grade.

First place won $75, second place took home $50 and third place received $25.

Judges were Rose Mary Shaw, PsyD, Cassandra Blake, Joseph Bene, Jr., PsyD, Mary Mills, MA, Helen Rodebaugh, PhD, Cathy McDaniels Wilson, PhD, Angela Ray, PhD, Kim Metz, PhD, Terry Kukor, PhD, Marge Kukor, Nancy Johnson, MA, Christopher Fiumera, PhD, Christy Tinch, PsyD, Janice Vidic, PhD, Pam Desuer, PhD, Linda Siroskey-Sabdo, MA, and Michael Ranney, MPA. A special thank you to the judges for donating their time to judge and to the donors for contributing award money!

If you are interested in judging future science days, contact Michael Ranney at mranney@ohpsych.org
Coverage that works as hard as you do!

Trust-sponsored Professional Liability Insurance

You work hard to be the best you can be. Nowadays, that includes being up-to-date on new rules, regulations, and ways to protect your patients and yourself. We work hard to ensure that your bases are covered in the event of a lawsuit, licensing board action, or other government investigation.

With the Trust, you get so much more than a malpractice insurance policy. You get an entire risk management program — with free risk management consultations from the Trust Advocate, educational workshops, independent learning opportunities, and premium discounts for participation in our risk management programs.

Are you getting ALL you can out of your professional liability insurance?

To find out, call the people you can trust at 1-877-637-9700 or visit us online at www.apait.org. Join more than 40,000 of your colleagues and get the peace of mind you deserve. You’ve worked hard for it!

Recent Policy Enhancements

- Protection for licensing board investigations and record keeping during retirement
- Protection for investigations of violations of the HIPAA Privacy Rule
- Protection for Medicare or Medicaid payment investigations
- Specific deposition expense reimbursement
- Increased reimbursement limits for “Loss of Earnings” and “Premises Medical Payments”

www.apait.org • 1-877-637-9700

* Underwritten by ACE American Insurance Company (ACE), one of the ACE Group of Companies. ACE is licensed in all U.S. states and operates through various underwriting offices of the ACE Group of Companies. Business by ACE Limited (NYSE: ACE) rated A+ (Superior) by A.M. Best and A+ (Strong) by Standard & Poor’s (Ratings as of March 31, 2023). Administered by TrustRead Management Services, Inc. for unnamed subject to underwriting.
For each question, there is only one possible choice. Please select the correct letter for each question.

**Advocacy in the Professional Practice of Psychology**

1. Possible future advocacy ventures may include all of the following except:
   A. prescriptive privileges.
   B. insurance benefits.
   C. provider restraints.
   D. caring for diverse patients.
   ___ True  ___ False

2. Advocacy is a critical component of the professional development for psychologists when?
   A. Retirement training
   B. Beginning of their careers
   C. Undergraduate training
   D. Never a critical component at any stage.
   ___ True  ___ False

3. Psychologists are more active in advocacy and political giving than most other health providers.
   ___ True  ___ False

**Working with Children of Chronic Illness...**

4. A structured interview with families of chronically ill children can yield information regarding:
   A. the onset of the chronic illness.
   B. how the chronic illness care has impacted on the family's current living conditions compared to past conditions.
   C. how successful the family has become in adjusting to the demands of caring for a chronically ill member.
   D. All the above
   ___ True  ___ False

5. During Phase III of the Intervention-Based Family Assessment, the psychologist:
   A. asks questions related to the family's constellation.
   B. makes a plan for intervention.
   C. intensifies the level of personal disclosure related to culturally- and religiously-based practices that could impact the care of the chronically ill member.
   D. is not concerned with how cultural and religious bases practices impact the family, so this area is not addressed in this model.
   ___ True  ___ False

6. Psychologists may need to balance and unbalance a very rigid family structure while understanding the reality of the impact of the chronic illness.
   ___ True  ___ False

**Mindfulness-Based Interventions**

7. “Soles of the Feet” meditation participants initially:
   A. found it difficult to practice the meditation procedure due to their inability to recall an aggressive episode in their immediate past.
   B. were halfway successful practicing meditation procedures
   C. were uncomfortable having their feet touched.
   D. all were successful with the meditation process.
   ___ True  ___ False

8. Kabat-Zinn was one of the pivotal figures in introducing mindfulness to Eastern cultures.
   ___ True  ___ False

9. Mindfulness training research is limited in its application, as most of the studies were either single-case studies or had a small number of participants.
   ___ True  ___ False

**Clinical Issues Among Immigrant Women**

10. According to the Pew Hispanic Center (2006), roughly ____ million of the immigrants living in the U.S. immigrated in some unauthorized form and are undocumented residents.
    A. 14
    B. 32
    C. 10
    D. 12
    ___ True  ___ False

11. Unlike earlier groups of female migrants, current profiles indicate that those who arrive now are typically younger, better educated, have never been married and are less likely to have children than earlier streams.
    ___ True  ___ False

12. Despite the many obstacles immigrants face, a new body of research indicates that generally immigrant groups, or more specifically first generation immigrants, have overall poorer mental health outcomes than those who are born in the U.S.
    ___ True  ___ False

**Marijuana: A Review of the Literature**

13. The five main medicinal uses for marijuana are:
    A. Inflammatory Pain; Anesthetic action; Antiemetic effect; Antiglaucoma effects and Appetite stimulation
    B. Inflammatory Pain; Anesthetic action; Social Use; Antiglaucoma effects and Appetite stimulation
    C. Inflammatory Pain; Anesthetic action; Antiemetic effect; Appetite stimulation
    D. Inflammatory Pain; Arousal action; Antiemetic effect; Antiglaucoma effects and Appetite stimulation
    ___ True  ___ False

14. Marijuana is a drug that helps AIDS patients with wasting syndrome:
    A. eat less food.
    B. eat more food.
    C. eat no food.
    D. become compulsive eaters.
    ___ True  ___ False

15. The minimum washout period for marijuana to leave the brain is 3 days, although normally it can last about 30 days in the brain.
    ___ True  ___ False

**Athletes and Problematic Eating**

16. When compared to all female athletes, the female aesthetic athletes were predicted to have:
    A. the least amount risk of all athletes.
    B. no risk among athletes
    C. some risk among athletes
    D. the most risk of all athletes.
    ___ True  ___ False

17. In the research regarding female athletes versus female non-athletes in the area of endurance, highly significant findings were obtained.
    ___ True  ___ False
Great workshops. Great people. Great time.

OPA’s 2010 Convention
“Psychology, Science, Practice and Advocacy in the Decade Ahead”

November 10-12, 2010
The Crowne Plaza North, Columbus

More than 25 workshops on billing, obesity, insurance, ethics, technology, medical setting, mindfulness, dealing with the courts, advocacy, health and behavior codes, forensic psychology and more!

Keynote address on The Fight for Psychology’s Priorities on Capitol Hill with Jeff Cook, APA Practice Organization

Plenary Session Panel on Healthcare Reform: What Does It Mean For You? With Peter Ambrose, Anthem, Cathy Levine, UHCAN Ohio, and Mary Jo Hudson, Director, Ohio Department of Insurance

Registration begins online in late August at www.ohpsych.org