Reaching the Margins: Serving the Underserved
### PAC Supporter Continued...

- Christine Charyton PhD
- Collin H. Christensen PhD
- Alyce M. Caine PhD
- Virginia F. Clark PhD
- Shern L. Cohen PhD
- Robert K. Conyne PhD
- Pamela K. A. Corbin PhD
- Chad D. Corbly PhD
- Douglas C. Darnall PhD
- Steven J. Davis PhD
- Kenneth A. DeLuca PhD
- Janet E. Dix PhD
- David S. Doane PhD
- Deborah L. Downey PsyD
- Elizabeth K. Drenen PhD
- Michael G. Drown PhD
- Nancy J. Duff-Boehm PhD
- Stephen W. Emerick PhD
- Sandra S. Foster PhD
- Catherine A. Gaw PsyD
- Charles E. Gerlach PhD
- Mary Goebel-Komala PhD
- Ruth E. Goldberg PhD
- Catherine M. Golden PhD
- William R. Gorga PhD
- Kathleen A. Grant PsyD
- Joseph A. Grochowski PsyD MDiv
- Alfred E. Grzegorek PhD
- Stephen A. Hall PsyD
- Larry E. Hamme PhD
- Elizabeth A. Hardy PhD
- Nannette J. Hart PhD
- Kristen E. Haskins PsyD
- Patricia J. Hayes PsyD
- Thomas W. Heitkemper PhD
- James L. Helmuth PhD
- Catherine L. Herzog PhD
- Fawn D. Hewitt PsyD
- Mary E. Hickcox PhD
- Andrew L. Hinkle PhD
- William C. House PhD
- Sherrie L. Ireland PhD
- Donna R. Jackson PhD
- Kurt W. Jensen PsyD
- James E. Kaplan PhD
- Mary E. Kaplar PhD
- Ronan M. Kisch PhD
- Rudite Mara Kleinman PhD
- Ronald J. Kovacs PsyD
- David A. Krauss PhD
- Phyllis R. Kuehn-Walters PhD
- Carroll E. Lahnisers PhD
- Norman S. Lanier PhD
- Jonathan P. Lehman PsyD
- Brenna C. LeJeune PsyD
- Kathryn A. Levesconte PsyD
- Mary Miller Lewis PhD
- Patricia Logan PhD
- Catherine M. Malkin PhD
- Jayne M. Malpede PhD
- Gregg A. Martin PhD
- Carolyn McCabe PhD
- Cathy L. McDaniels Wilson PhD
- William P. McFarren EdD
- Sharon L. McNamie PhD
- Dennis Jerome Meers PhD

### PAC Supporter Continued...

- Rena Mei-Tal PsyD
- Christopher M. Mesthot PhD
- Angela N.R. Miller PhD
- Jacqueline H. Morrison PhD
- Jill H. Mushkat PhD
- Leslie A. Netland PsyD
- Barbara A. Nicely PhD
- Victoria L. Norton PsyD
- Virginia M. Holley Ogletree
- Mary Anne Occurt PhD
- Stanley J. Palumbo PhD
- Anne W. Passino PhD
- Joseph P. Pecorelli PhD
- Sandra S. Phalen PhD
- Katherine T. Platoni PsyD
- Alice Randolph EdD MSCP
- Mary M. Rath PhD RN
- Teresa A. Reinhard-West PsyD
- Linda D. Rhyne PhD
- Christine A. Hovanitz Riehle PhD
- Carrie H. Robinson PhD
- Joseph A. Robinson MA
- Jeffery D. Rosenbaum PhD
- Thomas P. Ruf PhD
- Sandra W. Russ PhD
- James R. Ryan EdD
- Diana S. Santantonio EdD
- Daniel A. Schaefer PhD
- David P. Schwartz EdD
- Terry R. Schwartz PsyD
- Donald S. Scott PhD
- Patricia A. Semmelman PhD
- Richard E. Sexton PhD
- Joseph W. Shannon III PhD
- Herbert Shapiro PhD
- Jean R. Simmons PhD
- Barbara Sinclair PhD
- Gary J. Sipps PhD
- Carole P. Smith PhD
- Frances Smith Strickland PhD
- Randal J. Snyder PhD
- Debra K. Sowald PsyD
- Catherine Staskavich PhD
- Val V. Steigelmann PhD
- Susan J. Steinberg PhD
- Ted Strickland PhD
- Karl W. Stukenberg PhD
- Mary Ann Teitelbaum PhD
- Nathan D. Tomicki PhD
- Craig S. Travis PhD
- David F. Turner PhD
- Steven B. Van Auken PhD
- Robert J. Walker EdD
- Marilyn R. Wander PhD
- Richard A. Wantz EdD
- Brian L. Ward PsyD
- Dana D. Watts PhD
- Kari S. Watts PhD
- Donald R. Welsy PhD
- Robert N. Wendt PhD
- Chelsea R. Weyand PsyD
- Cynthia C. White PsyD
- Katharine B. Williams PhD
- Theodore W. Williams PhD
- Sally Wilson PhD
- Michael S. Witter PsyD

### PAC Supporter Continued...

- Edward J. Wojniak Jr. PhD
- Abraham W. Wolf PhD
- Priscilla A. Wood PsyD
- Janis G. Woodworth PhD
- Cori L. Yaeger PhD
- Susan M. Zarnowiecki PhD

### OPA Member ($10-$24 donation)

- Reginald C. Blue PhD
- Bonnie L. Fraser PhD
- Marjorie M. Isaacs PsyD
- Thomas C. Kalin PhD
- Jeremy D. Kaufman PsyD
- Phyllis J. Rosen PhD

### PAC Supporter Continued...

- Michael O. Ranney, MPA, Executive Director
- Karen Hardin, BA, Managing Editor
- Kathleen T. Heinlen, PhD, Editor

### STAFF

- Michael O. Ranney, MPA, Executive Director

*Articles in The Ohio Psychologist Review represent the opinions of the writers and do not necessarily represent the opinion of governance, member or staff of OPA. Acceptance of advertising does not imply endorsement by OPA.*
GET COVERED WITH PROFESSIONAL LIABILITY FROM CPH & ASSOCIATES.

Your practice is too important to leave unprotected.

INSTANT QUOTE IN LESS THAN A MINUTE AT CPHINS.COM

A++ PROFESSIONAL LIABILITY INSURANCE FOR PSYCHOLOGISTS

- Occurrence Form “Lifetime” Coverage
- Up to 50% Discount for Newly Licensed Professionals
- 10% Risk Management Discount
- 5% Online Discount
- Online applications processed in minutes: receive your proof of coverage immediately!
- 2 Free Hours of Attorney Consultations per year HIPAA Coverage
- Unlimited Defense Coverage
- State Licensing Board Coverage: $35,000 automatically and option to increase up to $100,000
<table>
<thead>
<tr>
<th>Page</th>
<th>Title</th>
<th>Author(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Letter from the Editor,</td>
<td>Written by: Ky Heinlen, PhD, PCC-S</td>
</tr>
<tr>
<td>5</td>
<td>Ohio Psychologists’ Perception of Obstacles Related to Accessing</td>
<td>Written by: Alyssa Frye, MA, Penny Koontz, PsyD and April Fugett, PhD</td>
</tr>
<tr>
<td></td>
<td>Mental Health Care</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Self-Reflectiveness, Modern Forms of Prejudice, and Serving the Underserved</td>
<td>Written by: Julia C. Phillips, PhD</td>
</tr>
<tr>
<td>12</td>
<td>Maximizing Your Teaching Effectiveness by Following the Ethics Code</td>
<td>Written by: Elizabeth V. Swenson, PhD, JD</td>
</tr>
<tr>
<td>14</td>
<td>Mindfulness Programs in the Workplace: Giving Attention to the Underserved</td>
<td>Written by: Allen D. McConnell, Jr., MA and Richard W. Sears, PsyD, MBA, ABPP</td>
</tr>
<tr>
<td>16</td>
<td>Colleague Assistance Program</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>A Feminist Critique of Traditional Conceptualizations or Female Agoraphobia</td>
<td>Written by: Kirby Reutter, PhD, LMHC</td>
</tr>
<tr>
<td>19</td>
<td>OPA’s 2015 Workshop Schedule</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>The Rise of Medical Tourism: Guidelines for Working with International Clients</td>
<td>Written by: Christina M. Rummell, PhD</td>
</tr>
<tr>
<td>24</td>
<td>Stereotype Threat, Self-Efficacy &amp; Career Expectations in Ethnic Minority College Students</td>
<td>Written by: Elizabeth Harris, PhD</td>
</tr>
<tr>
<td>27</td>
<td>Teaching Sexism to the Masses: A Quantitative Content Analysis of Changing Depictions of Gender Roles in Popular TV from 1961-2007</td>
<td>Written by: Breanna E. Sholtz and Scott W. Keiller, PhD</td>
</tr>
<tr>
<td>30</td>
<td>Mental Health Concerns and Body Dissatisfaction within the Competitive Male Fitness Community: A Review</td>
<td>Written by: Valerie M. Taton, MA and Stephanie S. Judson, PhD</td>
</tr>
<tr>
<td>32</td>
<td>Ohio Psychologist Continuing Education Quiz</td>
<td></td>
</tr>
</tbody>
</table>

**List of Advertisers:**

- APAIT - The Trust .......... 23
- Behavioral Health Associates .............. 22
- CPH & Assoc. ................. 2
- Glennon Karr .................. 26
- TherapyNotes .................... IBC

**Stay Connected**

- www.ohpsych.org
- 614.224.0034
- 800.783.983
- 614.224.2059
- [Ohio Psychological Association](http://www.ohiopsychologicalassociation.com)
- [facebook.com/ohiopsychologicalassociation](https://facebook.com/ohiopsychologicalassociation)
- [twitter.com/ohiopsychassn](https://twitter.com/ohiopsychassn)
- [linkedin.com/company/ohio-psychological-association](https://linkedin.com/company/ohio-psychological-association)
- [pinterest.com/ohiopsychassn/](https://pinterest.com/ohiopsychassn/)
- [youtube.com/user/OhioPsychAssn](https://youtube.com/user/OhioPsychAssn)
As a professional association, the Ohio Psychological Association has so much to celebrate in terms of our contributions to the profession of psychology and advocacy for the mental health population in Ohio. This annual publication reflects the depth and breadth of not only the populations we serve, but also the capacity in which we serve. With the exception of the articles presented by OPA's Poster Session winners, these articles are from psychologists all over the state who practice in clinical, research and educational settings.

Our theme this year is “Reaching the Margins: Serving the Underserved.” As professionals, this theme provides us with an opportunity to consider who the underserved are and to reflect on how we are personally serving these marginalized populations. I hope, as you read through this issue of the Ohio Psychologist, that you discover how to better serve the needs of the underserved of Ohio.

Two articles in this publication reflect on different practice settings including the workplace and higher education. In the article “Mindfulness Programs in the Workplace: Giving Attention to the Underserved,” authors Allen D. McConnell, Jr., MS and Richard W. Sears, PhD explore how the practice of mindfulness in workplace programs may help reach individuals who are not only underserved, but also may not typically consider utilizing services. Elizabeth V. Swenson, PhD, JD provides an ethical perspective in teaching in higher education in her article, “Teaching A Course: What Does the Ethics Code Mandate?”

Christina M. Rummell, PhD links practice settings with the population served in her article “The Rise of Medical Tourism: Guidelines for Working with International Clients.” With increased utilization of psychologists practicing in medical settings, as well as an influx of international patients, opportunities to serve those who live in other countries are becoming more common. Serving the underserved is not just about where we practice, but is also about whom we serve, and how we serve them. This is addressed in the article by Kirby Reutter, PhD, LMHC entitled “Female Agoraphobia: A Feminist Critique of Traditional Conceptualizations for Female Agoraphobia.” Dr. Reutter provides an in depth exploration of how our very conceptualization of a disorder shapes how we perceive the underserved.

This leads to the questions: what are the perceptions of psychologists about the barriers individuals face in gaining access to mental health services, and who are the underserved? The article, “Ohio Psychologists’ Perception of Obstacles Related to Accessing Mental Health Care” by Alyssa Frye, MA, Penny Koontz, PsyD and April Fugett, PhD paves the way to further our discussion in providing services to the underserved. This article complements the writing of Julia C. Phillips, PhD in “Self-Reflectiveness, Modern Forms of Prejudice, and Serving the Underserved” which leads us to examine how our own biases impact how we practice.

As is tradition, students, whose work was recognized at the OPA’s Annual Convention Poster Session, are invited to publish their findings in this publication. We are fortunate to have articles from each of the winners this year. Elizabeth Harris, PhD in her article “Stereotype Threat, Self-Efficacy and Career Expectations in Ethnic Minority College Students” shares the results of her quantitative quasi-experimental research on career expectations and stereotypes. In “Teaching Sexism to the Masses: A Quantitative Content Analysis of Changing Depictions of Gender Roles in Popular TV from 1961-2007,” Breanna E. Sholtz and Scott W. Keiller, PhD examine paternalism and the sexualization of women in the media. Serving males with body dissatisfaction who are involved in competitive fitness is the focus of the article “Mental Health Concerns and Body Dissatisfaction within the Competitive Male Fitness Community: A Review” written by Valerie M. Talon and Stephanie S. Judson.

Don’t forget you can earn credit for reading the Ohio Psychologist. Simply complete the quiz for continuing education at the back of the journal and send it to the OPA office.

We are very fortunate that as an organization, we are able to continue to support a peer-reviewed publication. Each of these articles has been reviewed by at least three members of the OPA Editorial Board whose names are highlighted to the left of this article. I would like to extend my sincere appreciation to them for the hours they volunteered to review the manuscripts submitted for publication. I would also like to extend my sincere appreciation to Karen Hardin who has done a wonderful job of managing the editing of this publication.

Finally as we look toward our next issue, please be thinking about how you would like to contribute. The theme for next year is “Future Frontiers of Psychology.” If you have an interest in publishing or reviewing an article please let me know. We will be adjusting our timetable for the publication of the Ohio Psychologist so look for more details to come.
Ohio Psychologists’ Perception of Obstacles Related to Accessing Mental Health Care

Alyssa Frye, MA, Penny Koontz, PsyD and April Fugett, PhD
Marshall University

Abstract

Individuals face various factors that may influence their utilization of mental health care. Underserved populations, especially those living in rural communities, face additional barriers to accessing mental health care compared to their urban counterparts. Two categories of barriers identified in the literature are tangible and attitudinal barriers. Tangible barriers include issues such as limited resources in the community, lack of transportation, appropriate childcare or financial constraints. Attitudinal barriers include stigma associated with mental illness, belief that the problem will not improve with intervention and a perceived lack of privacy. The perspectives of patients and their family members regarding access to mental health care in rural areas have been evaluated; however, research is quite limited regarding the perspectives of mental health care providers. Understanding more from the providers’ viewpoint will lead the way for further discussion and intervention that is crucial to providing mental health services to underserved populations.

Barriers exist in many communities inhibiting residents from accessing appropriate mental health care. Understanding how these barriers affect help-seeking behaviors provides a more complete picture of the systemic factors involved in mental health care. This is especially pertinent in rural areas, where many residents do not receive suitable mental health care. This study sought to obtain the perspectives of psychologists working in rural and urban communities regarding the factors they identify as impediments in access to mental health care for residents living in their region. It is hypothesized that a psychologists’ community type (rural or urban) will produce different results on the Barriers to Accessing Mental Health Care Survey, an assessment used to measure structural and attitudinal barriers (Appendix A), with the assumption that rural psychologists will report barriers such as a lack of available resources in the community, higher number of transportation issues, and a more salient lack of privacy.

LITERATURE REVIEW

Studies have been conducted regarding barriers to accessing mental health care from patients’ perspectives (Pepin, Segal, & Coolidge, 2009; Jackson et al., 2007). The barriers are uniquely defined in each article, with authors using a variety of terminology to describe two types including: tangible and perceived, structural and attitudinal, or extrinsic and intrinsic. Few of these studies have included the perspectives of patients’ families (Robinson et al., 2012; Murry, Heflinger, Suiter, & Brody, 2011). Even fewer articles examined barriers from the perspective of the mental health providers. More research is needed in this area to obtain a more complete picture of the systemic factors involved in mental health care.

Pepin et al. (2009) utilized the Barriers to Mental Health Services Scale (BMHSS) to examine intrinsic and extrinsic barriers among younger and older adults. Examples of intrinsic barriers included stigma, lack of help-seeking behaviors, lack of knowledge or fear about psychotherapy or the beliefs that their symptoms are relatively normal and do not require treatment. Extrinsic barriers included financial concerns, a lack of mental health care providers in their region, and transportation problems.

Pepin et al. (2009) established that the intrinsic and extrinsic barriers exist, but they were interested in the participants’ ranking of the barriers and differences between older and younger adults. The BMHSS surveys 10 known barriers to seeking mental health services. The authors believed that there is a significant difference between older and younger adults in regards to help-seeking behaviors, with older adults being more likely to view mental health care as unnecessary or more pejoratively. The authors failed to find a significant difference between age groups with their ranking of stigma, which ranked toward the bottom of the list. Their findings suggest that stigma may not be an influential barrier relative to other barriers.

Jackson et al. (2007) reviewed barriers to mental health care in a meta-analysis. The authors specifically discussed barriers to accessing mental health care in rural areas. They found a number of relevant barriers which included socio-demographic factors such as gender, age, and marital status, illness-related factors such as having a mental disorder, comorbidity, and psychological distress, and attitudinal factors such as stigma, stoicism, and self-efficacy (Jackson et al., 2007). The authors noted that the attitudinal factors had a lesser effect on the participants’ decision to seek mental health services than structural factors and may vary according to location, such as urban versus rural.

A number of studies address the experiences of patients and their families struggling with mental illness. Robinson et al. (2012) examined the barriers faced by patients with mental illness and their families in accessing mental health care in rural areas. The known barriers are identified as stigma, shortage of health care providers, reluctance to acknowledge problems when they exist, lack of family and community support, inadequate health insurance coverage, lack of privacy, financial constraints, transportation issues, and difficulty finding appropriate child care (Robinson et al., 2012). Differences in rural versus urban areas are important when discussing access to mental health care because large disparities may exist. Robinson et al. (2012) noted that more research is needed from the perspectives of medical and mental health care providers working in rural settings to obtain a more complete picture of the barriers faced by rural residents.
Another study was conducted with African-American families living in a rural community (Murry et al., 2011). The endorsed barriers to receiving mental health care in rural African-American families included stigma, cultural and general mistrust, lack of willingness from their children to receive services, lack of access, and lack of social support. The most frequently endorsed barrier was stigma, which contradicts other studies reviewed (Pepin et al., 2009); however, stigma may be culturally relevant and therefore reported more frequently in under-represented cultural groups (Murry et al., 2011).

Noticeably absent from the literature regarding barriers to mental health care are perspectives from health care providers, a general lack of research conducted within rural populations in the United States, and differences between barrier types (i.e. attitudinal/tangible). Therefore, it is imperative to fill the gap by conducting research in this area, to better understand where significant differences exist and to generate ideas on effective intervention options.

### METHODS

#### PARTICIPANTS

Psychologists (N = 241) working in Ohio participated in a study to measure their perspectives of the barriers faced by community residents in accessing mental health care. Participants were recruited through an email list serv provided by the Ohio Psychological Association. Links to the surveys were provided in an email message. Each psychologist anonymously completed a short demographic survey, which included: type of employment setting, number of years worked at current place of employment, county of employment, and the estimated number of residents in the city in which their practice is located. The participants also completed the Barriers to Accessing Mental Health Care Survey (BAMHCS) regarding residents of their practice community. Participants were divided into rural (n = 28) and urban (n = 213) based on the population of their employment county, using the 2013 Rural-Urban Continuum Codes (United States Department of Agriculture, Retrieved from: http://www.ers.usda.gov/data-products/rural-urban-continuum-codes.aspx).

#### DESIGN

The current study was designed to measure the barriers in accessing mental health care from the perspectives of psychologists in rural and urban areas of Ohio. We utilized the Barriers to Accessing Mental Health Care Survey, which was modeled after the Barriers to Care Evaluation scale (BACE). The BACE scale was found to have good test-retest reliability, internal consistency, and content and construct validity, with the majority of the items receiving kappa values from 0.61 to 0.80 (Clement et al., 2012). The 20-item survey is brief, and can be applied to a variety of mental health care settings. The respondents answer according to a 5-point Likert scale, ranging from ‘1 – Not a barrier’ to ‘5 – Significant barrier.’ Total scores can range from 20-100.

### RESULTS

A between-groups multivariate analysis of variance was performed to investigate differences in attitudinal and tangible scores on an assessment between rural and urban psychologists. There was a statistically significant difference between rural and urban psychologists on the combined dependent variables, F (2, 238) = 3.93, p < .05; Wilks’ Lambda = .97; partial eta squared = .03. Attitudinal and tangible barriers are reported differently from psychologists in rural and urban counties. Significant results were found for both variables when considered separately. A statistically significant difference exists for attitudinal barrier scores, F (1, 239) = 7.26, p < .05, partial eta squared = .03. An inspection of the mean scores indicated that attitudinal barriers were reported as more significant in rural counties (M = 33.5, SEM = 1.25) than urban counties (M = 29.9, SEM = .45). A statistically significant difference also exists for tangible barrier scores, F (1, 239) = 5.47, p < .05, partial eta squared = .02 where attitudinal barriers are also more significant than tangible barriers in rural counties (M = 30.39, SEM = 1.22) than urban counties (M = 27.34, SEM = .45). This provides evidence to suggest that attitudinal barriers are viewed by psychologists as a more significant obstacle to accessing mental health care in rural areas.

### DISCUSSION

It was hypothesized that there would be a significant difference in attitudinal and tangible barrier scores between rural and urban Ohio psychologists. Results support this hypothesis, indicating that rural and urban Ohio psychologists significantly differ in their perception of barriers to accessing mental health care in their community. Attitudinal barriers, such as stigma and a perceived lack of privacy, are reported to be a more significant barrier for patients in accessing mental health care in rural areas, which supports the limited literature on this topic (Robinson et al., 2012).

### IMPLICATIONS

Obtaining a more complete view of the barriers to accessing mental health care can influence systemic factors, especially in rural communities. This knowledge can pave the way in how the community works together to overcome those barriers and therefore, discover ways to enhance access to mental health, especially in underserved areas. Therefore, areas for future research could include identifying successful interventions for overcoming barriers in rural communities to allow greater access to mental health care.

### LIMITATIONS

This data was obtained from psychologists working in Ohio and was divided into rural and urban categories; however, defining ‘rural’ is not straightforward. Disagreement is common when researching uniform methods of dividing rural from non-rural counties (Hall et al., 2006). Therefore, rural communities are generally defined as any community that fails to meet criteria for urban designation and are not within a certain radius of an urban city. Additionally, there is a gap between the number of rural and urban psychologists in this study; however, this highlights an already-known issue that there are fewer psychologists practicing in rural areas.
### Appendix A: Barriers to Accessing Mental Health Care Survey

To what degree do you believe the following is a barrier for individuals in your community who seek mental health care?

<table>
<thead>
<tr>
<th></th>
<th>1 = Not a barrier</th>
<th>2 = Minimal barrier</th>
<th>3 = Mild barrier</th>
<th>4 = Moderate barrier</th>
<th>5 = Significant barrier</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>There are stigmatizing attitudes regarding mental health in the community.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Privacy is a huge concern for residents in this area.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Residents believe mental health care would probably not help them.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Residents are reluctant to acknowledge that a mental health problem exists.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>residents have concerns about the characteristics of the psychologists (i.e. age, gender, race, etc.) in this community.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>There is a widely-held belief that self-reliance is the best option when it comes to mental health issues.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>residents feel embarrassed or ashamed regarding help-seeking behaviors.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>residents are generally unaware of the mental health services in this community.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>residents have difficulties related to a lack of reliable transportation.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>residents have difficulties related to insufficient affordable child care services.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>residents have difficulty talking about or expressing their emotions.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>residents do not want to burden anyone else with their problems.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>most residents would prefer to seek help from their religious leader.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td>residents worry about how seeking help would affect their employment status or employment opportunities.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>residents have concern about how their family members or friends would perceive them seeking mental health care.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td>Many residents experience financial difficulties that prevent them from seeking help.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17.</td>
<td>residents have had a previous negative experience with mental health care.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18.</td>
<td>residents are unable to travel the long distance to see the nearest psychologist.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19.</td>
<td>residents have no available trusted family members to care for their children while they seek help.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20.</td>
<td>most residents talk about their psychological issues with their primary care physicians.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other Concerns:

_______________________________________________________
_______________________________________________________
_______________________________________________________

Type of setting where you practice:

- 1. Primary care
- 2. VA hospital
- 3. Psychiatric hospital
- 4. General hospital
- 5. Private practice
- 6. Community mental health center
- 7. Corrections
- 8. Residential treatment facility
- 9. Other

Number of years you've worked at this setting:

- 1. 0-5 years
- 2. 5-10 years
- 3. 10-15 years
- 4. 15-20 years
- 5. 20+ years

Estimated population of community where your work site is located:

- 1. 1-5,000
- 2. 5,001-10,000
- 3. 10,001-20,000
- 4. 20,001-30,000
- 5. 30,001-40,000
- 6. 40,001-50,000
- 7. 50,000-60,000
- 8. 60,001-70,000
- 9. 70,001+

www.ohpsych.org - 7
**References**


**About the Authors**

**Alyssa Frye** is a clinical psychology doctoral student at Marshall University in Huntington, West Virginia. Her primary research interests include issues pertinent to underserved populations and utilization of mental health care. Additionally, she has an interest in advocacy and social justice.

**April Fugett, PhD** is an Associate Professor and the Undergraduate Program Coordinator in the Psychology Department at Marshall University in Huntington, WV. Her research interests include psycholinguistics, technological and popular culture influences on cognition, research design, and statistical analyses.

**Penny Koontz, PsyD** is a licensed clinical psychologist in the state of Ohio. She is an Assistant Professor and Director of the Psychology Clinic at Marshall University in Huntington, WV. Her research interests include provision of psychological services to underserved populations, clinical health psychology, and geropsychology.

**Author Note**

Correspondence concerning this article should be addressed to:

Alyssa Frye  
Department of Psychology  
Marshall University  
One John Marshall Drive  
Huntington, West Virginia 25755  
Email: adkins577@marshall.edu
Self-Reflectiveness, Modern Forms of Prejudice, and Serving the Underserved

Julia C. Phillips, PhD
Cleveland State University

Abstract

Many strategies and interventions for serving the underserved focus on the underserved populations themselves. This article focuses instead on the importance of self-reflectiveness for practitioners about modern forms of prejudice as foundational to effectively serving the underserved. Research highlights the need for psychologists to actively confront the possibility that they have unrecognized biases while at the same time holding egalitarian beliefs and values for social justice (e.g., Nosek et al., 2007). Implications and recommendations are discussed.

Three foundational competency clusters in Rodolfa’s et al. (2015) model of professional competencies for psychologists are imperative to effectively serving the underserved, especially when considering how contemporary forms of prejudice may affect our work (Sue & Sue, 2012). The first competency includes maintaining a Scientific Knowledge Base related to sociocultural issues affecting the behavior of individuals and the dynamics between groups. Studies demonstrate the negative effects of contemporary forms of prejudice (e.g., Nosek et al., 2007; Owen, Tao, Imel, Wampold, & Rodolfa, 2014; Neville, Spanierman, & Doan, 2006), but it may be difficult to stay current on the many studies that are published in a variety of journals in psychology, particularly in other specialty areas (e.g., Wang, Leu, & Shoda, 2011) and outside the field (e.g., Cooper et al., 2012). The second foundational competency, Professionalism/Ethics, includes self-examination of professional practice with a critical eye and the help of colleagues’ feedback. This type of examination is more difficult when well-intentioned psychologists consider that they may have hurt or offended someone because of biases that are hidden to themselves (Sue, 2010). Finally, Cultural and Interpersonal Competency is exhibited when psychologists “integrate and apply theory, research, professional guidelines, and personal understanding about social contexts to work effectively with diverse” (Rodolfa et al., p. 75) people, the culmination of an integration of the first two competencies. Bringing these three competencies together, I briefly will highlight research on modern forms of prejudice, discuss the implications for practice, and focus on the importance of self-reflectiveness for psychologists as they consider this information.

Although overt prejudice has decreased in U.S. society as its members embrace equal rights, scholars have increasingly focused on subtle forms of isms or prejudice demonstrated by people who espouse egalitarian views (e.g., Pearson, Dovidio & Gaertner, 2009; Neville, Awad, Brooks, Flores, & Blumel, 2013, Nosek et al., 2007). Much of the current scholarship on modern forms of prejudice has focused on racism, including discussions of aversive racism (e.g., Dovidio, Gaertner, Kawakami, & Hodson, 2002), implicit versus explicit attitudes (e.g., Nosek et al., 2007), racial microaggressions (Sue et al., 2007), and color-blind racial ideology (Neville et al., 2013). However, the concept of benevolent sexism also has been discussed alongside hostile sexism (e.g., Lee, Fiske, & Glick, 2010). Additionally, many scholars identify microaggressions toward a variety of stigmatized groups, including women, sexual minorities, and people with disabilities (e.g., Nadal, 2013; Sue, 2007) and the implicit attitudes test has been used to examine attitudes towards young versus old people, women versus men, people with and without disabilities, and many other groups (for review see Banaji & Greenwald, 2013; Nosek et al., 2007).

What does research tell us about modern forms of prejudice? First, people who are well-intended and committed to equality are not immune from holding unconscious biases (Banaji & Greenwald, 2013; Dovidio et al., 2002; Nosek et al., 2007). Additionally, this idea is typically difficult to face, so much so that Dovidio and his colleagues coined the term “aversive racism” because people are averse to the idea that they have unconscious racist attitudes and that their actions are discriminatory. However, research results suggest that especially in conditions that are ambiguous, or when participants can point to other criteria that supposedly explain their behavior, participants make choices that favor White people and disadvantage others (for review, see Dovidio et al., 2002). These participants remain unaware of their racism because they point to factors other than race that explain their behavior. Psychologists make complex decisions every day in which such biases might emerge. For example, whether one will take or refer a client when one’s caseload is almost full often depends on many factors that should have little to do with race/ethnicity. Yet it is conceivable that psychologists might decide more often to take White clients and refer others, but point to other factors to explain their decisions, thus maintaining the illusion that they did not discriminate.

Similarly, in research on implicit associations that show the degree to which we prefer one group over another (e.g., White people over Black people) or associate certain stereotypes with one group over another (e.g., women with family and men with careers or White versus Black people with weapons), results suggest that stereotypes as well as preferences for one group over others exist for most people in the U.S. (see Banaji & Greenwald, 2013; Nosek et al., 2007). These results often hold even for people who belong to the groups...
that are least preferred (e.g., a preference for young people among older adults) and in fact, the preference for younger versus older adults is one of the strongest and most consistent preferences amongst people in the U.S. (Banaji & Greenwald, 2013; Nosek et al., 2007). Recently, Greenwald and Pettigrew (2014) hypothesized that preferences for in-groups accounts for more variance in discrimination than hostility toward out-groups. This idea is yet to be fully examined in research, but psychologists would do well to examine whether or how their own preferential treatment for in-groups perpetuates inequality for the underserved. If we consistently give the best treatment to in-groups, or even schedule clients who belong to in-groups at the most convenient therapy times, we are doing a disservice to those in the out-groups. If you have not done so already, you can test yourself on your implicit associations at https://implicit.harvard.edu/implicit/. Find a trusted group of colleagues who also are willing to take these tests in order to have an enriching, self-reflective discussion of the implications for practice.

Along a different line, microaggressions are the subtle insults or indignities that minorities face on a daily basis (for review, see Sue, 2010; Sue et al., 2007; Nadal, 2013) and research demonstrates the negative effects of microaggressions not only in daily life (e.g., Nadal, Wong, Griffin, Davidoff, & Sriken, 2014; Wang et al., 2011), but also in therapy (e.g., Constantine, 2007; Owen, Tao, & Rodolfa, 2010; Owen et al., 2014). As originally discussed by Pierce, Carew, Pierce-Gonzalez, and Willis (1978) and further discussed by others (e.g., Nadal, 2013; Sue et al., 2007; Sue, 2010), microaggressions are overtly demeaning toward others based on their cultural identities or invalidating of their experiences as cultural minorities. Additionally, these authors note that microaggressions are often subtle and the effects on the targets are not in line with the intentions of those who engage in the microaggression. In fact, they highlight that persons engaging in microaggressions are often unaware of their impact on others, beyond some anxiety that the interaction did not go well. In a recent study of racial and ethnic minority clients, Owen et al. (2014) reported that 53% of racial/ethnic minority clients reported that microaggressions related to their cultural identities had occurred and only 24% of those who had experienced microaggressions discussed it with the therapist. Experiencing microaggressions was associated with lower working alliances with counselors for those clients who did not discuss it in therapy. Similarly, women clients who had experienced gender microaggressions in therapy also reported lower working alliances and more negative outcomes (Owen et al., 2010). Thus, recognizing that a microaggression has occurred and discussing it with the client is imperative for psychologists.

One type of microaggression as applied to race and ethnicity is color-blindness or the idea that we are all equal and color does not matter (Sue et al., 2007; Sue, 2010). This type of microaggression is invalidating to people of color because it invalidates their experiences of race and ethnicity as defining features of life in the U.S. Neville et al. (2013) further discuss that color-blindness as a racial ideology being comprised of color evasion (the avoidance of seeing differences in an effort to promote racial sameness), and power evasion (denial that racial inequalities and White privilege exist). Colorblind attitudes were associated with lower levels of empathy for African American clients in an analogue study (Burkard & Knox, 2004) and with lower levels of self-reported multicultural competence and actual competence in integrating race/ethnicity in a conceptualization task among mental health professionals and trainees (Neville, Spanierman, & Doan, 2006). Thus, examining the degree to which our attitudes are consistent with color-blind racial ideology is important to effectively serving clients of color.

Thus, to combat stereotypes and negative images of minority individuals, psychologists should engage in activities that expose them to people and images that counter stereotypes.

It should be noted that evaluative conditioning is effective in changing negative implicit biases (Hofmann, De Houwer, Perugini, Baeyens, & Crombez, 2010), particularly in people who are motivated to change (Steffens, 2004) and who are open to diversity (Chao, Wei, Spanierman, Longo, & Norhart, 2015). Thus, to combat stereotypes and negative images of minority individuals, psychologists should engage in activities that expose them to people and images that counter stereotypes. Continuing education programs should capitalize on these findings by presenting research data on the negative effects of implicit biases and sharing information and images that disconfirm stereotypes (Jackson, Hilliard, & Snyder, 2014). Programs can also emphasize the importance of psychologists engaging in friendships with diverse people, including diverse communities in daily life, and seeking out positive models of diverse people in media consumption (Dasgupta & Rivera, 2008). Thus, well-intentioned psychologists who can openly admit their implicit biases or modern isms also have research based strategies for change.

In conclusion, it is critical that we as psychologists consider these bodies of research and critically reflect on how they may apply to our practice. Doing so takes courage as our views of ourselves likely don't include hidden biases or engaging in hurtful microaggressive behaviors towards others, especially clients. However, it is likely that we are not 100% different from those in the U.S. as a whole who have taken the implicit attitudes test (Nosek et al., 2007) or from those who have worked with clients in psychotherapy research that has demonstrated the negative effects of modern forms of prejudice (e.g., Neville et al., 2006; Owen et al., 2010; Owen et al., 2014). As such, examining various areas of bias, preference, and stereotyping is a critical, on-going process for the sake of serving the underserved.

References


---

**Author Note**

Correspondence concerning this article should be addressed to:

Julia C. Phillips
Counseling, Administration, Supervision, and Adult Learning
Cleveland State University
2121 Euclid Avenue
Julka Hall 275
Cleveland, Ohio 44115
Phone: (216) 687-5424
Email: j.c.phillips6@csuohio.edu

**About the Author**

Dr. Julia Phillips is an Associate Professor in the Counseling, Administration, Supervision, and Adult Learning Department at Cleveland State University. She is Co-Director of Training for the APA-accredited doctoral specialization in Counseling Psychology in the College of Education and Human Services. She received her PhD in Counseling Psychology from The Ohio State University in 1992 after completing her internship at Michigan State University Counseling Center. Dr. Phillips is a licensed psychologist in the State of Ohio and she practiced at the University of Akron Counseling Center for 19 years, providing leadership for their APA-accredited internship program prior to joining the faculty at CSU in 2014. Dr. Phillips has research and scholarly interests in professional issues, training of psychologists, and diversity issues. She is a Fellow of the American Psychological Association and active in leadership activities for Division 17, the Society of Counseling Psychology.

www.ohpsych.org - 11
Maximizing Your Teaching Effectiveness by Following the Ethics Code

Elizabeth V. Swenson, PhD, JD
John Carroll University

Abstract

An excellent way to increase one's professional development is to teach a course at the college level. The Principles of Psychologists and Code of Conduct (APA, 2010) is cited to show important ethical features of the syllabus, student disclosure of personal information, and evaluating student performance. Vignettes illustrate each relevant standard, covering ethical mistakes commonly made in the classroom.

Are you thinking of teaching a course or two to add to your professional development, and possibly to add some continuing education hours to your total? If so, there are some ethical issues to keep in mind as you construct your course and meet your students. Being creative and responsive to your learners' needs can both go along with accreditation requirements and the ethics code standards related to teaching.

THE COURSE SYLLABUS

Your course syllabus acts as a contract between you, as a representative of your institution, and your students. Looked at in this way, it takes on a gravity it might not ordinarily have had. Consider Standard 7.03 of the Principles of Psychologists and Code of Ethics (APA, 2010).

7.03 Accuracy in Teaching
(a) Psychologists take reasonable steps to ensure that course syllabi are accurate regarding the subject matter to be covered, bases for evaluating progress and the nature of course experiences. This standard does not preclude an instructor from modifying course content or requirements when the instructor considers it pedagogically necessary or desirable, so long as students are made aware of these modifications in a manner that enables them to fulfill course requirements.

Standard 7.03 indicates that a balance needs to be struck between spontaneity and careful course planning.

Consider the following example. Margo Likely, PhD, MLS, takes an opportunity to teach Introduction to Legal Psychology at North West Central University. The course will enroll both graduate students and advanced undergraduates. Wanting to save plenty of time to discuss current events in the psycho-legal area, she sets forth a loosely organized schedule. Students begin to complain after a few weeks that the last topics on the syllabus, which many think will be the most interesting, are not likely to be covered in the class. In response, Dr. Likely told the students that they would still be covering these topics, but on their own, by reading the assigned chapters. In addition, some describe Dr. Likely's lectures as uninteresting and only opportunities for Dr. Likely to pontificate on esoteric legal subjects. Realizing that there is little time to revise the course, Dr. Likely adds a class activity which she feels will engage students’ interest. Students will attend a jury trial at the local courthouse and enact the most interesting part or character in the trial in class. This will replace the grade on one of the three exams.

In this scenario there are several issues that run afoul of Standard 7.03(a). The subject matter to be covered promises more topics than are feasible under this instructor’s teaching style. This is not unusual for an instructor’s first time teaching a class. Dr. Likely needed to pay particular attention to the schedule and her ability to meet it. This certainly does not mean that other pedagogically important subjects cannot be inserted during the semester, but this should be done carefully to maintain the integrity of the course and the syllabus. More problematic is the addition of the class activity. It is important to maintain the basis for assessing student achievement. Not only does this new requirement replace an exam, but it necessitates students leaving campus, their homes, or their jobs to travel to another location and at a time other than class meeting time and place. If this were not difficult enough for some students, being sure to show up at a court house when a jury trial is being conducted is not always possible. Students need to be reasonably sure of the course content, activities, and basis for assessment in sufficient time to drop the course and pick up another. Usually this means the first week of class. Changing the method of assessing student learning is reinforced by Standard 7.06.

7.06 Assessing Student and Supervisee Performance
(a) In academic and supervisory relationships, psychologists establish a timely and specific process for providing feedback to students and supervisees. Information regarding the process is provided to the student at the beginning of supervision.
(b) Psychologists evaluate students and supervisees on the basis of their actual performance on relevant and established program requirements.
Even though this standard refers to “supervisee,” “student” can be substituted.

In Dr. Likely’s legal psychology class, students study the psychological research on the death qualification of jurors. Studies show that when prospective jurors who have such strong beliefs about the death penalty that they could not be part of a jury considering imposing it are eliminated from a jury it tends to be more conviction prone. In class discussions of the death penalty and of protecting the rights of criminal defendants more generally, a student continuously speaks out in favor of “getting rid of the dregs of society who commit not only murder but any kind of violent felonies.” Dr. Likely speaks to the class about errors in convictions that can result from false confessions and eye witness identifications as well as the fact that minorities are disproportionately charged and convicted. These facts only serve to enrage the student who believes that convicted felons are always factually guilty and get the punishment they deserve. Dr. Likely lowered the student’s grade from a C+ to a D-, believing that he did not fully understand the material.

This scenario is one that was anticipated by standard 7.06. Class comments and opinions were not part of relevant and established requirements.

### STUDENT DISCLOSURE OF PERSONAL INFORMATION

In psychology, more so than in other disciplines, material is enriched by being able to relate it to one’s own experience. The ethics code deals with one aspect of this in Standard 7.04.

#### 7.04 Student Disclosure of Personal Information

Psychologists do not require students or supervisees to disclose personal information in course- or program-related activities, either orally or in writing, regarding sexual history, history of abuse and neglect, psychological treatment and relationships with parents, peers and spouses or significant others except if (1) the program or training facility has clearly identified this requirement in its admissions and program materials or (2) the information is necessary to evaluate or obtain assistance for students whose personal problems could reasonably be judged to be preventing them from performing their training- or professionally related activities in a competent manner or posing a threat to the students or others.

Consider another example. Jim MacDonald, PsyD has taught required courses in developmental psychology for several years. He feels that since we all have been children, it is important for his students to reflect on their childhood and relate it to what they are learning in the course. During the course of the semester there are four writing assignments based on this idea. One of these is related to the first time a student can remember being aware of their sexual orientation, how they came out to their parents and how their parents reacted to this revelation. The second had to do with the students’ recollection of the discipline practices of their parents and how they feel this shaped their personalities, behavior, and ideas about disciplining their own children. For the third paper students were to write on their fears as a child, how these developed as they grew in to adolescence, and the specific strategies (if any) used to treat them. The fourth assignment asked students to reflect on their experiences with people from races and ethnicities other than their own and their own feelings of racism. These usually included interactions with friends or family members. Many students enjoyed writing these papers, especially since they did not require any research references or outside reading, but not infrequently the writing indicated that the topic was a painful one to remember. On average, two to three students approached Dr. MacDonald every year with a request to substitute another topic or to make up the facts. Dr. MacDonald refused these requests as they would defeat the learning purpose of the papers.

This scenario is one that is anticipated in standard 7.04. The exception, that this information is necessary to identify troubled students, is not relevant. Alternatively, that a student will know in advance about the assignments does little to alleviate the ethical issue because the course is required. Although there surely is some validity to being able to relate course material to one’s own development, this does not extend to needing to share it with the instructor, and then to receive a grade for it. Dr. MacDonald could instead ask students to reflect on these matters or to write papers that are fiction, and so label them. (Swenson, 2012)

### CONCLUSION

This article has discussed several of the most important and relevant ethics code standards that guide ethical teaching. These include assessment, the role of the syllabus, and disclosure of personal information.

### References


### Author Note

Correspondence concerning this article should be addressed to:

Elizabeth V. Swenson
Department of Psychology
John Carroll University
University Heights, Ohio 44118
E-mail: swenson@jcu.edu

### About the Author

Elizabeth V. Swenson is a Professor of Psychology at John Carroll University. She earned her BS from Tufts University, MA and PhD from Case Western Reserve University in educational psychology, and JD from Cleveland State University. Her teaching interests are in professional ethics, legal psychology, children and families in the legal system, and the effects of hospitalization on children’s development. Dr. Swenson is a fellow of the American Psychological Association, the Midwestern Psychological Association, and the Phi Beta Kappa Society. She is a psychology department consultant for the Society for the Teaching of Psychology and a team leader/consultant-evaluator for the Higher Learning Commission of the North Central Association.
Mindfulness Programs in the Workplace:
Giving Attention to the Underserved

Allen D. McConnell, Jr., MS and Richard W. Sears, PsyD, MBA, ABPP
Union Institute & University

Abstract

Interventions utilizing mindfulness have gained increasing attention in recent years, and a number of them are now considered evidence-based practices. Since mindfulness involves strengthening one’s capacity to pay attention, and to work wisely with thoughts, emotions, and body sensations, these interventions are now being applied in workplace settings. Workplace programs have the potential to reach more underserved populations, who might not normally have the means or interest to seek out services for the prevention of stress and mental health issues. In this article, we explore some of the evidence for using mindfulness in the workplace.

MINDFULNESS PROGRAMS IN THE WORKPLACE

In last year’s Ohio Psychologist (McConnell & Sears, 2014), we defined mindfulness and discussed general concepts for its use in an organizational setting. In this article, we will investigate specific interventions and touch upon recent research.

Mindfulness involves strengthening one’s capacity to pay attention, and to work wisely with thoughts, emotions, and body sensations (Kabat-Zinn, 2003; Sears, 2014). Mindfulness programs are becoming more common in the workplace, and offer a variety of techniques and interventions associated with attention, stress management, and emotional intelligence. Workplace programs have the potential to reach more underserved populations, who might not normally have the means or interest to seek out services for the prevention of stress and mental health issues (Sears, Rudisill, & Mason-Sears, 2006). Given that a number of mindfulness-based clinical interventions are now considered evidence-based (Hofmann, Sawyer, Witt, & Oh, 2010; Williams, 2006), interest has grown in applying these techniques to an organizational setting.

MINDFULNESS-BASED STRESS REDUCTION

One of the original and most popular mindfulness programs, “Mindfulness-Based Stress Reduction” (MBSR; Kabat-Zinn, 2013), has been successfully adapted for a work environment. Davidson and colleagues (Davidson, Kabat-Zinn, Schumacher, Rosenkranz, Muller, et al, 2003) offered an eight-week MBSR program during working hours to a group of 25 employees at a biotechnical organization. The participants were compared to a wait-list control group (N = 16). Participants in both groups were given an EEG to test for emotional responses and an influenza vaccine to test for antibody titer at the end of the program. Results indicated that MBSR participants experienced greater physical and psychological health compared to the control group. Specifically, MBSR participants had more antibody titer and the EEG results showed greater activation in the left anterior regions of the brain, which is associated with positive emotional expression (e.g., joy, happiness). In comparison, the control group had less antibody titer and greater activation in the right anterior regions of the brain, which is related to negative emotional expression (e.g., anxiety and depression).

ACCEPTANCE AND COMMITMENT THERAPY

Stress management programs based on acceptance and commitment therapy (ACT; Hayes, Strosahl, & Wilson, 2012) have also been offered in the workplace. Flaxman and Bond (2010a; 2010b) have offered a variety of stress management programs, such as ACT and Stress Inoculation Training (SIT), to a group of government employees in the United Kingdom. The ACT program provided participants the opportunity to practice mindfulness exercises that focused on increasing present moment awareness, reducing unhealthy and unproductive thoughts and emotions, and learning to develop a core sense of self. Flaxman and Bond (2010b) found the ACT program to be more effective than a control group. Specifically, 69% of the participants reported a reduction in work-related distress. Flaxman and Bond (2010a) have also compared the ACT program to the SIT program. Participants in the SIT program are trained on relaxation meditation) and are encouraged to implement these techniques in their daily life at work. The Institute for Mindful Leadership cites survey results from 80 of their participants, representing a total of 12 organizations that support the benefits of their programs. Specifically, 93% of participants reported the trainings offered by the Institute for Mindful Leadership improved their ability to be innovative; 89% reported being better able to listen to themselves and others, and almost 70% reported the training programs to improve their ability to make strategic decisions. Similarly, the Potential Project (2011) offers a Corporate-Based Mindfulness Training (CBMT) program that assists participants in applying mindfulness to specific areas at work (e.g., emailing, meetings, presentations, communication, work breaks, and traveling). The CBMT program is

OTHER MINDFULNESS PROGRAMS

Private organizations have also developed mindfulness programs that can be offered to employees in an organizational setting; however, the empirical evidence for these programs is lacking. For example, The Institute for Mindful Leadership (2012) offers a series of courses and workshops. The “Mindful Leadership and Wellness” course consists of a weekly, two hour class over the course of seven weeks. Participants are taught basic mindfulness techniques (e.g., sitting meditation) and are encouraged to implement these techniques in their daily life at work. The Institute for Mindful Leadership cites survey results from 80 of their participants, representing a total of 12 organizations that support the benefits of their programs. Specifically, 93% of participants reported the trainings offered by the Institute for Mindful Leadership improved their ability to be innovative; 89% reported being better able to listen to themselves and others, and almost 70% reported the training programs to improve their ability to make strategic decisions. Similarly, the Potential Project (2011) offers a Corporate-Based Mindfulness Training (CBMT) program that assists participants in applying mindfulness to specific areas at work (e.g., emailing, meetings, presentations, communication, work breaks, and traveling). The CBMT program is
based on eight attitudes: presence, patience, kindness, joy, beginners mind, non-judging, acceptance, and letting go. There is currently no scientific data on the influence of the CMBT on its participants.

“Mindfulness at Work” is a relatively new program that can be offered in a traditional group setting as well as in an online classroom environment (Wolever, Bobinet, McCabe, Mackenzie, Fekete, et al., 2012). The program consists of 12 weekly one hour classes and a two-hour intensive offered during the 10th week of the course. Participants are educated on various mindfulness and stress reduction techniques that are aimed at increasing their work productivity. Wolever et al. (2012) recently compared the “Mindfulness at Work” program with a Viniyoga Stress Reduction Program for a group of employees at a national insurance organization. No significant differences were found between the two programs. Both programs were found to effectively reduce work stress, improve quality of sleep, and improve heart-rate variability. Interestingly, the researchers noted a lower rate of attrition and higher participation in the “Mindfulness at Work” program that was offered online compared to in a traditional classroom. However, there were no significant differences between the two delivery formats in regards to influencing stress, sleep quality, and heart rate variability in participants of the program.

Other studies have used meditation-based programs, which are similar yet different from the mindfulness programs discussed previously. For example, Arias (2008) offered a 20-week transcendental meditation program to business executives. The program consisted of two, 60-minute meditation sessions every week. The techniques taught in the program focused on (1) attention focusing development, and (2) mind introspection orientation towards the cultivation of compassion. Participants in the group were also given 20-minute homework assignments to practice the meditation techniques on a daily basis. Executives reported that the transcendental meditation program was effective in reducing their stress and increased their ability to manage work conflicts and engage in more effective leadership skills on a short-term basis.

In a similar study, Dolman and Bond (2011) offered a program based on Samarpan meditation. The goal of Samarpan meditation is to quiet the mind and reduce thoughts in order to reach a state where individuals can feel balanced, calm, and relaxed. The study consisted of three groups: (1) a group participating in the Samarpan meditation program, (2) a group engaging in various cognitive or physical exercises, and (3) a control group. The Samarpan group was instructed to meditate for 45 days and to complete a journal for 45 days. Participants also completed a “life wheel” every two weeks where they would rate their level of satisfaction in their life. The second group was instructed to engage in a mindless activity (i.e., one that does not require much thought, such as walking) that they usually did not participate in for 30 minutes per day over the course of 45 days. Results indicated that 90% of participants in the Samarpan meditation group reported positive results compared to only 52% of the second group. Specific results for the Samarpan meditation group included 61% feeling calm, 36% enjoying the opportunity to leave everything and have time to themselves, 22% experiencing better quality of sleep, and 22% developing a different perspective on life. Participants also reported feeling more relaxed, refreshed, peaceful, worrying less, and having clearer thoughts.

CONCLUSION

Overall, work wellness programs based on mindfulness are more effective in reducing work related stress, illness, and burnout compared to wait-list control groups. However, research indicates that mindfulness programs offered in the work place are as effective as other stress management programs, such as SIT and a Viniyoga Stress Reduction Program. More research is still needed to examine the impact of mindfulness training on workplace employees compared to other stress management programs.

References


Mindful Programs in the Workplace: Giving Attention to the Underserved

References Continued...


About the Authors

Allen McConnell, MS is a doctoral candidate in the clinical psychology program at Union Institute & University. He previously earned his master’s degree in human development and family science at The Ohio State University. His research interests include co-parenting, family systems, developmental disabilities, and the integration of psychology and spirituality. Professionally, Allen has 17 years of experience working with individuals with chronic medical conditions and developmental disabilities. Currently, Allen is completing his predoctoral internship at a community mental health center in Battle Creek, Michigan. He can be reached via email at allen.mcconnell@email.myunion.edu.

Richard W. Sears, PsyD, MBA, ABPP, is a psychologist in Cincinnati, where he runs a private psychology and consultation practice, and is core faculty in the PsyD Program at Union Institute & University. Dr. Sears is lead author of Mindfulness in Clinical Practice, Consultation Skills for Mental Health Professionals, Mindfulness: Living through Challenges and Enriching Your Life in this Moment, Perspectives on Spirituality and Religion in Psychotherapy, Building Competence in Mindfulness-Based Cognitive Therapy, and Mindfulness-Based Cognitive Therapy for PTSD (Wiley-Blackwell). His website is www.psych-insights.com.

The Ohio Colleague Assistance Program (OPA-CAP) was started in 2006 when the Ethics Committee of the Ohio Psychological Association formed a subcommittee to investigate the feasibility of a Colleague Assistance Program for Ohio psychologists.

Over the past 8 years, OPA-CAP has developed a mission statement and philosophy, streamlined a referral and intervention process, conducted several training sessions, developed a list of resources and identified a small number of providers statewide.

The OPA-CAP program is based on principles of self-care, prevention, early intervention and treatment to Ohio psychologists. It seeks to create a climate which normalizes self-care and help-seeking. In so doing, OPA-CAP aims to keep stressed or distressed psychologists from becoming impaired, and when indicated to link them to providers for treatment.

The mission of OPA-CAP is to provide Ohio psychologists with help accessing services to maintain or restore professional functioning in order to protect client welfare. In the role of providing care to others, psychologists themselves often need support which is difficult to obtain because of the confidential nature of their work. State law and established ethical standards require psychologists to recognize when their objectivity or competency may become impaired. OPA-CAP purports to prevent the occurrence of impairment and to smooth the referral process when treatment is needed or desired. The program does so by providing relevant education and confidential referral services to all Ohio psychologists.

OPA-CAP is currently looking for additional providers across the state to provide care to those that seek treatment. In the coming weeks, you will receive an OPA-CAP brochure highlighting our current mission, vision and more.

The OPA-CAP Committee encourages you to review this material and consider becoming a provider.
A Feminist Critique of Traditional Conceptualizations for Female Agoraphobia

Dr. Kirby Reutter, PhD, LMHC
Gateway Woods

Abstract
Agoraphobia was originally conceptualized as the struggle between individuals and the transformation of public spheres in modern society. Thus, agoraphobia was regarded as three-dimensional, including aspects of the individual, aspects of public space, and aspects of society. However, Freud introduced a paradigm in which pathology was conceived as innately psychogenic—and often the province of women. In this sense, psychoanalysis was inherently androcentric a bias which continues to nuance psychotherapy. It is not surprising that behavioral, cognitive, and pharmacological models have continued to conceptualize agoraphobia both as a problem of individuals and as a problem of women—in short, as a problem of individual women. Thus, most traditional models seem to favor a female-deficit interpretation of agoraphobia. However, the feminist perspective more accurately restores the two lost dimensions of this disorder—namely, public space and society. In this article, we will briefly examine how public space and society impact the individual. In particular, we will explore how society tends to pathologize women who step outside of their culturally-prescribed roles—or who internalize them all too well.

INTRODUCTION

As currently conceptualized, agoraphobia is predominantly a female disorder (McHugh, 2008). For example, approximately 75 to 95 percent of diagnosed agoraphobes in the United States are female, with comparable statistics reported in other countries. Similarly, females receive diagnoses of panic disorder with agoraphobia three times more frequently than males, and also exhibit the avoidant behaviors characteristic of this disorder at the same ratio. Furthermore, the disproportionate percentage of female diagnoses only increases with severity; for example, 90 percent of severe agoraphobes are female. The DSM-IV-TR (2000) previously described agoraphobia as “anxiety about, or avoidance of, places or situations from which escape might be difficult (or embarrassing) or in which help may not be available in the event of having a panic attack or panic-like symptoms” (page 429). It is fascinating to note that literally on page 310 of the DSM-IV-TR (2000) the word she was used instead of the word he.

Interestingly, agoraphobia was not always conceptualized or reported as a predominantly female disorder. In fact, the initial preponderance in diagnosis was actually male (Callard, 2003). Agoraphobia as a documented pathology first surfaced in the early 1870’s. Originally, numerous appellations competed in their attempts to describe the disorder. For example, one German theorist suggested the term Platzschwindel, or “downtown dizziness,” while a Frenchman proposed the phrase peur des espace, or “fear of space.” Thus, various nomenclatures sought to capture the essence and source of the phobia: squares crowds, public spaces, or spaces in general. However, these early theorists failed to recognize the single, underlying theme running through all of these competing diagnoses: the problems and perils of living in a modern metropolis.

Based on these roots, Callard identifies three dimensions of agoraphobia: the individual, public space, and society. These three dimensions provide a functional framework for evaluating the various models of psychotherapy which have attempted to explain and treat this disorder. Interestingly, traditional models have completely missed the full scope of agoraphobia by focusing exclusively on individual pathology—while completely neglecting the role of public space and the greater society. In fact, only recent feminist models have recaptured the original complexity of the disorder by taking into account all three dimensions.

PSYCHOANALYTIC PERSPECTIVES FOR AGORAPHOBIA.

While Freud himself commented little on agoraphobia in particular, he set the theoretical groundwork which his followers subsequently applied to all manner of phobic disorders. Thus, psychoanalysts have tended to view and treat agoraphobia as a “deep-seated individual psychopathology,” characterized by the Freudian concepts of intrapsychic conflict, fixation, regression, projection, displaced aggression, displaced sexuality, dependent personalities—and even penis envy (McHugh, 2008). For example, Otto Fenichel, an American psychoanalyst from the mid-1900’s, argued that open spaces in public could be “unconsciously conceived as an opportunity for sexual adventures.” Thus, as Fenichel reasoned, “the fear of open streets often functioned as a defense against exhibitionism.” Following this line of logic, Fenichel wrote the following analysis of his client, a female agoraphobe (Callard, 2003; page 43):

Her anxiety attacks... had the unconscious [yet] definite purpose of making her appear weak and helpless to all passers-by. Analysis showed that the unconscious motive of her exhibitionism was a deep hostility, originally directed towards her mother, then deflected onto herself. “Everybody, look!” her anxiety seem to proclaim. “My mother let me come into the world in this helpless condition, without a penis!”

www.ohpsych.org - 17
While interpretations of this nature may seem overly zealous to a modern audience, let us not forget that more contemporary models perpetuate some of the same basic assumptions inherent in this analysis. For example, psychologists continue to view agoraphobia as a predominantly female problem stemming from early childhood experiences and relationships. In fact, psychodynamic theorists still conceptualize agoraphobia primarily as a function of anxious attachments, and treat the disorder accordingly.

**REVIEW OF OTHER TRADITIONAL APPROACHES.**

According to the traditional behaviorist paradigm, agoraphobia results from negative synergy between classical and operant conditioning. First, an adverse panic-inducing event (e.g., anxiety attack) is paired with a typically benign event (e.g., riding the subway). Secondly, this association becomes further entrenched as a result of negative reinforcement via avoidance behaviors. According to the cognitivist perspective, agoraphobia primarily results from irrational, pathogenic ideation within the individual. Finally, according to the pharmacological conceptualization, agoraphobia results from neurological anomalies which trigger sensations of anxiety. While each of these traditions (ranging from psychoanalytic to pharmacological, from behavioral to cognitive) may offer important insights, they also share a common deficiency in scope: a one-dimensional focus on the individual (McHugh, 2008).

Thus, all of these models are inconsistent with the historic conceptualization of agoraphobia as a three-dimensional problem. While each of these paradigms acknowledges the dimension of public space, they only do so incidentally. For example, public space is merely regarded as the forum in which individual psychopathology manifests—not as an etiological or casual source of its own. Thus, the onus of pathology rests squarely on the individual, without accounting for legitimate perils which continue to persist in places of public convergence. Furthermore, the societal dimension is entirely omitted in all of these traditions. In this sense, psychology has barely progressed beyond Freudian speculations such as those proffered by Otto Fenichel.

**AGORAPHOBIA FROM THE FEMINISTIC PERSPECTIVE**

Contrary to traditional paradigms, the feminist model has finally restored agoraphobia to its original conceptualization by accounting for all three dimensions: the individual, public space, and society. Notice that these three dimensions represent increasingly expansive units of analysis. Psychoanalytical/dynamic, cognitive/behavioral, and pharmacological traditions have all reported correlations between individual characteristics and agoraphobia. However, feminist researchers such as McHugh (2008) have also reported empirical correlations between this disorder and conditions which exist both in public spaces and society at large.

**THE DIMENSION OF PUBLIC SPACE**

Cognitive theorists have been especially responsible for conceptualizing agoraphobia as “irrational”—placing the onus of pathology on women. This conceptualization derives from the assumption that our public spaces are indeed safe for women. However, let us not forget that public spaces were historically the province of men for millennia. Not surprisingly, the literature indicates that females are socialized since childhood to fear strangers—and male strangers in particular—when present in public spheres. For example, Hoffart and colleagues (2006) found a much stronger correlation between inter-personal fears and agoraphobic symptoms than between intra-personal fears and agoraphobia. Thus, these researchers concluded that “women who are not overtly phobic lead environmentally restricted lives” (McHugh, 2008). Perhaps the threat of rape best epitomizes this argument. According to Rozeo (2008), “women’s fear of crime, especially rape, results in their use of more precautionary behaviors than men. Fear of rape is also the best predictor of the use of isolation behaviors, such as not leaving the house.”

In short, clinical psychologists who label women’s fear of public spaces as “irrational” may be operating from an androcentric perspective. After all, most public venues have historically been produced by male architects, populated by male criminals, and policed by male officers. Thus, it is not difficult to surmise how men may fail to appreciate the female experience. In this sense, agoraphobia may be less “irrational” than most theorists have assumed (McHugh, 2008).

**THE DIMENSION OF SOCIETY**

In addition, we must also realize that agoraphobia, like many other DSM diagnoses, is a cultural construct. In fact, the DSM itself is an excellent guide for determining what constitutes or does not constitute socially acceptable behavior in twenty-first century America. In this sense, the DSM is as much a social commentary as it is a tool for clinical diagnosis. Thus, it is not surprising that numerous DSM criteria—not to mention entire disorders—continue to evolve over time. It is particularly fascinating to note the precise timing of when certain disorders suddenly rise to diagnostic prominence.

For millennia, women did not have to leave their immediate vicinity to perform homemaking responsibilities. (In fact, this phenomenon remains the case in rural regions of the planet). Thus, women were never considered pathological for remaining at home; on the contrary, this behavior was socially prescribed. However, with the urbanization of American and European life in the late 1800’s, women were increasingly required to leave their homes in order to meet their domestic obligations. Therefore, it is fascinating to note that precisely during this era diagnoses of agoraphobia began to emerge. In other words, as soon as women could not continue to perform their traditional roles due to changing conditions in society, they were diagnosed as pathological. Does this explanation seem far-fetched? If so, then please recall the DSM excerpt referenced in the introduction: “Individual’s avoidance of situations may impair their ability… to carry out homemaking responsibilities (e.g., grocery shopping, taking children to the doctor).” Needless to say, behaviors which defy existing norms are the quickest to receive diagnostic labels.

In short, society exerts immense influence in determining which behaviors are considered pathological or not. Ironically, the evidence clearly indicates that females are collectively socialized towards agoraphobic tendencies—as long as these tendencies do not become too extreme for male hegemony. Thus, women find themselves caught in a classic double-bind: “Be submissive and docile—but not useless!” Consider the following research findings, all extracted from McHugh (2008):

- Girls are more restricted and supervised and are given less encouragement to explore their environments.
- Women in general are taught to be anxious, fearful, and dependent and to restrict their mobility in varied ways.
- Unstable or unsatisfactory marriages [sometimes] get worse as the agoraphobe gets better.

The Ohio Psychologist July 2015 - 18
• In particular, the jealousy, interrogation, and surveillance behaviors of the husbands [of some agoraphobes] are very similar to the spouse behaviors reported by battered women.
• Male batterers typically maintain control by limiting the wife’s geographical and temporal mobility and by restricting her social interactions with her family and friends.

Obviously, each of these points is pregnant with discussion, which space will not allow. However, please note the common threads running through these excerpts: societal expectations in conjunction with historic male hegemony. In this sense, agoraphobia is perhaps just as easily conceptualized as a symptom of society—and not merely the pathology of particular individuals.

CONCLUSION

The implications of the expanded perspective of the feminist paradigm should not be underestimated. If agoraphobia is only viewed from the limited scope of individuality, then the preponderance of women agoraphobes must confirm the female-deficit interpretation: In other words, something is wrong with women. However, if agoraphobia is viewed from a larger lens which encompasses both interpersonal confluence (public space) and social institutions (society), then a different picture emerges—one that seems androcentric, and perhaps, at times, even misogynic. Thus, the ongoing prevalence of agoraphobia amongst females might be another remaining artifact (at least at the societal level) of historic patriarchal hegemony.

References


About the Author

Dr. Kirby Reutter, PhD, LMHC is a bilingual licensed psychologist employed by the Gateway Woods residential treatment program for delinquent and troubled youth. Dr. Reutter holds a bachelor’s degree in Spanish Studies as well as two advanced degrees in psychology. Dr. Reutter has conducted original international research on spiritual coping, which has been published by three different sources. Most recently, Dr. Reutter presented his research findings at MIT in Cambridge, Massachusetts. Dr. Reutter specializes in treating traumatized youth, providing psychological evaluations for adoptive couples, and working with Spanish-speaking clients.

ANNOUNCING THE OHIO PSYCHOLOGICAL ASSOCIATION

2015 SUMMER & FALL WORKSHOP SCHEDULE

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
<th>City</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 31</td>
<td>Early Intervention for Injured Workers: OPA’s Program for BWC - (6 CE)</td>
<td>Cincinnati</td>
</tr>
<tr>
<td>August 28</td>
<td>Glenn Karr’s Annual Ethics Workshop: Focusing on New Psychology Board Rule Changes Effective in 2015 - (4 CE - Ethics)</td>
<td>Columbus</td>
</tr>
<tr>
<td>August 29</td>
<td>Understanding the ICD-10-CM - (6 CE)</td>
<td>Columbus</td>
</tr>
<tr>
<td>September 11</td>
<td>Early Intervention for Injured Workers: OPA’s Program for BWC - (6 CE)</td>
<td>Cleveland</td>
</tr>
<tr>
<td>September 25</td>
<td>Interpreting the MMPI-2-RF - (6 CE)</td>
<td>Cleveland</td>
</tr>
<tr>
<td>October 2</td>
<td>Practical therapeutic techniques you can use with post traumatic stress disorder clients - (3 CE)</td>
<td>Columbus</td>
</tr>
<tr>
<td>October 2</td>
<td>Effective treatment techniques for borderline personality disorder clients! (3 CE)</td>
<td>Columbus</td>
</tr>
<tr>
<td>October 30-31</td>
<td>Union of Psychology &amp; Spirituality Retreat - (11 CE)</td>
<td>Mohican State Park</td>
</tr>
</tbody>
</table>

Watch your inbox for more information about online registration!

www.ohpsych.org/mce/ce-opportunities
The Rise of Medical Tourism: Guidelines for Working with International Clients

Christina M. Rummell, PhD
Summa Health System and Notre Dame College

Abstract

With growing numbers of psychologists working in medical settings, and growing numbers of patients traveling to the United States to seek medical care, psychologists may be encountering increased numbers of international clients. This article discusses recommendations for culturally-relevant practice with international clients, including understanding cultural identity, working with interpreters, culturally responsive assessment and diagnosis, and culturally responsive therapy. A few illustrative examples from the author’s own clinical experiences are provided.

In recent years, increasing numbers of people have been traveling to other countries to access medical treatment—a phenomenon termed ‘Medical Tourism’ (Hanefeld, Horsfall, Lunt, & Smith, 2013). Many patients from non-Western cultures now choose to travel abroad to countries like the US, Canada or the UK to receive medical care, especially for surgical procedures and specialized treatments such as those for fertility (Lunt & Carrera, 2010). Additionally, with growing numbers of psychologists working in primary care settings and other health-related venues such as bariatric surgery, oncology, pain management, sleep medicine and medical schools, the likelihood of psychologists encountering international clients is increasing (Jensen & Turk, 2014; McDaniel & deGruy, 2014; Robiner, Dixon, Miner, & Hong, 2014). Therefore, a review of recommendations for assessing and treating culturally diverse clients is timely.

UNDERSTANDING IDENTITY

As part of basic multicultural competence, psychologists should seek to educate themselves about various cultures outside of the time spent engaging in therapy (American Psychological Association, 2002). It is important to have basic information about each client’s cultural identities, including but not limited to: gender, sexual identity, race/ethnicity, religious affiliation, national origin, indigenous heritage and age or other generational influences (Hays, 2008).

However, what can be more therapeutically useful is to understand the client’s own meaning behind these identities. Integrating both types of information can help the psychologist form hypotheses and ask questions that are more in line with the reality of daily life for the client (Hays, 2008).

Information about a client’s culture of origin also gives the psychologist clues about the client’s world-view, values, and behavior. For example, while European American cultures place high value on egalitarian relationships, other cultures, such as Arab, Asian, African, and Latino/a, place high value on respect for authority figures (Morales, 1999). Therefore, the use of first names as a way to show equality and decrease social distance by American psychologists may actually be perceived as offensive by some clients. In light of this, many healthcare systems are moving toward the norm of addressing all patients by a formal title such as Mr., Mrs., or Miss until invited to do otherwise (Cosgrove, 2014). Similarly, norms such as personal space, eye contact, silence, and punctuality vary from culture to culture. As an example from my personal work, one Saudi Arabian client requested that her appointments be scheduled after 1:00 p.m. because arriving to the clinic early in the morning was inconsistent with her cultural practice. When appointments were scheduled early, it was not uncommon for her to be up to 30 minutes late.

WORKING WITH INTERPRETERS

When the psychologist does not speak the client’s primary language and a therapist fluent in that language is unavailable, the use of an interpreter may be required. As a rule, an interpreter should be a qualified person who is not in a close social relationship with the client (Hays, 2008). Allowing a client’s friends, children or parents to interpret creates an unfair dual relationship between the client and that person. It may also introduce bias or confidentiality issues into the therapeutic relationship. In planning ahead for a session with an interpreter, it is important to allow extra time for the appointment, as there will be more speaking time involved (Paniagua, 2005). Make sure there are at least three chairs in the office, and for spoken language, position them; so that, the client and the psychologist are facing each other. Questions should be asked directly to the client, not to the interpreter. Speak in simple sentences, void of colloquial phrases, and ask single questions to allow the interpreter time to interpret (Hays, 2008). Skilled interpreters should translate your words and the client’s words verbatim – if you say, “I will see you next week,” the interpreter should say, “I will see you next week,” rather than, “She will see you next week.” Similarly, if the client says, “Arabic coffee is strong and served in small cups,” the interpreter should not say, “She’s describing what Arabic coffee is.” Finally, it may be helpful to seek consultation from a cultural consultant or interpreter outside of the therapeutic context regarding best-understood ways to describe and explain psychological constructs (Hays, 2008).
Many factors can influence clients’ performance on and response to assessment questions. Language fluency, quality of interpretation, variations in cultural norms, interview style and pace, among others may all impact the outcome of the assessment.

Psychologists and other medical providers should attempt to be as specific and concrete as possible when asking diagnostic questions, or else the validity of the assessment may be threatened. For example, the diagnostic criteria for binge eating disorder specify that a patient must eat a large amount of food in a short period of time (larger than a typical meal), and feel loss of control during the episode (American Psychiatric Association, 2013). The perception of “feeling out of control” with one’s eating may vary from culture to culture. In addition, the quantity of food consumed at an “average” meal may be vastly different depending on the cultural group and the specific meal in question (Kulick & Menely, 2005). Therefore, asking patients for descriptive information, such as their usual day of eating in this example, as well as their answers to the diagnostic questions, may prove helpful for comparison.

Certain components of the typical structured clinical interview may be confusing or even offensive to some clients (Hays, 2008). For example, questions about substance abuse, suicidal ideation, or sexual relations may be offensive to patients of conservative religious backgrounds such as Mormon or Muslim (Almeida, 2005). However, these questions should not be avoided in assumption that because a person’s religion forbids the practice, she or he is not engaging in it. Rather, prefacing questions by saying, “I understand that this may not apply to you, but I must ask it of everyone,” may provide helpful insight. With the use of an interpreter who is of the same cultural background as the client, allowing the interpreter to state that he or she has also been required to translate the questions may be helpful to diffuse or prevent personal offense. I recall one incident where a Muslim client’s son, who was present during the interview, was greatly offended that the interpreter had translated my questions about substance use to his mother. He believed that the interpreter, also being of Muslim culture, should have known that these questions were inappropriate and not ever translated them. However, after explaining that the interpreter had made a commitment to translate everything I asked the client, he understood and provided me with suggestions for future interviews.

Further, what might appear symptomatic in European American culture may be within the spectrum of normal expression in other cultures. For example, one Spanish female patient was hospitalized multiple times within six months for seizure-like symptoms. However, medical tests failed to reveal any organic cause. During my interview with her, it became apparent that these seizures were precipitated by a psychological stressor, such as an argument, each time they occurred. In Hispanic culture somatic expression of psychological stress is a culturally appropriate response (Escobar et al., 1987). This took my treatment with her in a very different direction than it would have without this information.

Psychologists conducting psychotherapy with clients from other cultures may find success in using an eclectic approach to treatment (Hays, 2008; Lazarus & Beutler, 1993). In other words, this means demonstrating flexibility in which techniques and interventions are employed depending on which best fit the nature of the client. Developing treatment goals and plans collaboratively with clients to ensure that they fit with the client’s cultural context and preferences are suggested (Hays, 2008). Similarly, drawing on client strengths and supports, such as religious beliefs or alternative therapies like acupuncture, may encourage coping. Before using manualized treatment protocols developed in Western nations, evaluate them for applicability to diverse cultures. For example, the assertiveness training component of many CBT protocols for binge eating and depression may not fit for persons from Asian or Arab cultures, or religiously conservative women (Almeida, 2005; Ashton et al., 2009; Fairburn 2013).

Finally, consider cultural-related expectations and beliefs regarding psychotropic medications (Hays, 2008). Suggesting a psychiatric evaluation for antidepressant or anti-anxiety medication to some clients may lead them to mistakenly believe you think they are extremely psychiatrically ill, and they may withdraw from treatment. As one patient from Egypt told me, “In my country, if you go to the psychiatrist, people think you are crazy.” This patient also balked at my recommendation for supportive individual psychotherapy until I had re-framed it as simply “having someone to talk to during a stressful time,” a common practice in U.S. culture. The de-stigmatization of receiving mental health care may be an important piece for clients who are required to receive an evaluation or treatment as part of their broader health care.

With growing numbers of psychologists working in medical settings, and growing numbers of patients traveling to the United States to seek medical care, psychologists may be encountering increased numbers of international clients. Providing culturally sensitive care is crucial for ethical and competent treatment of these client populations. This article is meant to serve as a brief primer for psychologists. However, it would be impossible for every psychologist to know everything about every culture. Thus, knowing the limits of one’s own cultural competence, and knowing when to seek consultation or supervision is key to providing the highest standard of care.
The Rise of Medical Tourism: Guidelines for Working with International Clients

Author Note

Correspondence concerning this article should be addressed to:
Christina M. Rummell, Ph.D.
Summa Akron City Hospital
Bariatric Care Center
95 Arch St., Ste. 260
Akron, Ohio 44304
Email: RummellC@summahealth.org

About the Author

Christina Rummell received her Ph. in Counseling Psychology from the University of Akron. She is a psychologist specializing in the evaluation and treatment of weight loss surgery patients at Summa Health System’s Bariatric Care Center in Akron, Ohio. She is also an adjunct psychology professor at Notre Dame College in South Euclid, Ohio. Her research and clinical interests include: eating disorders, obesity, health psychology, gender roles, sexuality, and psychometrics.
Connecting ALL Psychologists to Trust Sponsored Professional Liability Insurance

Coverage at every stage of your career... And no association membership required to apply!

Connect with The Trust whenever you’re providing psychological services – as a student, in supervised post-graduate work, in research and education, in professional practice... In so many ways, we have you covered and connected to:

- Broad coverage at affordable rates
- Free risk management consultations
- Excellent customer service
- A variety of premium discounts
- Optional Business Office insurance

Move your coverage to The Trust. It’s easy!

- Simply apply and provide us with proof of current coverage. We’ll do the rest.
- No gap in coverage (seamless transition)
- No costly tail (we pick up past years)
- 10% discount for switching coverage

Questions or concerns?
Call us at 1-877-637-9700

For Psychologists By Psychologists

www.trustinsurance.com • 1-877-637-9700

* Insurance provided by ACE American Insurance Company, Philadelphia, PA and in some jurisdictions, other insurance companies within the ACE Group. The product information above is a summary only. The insurance policy actually issued contains the terms and conditions of the contract. All products may not be available in all states. Surplus lines insurance sold only through licensed surplus lines producers. Administered by Trust Risk Management Services, Inc. ACE USA is the U.S.-based retail operating division of the ACE Group, a global leader in insurance and reinsurance, serving a diverse group of clients. Headed by ACE Limited (NYSE: ACE), a component of the S&P 500 stock index, the ACE Group conducts its business on a worldwide basis with operating subsidiaries in more than 50 countries. Additional information can be found at www.acegroup.com/us.
Stereotype Threat, Self-Efficacy and Career Expectations in Ethnic Minority College Students

Elizabeth Harris, PhD
University Hospitals/UH Rainbow Babies and Children

Abstract

A quantitative quasi-experimental design was used to evaluate stereotype threat, self-efficacy and perception of barriers as predictors of career expectations. The data were analyzed with a “t” test, bivariate correlations and multiple regressions. The “t” test failed to find statistically significant differences of career expectations based on stereotype threat. As predicted, bivariate analyses yielded a positive correlation between self-efficacy and career expectation, and a negative association between perception of barriers and career expectations. A multiple regression analysis indicated that stereotype threat, self-efficacy and perception of barriers in combination, have a statistically significant contribution to the prediction of the outcome variable career expectations.

INTRODUCTION

Stereotype threat refers to an individual’s perception of potentially confirming a negative stereotype about his or her group. Steele and Aronson’s (1995) framework supports the theory that multiple factors contribute to an individual’s susceptibility to stereotype threat. Researchers assert that stereotypes have been attributed to social cultural and social psychological factors (Robbins et al., 2006). Peer support has been found to have a significant influence in the achievement of African American college students (Harper, 2006). Researchers have also identified that an individual must be able to perceive themselves as being capable of obtaining success as defined by established goals through the identification of leaders from similar ethnic backgrounds (Brown and Day, 2006). Perception of racism was found to have a significant contribution to the vulnerability of stereotype threat (Bynnem et al., 2006). Additionally, long-term planning is necessary for academic motivation and occupational attainment to assist in relating academic goals to career aspirations (Beal & Crockett, 2010). In the absence of peer support, leadership, long-term planning and the presence of racism, stereotype threat may have very detrimental effects to one’s self-efficacy which can in turn, affect performance and goals. Based on the findings of prior research, authors support that it may be necessary to explore what effect stereotypes have on career aspirations and expectations. This study has sought to explore this relationship.

RESEARCH METHOD

The study utilized a quantitative quasi-experimental design. For this study, the independent variables were stereotype threat, perception of barriers and self-efficacy. The dependent variable is career expectations. The study used a “t” test, correlation and multiple regression analysis to test the hypotheses. An alpha level of .05 was used.

PARTICIPANT FLOW

Data in this study was collected during the 2012-2013 school year. Students were recruited from a 4-year university from an online based research participation system. Participants had an option of which studies on the participation system they wished to participate in. Those students who agreed to participate were given the Informed Consent Form. The study yielded 121 participants. The Informed Consent Form included study procedures and necessary contact information. Students were informed that participation is strictly voluntary, and no penalty resulted from non-participation. Once the Informed Consent Form was provided, the students completed the survey. The demographic questionnaire, Adapted Stereotype Vulnerability Scale (ASVS), Career Decision-Making Self-Efficacy Scale-Short Version (CDMSE-S), Perception of Barriers Scale (POB) and Career Expectations Scale (CE) were included in the survey. Participants were randomly assigned to either to the stereotype threat group, or the control group by alternating assignments. In the stereotype condition, the adapted stereotype vulnerability scale (ASVS) was presented first. In the control condition, the ASVS was presented last. There were 60 participants in the stereotype threat condition and 61 participants in the control condition. Of the 60 participants in the stereotype threat condition, 25 identified themselves as ethnic minorities. Students were informed that they would be expected to complete the assessments during a selected time slot and that it may take 20-30 minutes to complete. Students were debriefed at the conclusion of the study once all survey responses have been collected. Once the participants submitted completed surveys, a random number was assigned to each participant to protect student privacy. The assessments were manually scored and were entered into SPSS for Windows and analyzed.
Hypothesis 3 stated that ethnic minority college students’ scores on self-efficacy will be positively correlated with career expectations. There was a positive correlation between career decision self-efficacy (M = 89.79, SD = 13.23) and career expectations (M = 77.19, SD = 10.62); r = 0.511, n = 121, p < .001.

Hypothesis 4 stated that exposure to stereotype threat, perception of barriers, and career self-efficacy will significantly contribute to the prediction of career expectations among college students. When career expectations among students was predicted it was found that stereotype threat (β = -.381, p = .031), perception of barriers (β = .118, p = .033) and career decision-making self-efficacy (β = .330, p < .001) were significant predictors. The overall model fit was R^2 = 0.586. The full model was statistically significant F = (3, 117) = 20.42, p < .001. These three variables in combination significantly contribute to the prediction of career expectations.

**DISCUSSION**

It was hypothesized that exposure to stereotype threat, perception of barriers and career self-efficacy would significantly contribute to the prediction of career expectations among college students. This hypothesis was confirmed. All three variables contributed to the prediction of the dependent variable. While there is extensive research on career expectations (Shih, Bonam, Sanchez & Peck, 2007; Freeney & Fellenz, 2011; McWhirter, Crothers, & Rasheed, 2000) only few efforts have been made to explain the relationship between psychological and social cultural predictors and career expectations. Research on stereotype threat has informed the hypothesis of the current study by asserting that the endorsement that stereotype threat can have an acute impact on performance and a long-term effect on self-beliefs (Quiamzade & Croizet, 2007). Self-beliefs have a crucial role in how they inform individual career expectations and career decision-making. The findings in the current study did not indicate a significant relationship between stereotype threat and career expectations in hypothesis one but findings did reveal a significant relationship between all three of the predictor variables and career expectations in hypothesis four. The cause for this occurrence remains unclear. It is arguable that this may be explained by an intensity of all three predictor variables when they interact. Researchers suggested in previous stereotype literature that socio-cultural or psychological influences in combination contribute to vulnerability to stereotype threat (Robbins, et al., 2006; Taylor & Graham, 2007).

Hypothesis 1 stated that ethnic minority college students in the stereotype threat condition will score significantly lower on career expectations as compared with their counterparts in the control group. White college students’ scores will not significantly change resulting from experimental (stereotype threat) versus control condition. The mean of ethnic minority students in the threat condition (M = 75.09, SD = 14.94) was not significantly different from the mean of ethnic minority students in the control condition (M = 75.92, SD = 12.00); (t (21) = -.147, p = 0.47). The mean of Caucasian students in the threat condition (M = 78.58, SD = 10.65) was not significantly different than the mean of Caucasian students in the control condition (M = 80.03, SD = 8.09); (t(68) = -.637, p = .142).

Hypothesis 2 stated that perception of barriers will negatively correlate with career expectations among college students. That is, the higher the reported levels of barriers, the lower the scores on career expectations. There was a negative correlation between perception of barriers (M= 116.54, SD= 17.68) and career expectations (M= 77.19, SD= 10.62); r = 0.450, n = 121, p < .001.
Stereotype Threat, Self-Efficacy and Career Expectations in Ethnic Minority College Students

References


About the Author

Elizabeth Harris, PhD is a postdoctoral fellow in the Division of Child and Adolescent Psychiatry at University Hospitals/UH Rainbow Babies and Children. Her special interests include sociocultural and systemic stressors, ADHD, anxiety disorders, disruptive behavior disorders and parent-child relationships. She earned a bachelor’s degree in psychology from the University of Toledo; and a master’s in psychology and a doctorate in counseling psychology from Walden University. She was previously recognized for an excellent non-empirical poster submission at the 2013 Cleveland Psychological Association poster session and she is presenting her research in a grand rounds lecture for the department of psychiatry at University Hospitals.

Glennon J. Karr
Attorney at Law

Legal Services for Psychological Practices

(614)848-3100
Outside the Columbus area,
The Toll Free No. is (888) 527-7529
(KARRLAW)

Fax: (614) 848-3160
E-Mail: gkarr@karrlaw.com

1328 Oakview Drive
Columbus, Ohio 43235
A culture’s values are shaped by and displayed in its entertainment. For the last six decades, American families have gathered around televisions to watch beloved shows, absorbing media messages. Women’s fight for equality has grown alongside the bustling entertainment industry, but do television programs reflect this movement? The once accepted, moreover expected, role of a man was to be domineering and controlling, while women were to be obedient and helpless. Children’s developing ideas about femininity and masculinity are shaped, in part, by gender stereotypes presented in media which affect their perceptions of self and others (Bem, 1993). By analyzing media over the decades, we can observe changes in gender stereotypes.

Gender norms prescribe certain roles and behaviors for men, and others for women, thereby pressuring people to conform to cultural expectations in order to obtain social rewards and avoid punishment and rejection (Bem, 1981). Masculine norms include dominance, power over women and living a playboy lifestyle of casual sex (Mahalik et al., 2003). Feminine norms encourage objectification (and self-objectification) of women by prescribing a thinness ideal and investment in appearance (Mahalik et al., 2005). Differing gender norms for men and women are perpetuated and amplified by media portrayals of female characters who are submissive to male characters. What are the dangers of media depictions of male domination and sexualization of women? According to Albert Bandura’s Social Learning Theory (Bandura, 1977), people learn through observing others’ behavior, and the consequences of those behaviors. If sexist stereotypes permeate television, such portrayals may shape viewers’ attitudes about what is normal for men and women and their relationships.

Male dominance is a sexist norm that is prevalent in media. In advertising, for example, men are typically featured in more prominent, powerful and professional roles (Paek, Nelson, & Vilela, 2011), whereas women are often stereotyped as dependent on men, and are portrayed as beautiful but unintelligent, irrational, weak and vulnerable (Acevedo, 2006; Stankiewicz & Rosselli, 2007). For example, Stankiewicz and Rosselli (2007) point to an advertisement for a perfume entitled “Dior Addict,” in which a nearly nude woman flails about on the floor; she is helpless, pathetic and out of control. Similarly, an analysis of sexist content in movies found that women were at least three times more likely than men to be shown in revealing clothing or partially naked, and that, between 2007 and 2012, movies with nudity of teenage female characters increased by 32% (Zurko, 2013).

METHODS

In the present study, we investigated changing trends in the sexist content of TV, focusing on sexualization and paternalism. We chose TV shows that were ranked in the top 20 most-watched shows of the year according to Nielsen Ratings (Marsh & Brooks, 2013) from 1961 to 2007. Additional inclusion criteria were that the programs depicted family life with at least one child or adolescent character, and were available to view online (e.g., YouTube, Netflix, Hulu) or on television at the time of data collection. Each episode was individually transcribed, then each episode was independently coded by two viewers trained to adhere to operational definitions (reported later) while watching the episode and following the transcript. A total of four advanced psychology undergraduates (three female) counted occurrences of each variable, and typed brief rationales to support their decisions. The interrater reliability agreement of our four judges was in the range labeled as “fair” to “moderate,” Krippendorff’s alpha (Hayes & Krippendorff, 2007) α=.35 for Paternalism; α=.40 for Sexualization of Women, and; α=.53 for Sexualization of Men). We analyzed 37 episodes from 16 different shows, creating a total of 74 coded scripts. The shows analyzed were Hazel, The Beverly Hillbillies, The Andy Griffith Show, The Lucy Show, Here’s Lucy, Happy Days, Good Times, One Day At A Time, Facts of Life, The Cosby Show, Growing Pains, Roseanne, Home Improvement, Jesse, Everybody Loves Raymond, and Two And A Half Men.

We predicted that:

- **H1**: depictions of dominative paternalism in popular TV have decreased over time.
- **H2**: women are sexualized more often than men in popular TV across time.
• H3: sexualized depictions of both women and men in popular TV have increased over time.

Dominative paternalism was operationally defined as comprising “a desire to dominate and control” another person, “and an inclination to view them as childlike.” (Kilianski & Rudman, 1998), reflecting beliefs that one person should be subordinate or submissive to another person, and should be excluded from leadership positions (Fields, Swan, & Kloos, 2010). We counted occurrences of an adult character exhibiting any of the following: treating another adult as childlike: being condescending; infringing upon the other’s autonomy and freedom; controlling the other’s money, shared money, or other resources; or trying to control the other by threats of violence, psychological intimidation, or other abusive behaviors, whether presented seriously or for laughs. We excluded all occurrences of interactions in which one party was behaving within an officially sanctioned authoritative role such as teacher or police officer, as well as all interactions between adult parent and child, for which paternalism is appropriate. Each occurrence was further subcategorized by the gender of the characters: Male dominating Male (M dom M), Male dominating Female (M dom F), Female dominating Female (F dom F), or Female dominating Male (F dom M).

Sexualization of women and men was operationally defined as the presentation of a female or male character as an object for the pleasure of others rather than herself or himself. Sexualization occurs when: a person’s value comes solely (or largely) from his/her sexual appeal or behavior, to the exclusion of other behaviors; a person is held to a standard that equates physical attractiveness (narrowly defined) with being sexy; a person is sexually objectified – made into a thing - for others’ sexual use rather than seen as a person with the capacity for independent action and decision making; or, sexuality is inappropriately imposed on the person (APA, 2007). Inclusion criteria were: references to weight, attractiveness, body shape, cosmetics, physique, strength or other aspects of physical appearance; references to sexual behavior or expectations; references to breasts or genitalia; nudity or revealing clothing; verbal degradation towards a character due to promiscuity, looks, etc.; displays of low self-esteem due to appearance or gender role; or references to prostitution, stripping, exotic dancing. We excluded all examples of healthy, clearly consensual sexuality, flirting, romance, or joking that all involved characters appeared to enjoy mutually.

**RESULTS**

**TABLE 1:** Descriptive statistics of the main study variables. Means and Standard Deviations of Frequency Counts of Study Variables per Episode

<table>
<thead>
<tr>
<th>Variable</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paternalism</td>
<td>4.09</td>
<td>4.13</td>
</tr>
<tr>
<td>M dom F</td>
<td>1.85</td>
<td>2.79</td>
</tr>
<tr>
<td>M dom M</td>
<td>1.16</td>
<td>2.39</td>
</tr>
<tr>
<td>F dom F</td>
<td>0.57</td>
<td>1.10</td>
</tr>
<tr>
<td>F dom M</td>
<td>0.86</td>
<td>1.47</td>
</tr>
<tr>
<td>Sexualization of Women</td>
<td>2.10</td>
<td>2.03</td>
</tr>
<tr>
<td>Sexualization of Men</td>
<td>0.86</td>
<td>1.30</td>
</tr>
</tbody>
</table>

Note. M dom F = male character dominating a female character; M dom M = male character dominating a male character; F dom F = female character dominating a female character; F dom M = female character dominating a male character.

H1 was supported. Depictions of Dominative Paternalism in popular TV decreased over time (r = -.42, p = .01.) Female characters are less dominated in later years, M dom F r = -.38, p = .02; F dom F r = -.39, p = .02).

**FIGURE 1:** Occurrences of domination of female characters by year of initial broadcast of episodes.

For male characters, no statistically significant trends were found over time (M dom M r = -.22, p = .19, ns; F dom M r = -.06, p = .74, ns).

**FIGURE 2:** Occurrences of domination of male characters by year of initial broadcast of episodes.

H2 was supported. On average, women are sexualized more often than men in episodes of popular TV (Sexualization of Women M=2.10; Sexualization of Men, M=0.86), and the different rates for women and men are statistically significant, t(37) = 4.58, p < .001. Thus, for every one time a man was sexualized, women were sexualized twice.

H3, our prediction that sexualized depictions of women and men in popular TV have increased over time, was not supported. The correlations of occurrences of sexualization with year of initial broadcast of the episode fell short of statistical significance (Sexualization of Women: r = .28, p = .09, ns; Sexualization of Men: r = .26, p = .12, ns).

**FIGURE 3:** Occurrences of sexualization of female and male characters by year of initial broadcast of episodes.
DISCUSSION

From 1961 through 2007, TV depictions showed a decrease of dominative paternalism in that women were less frequently dominated in more recent years. Other findings were that men, across time, were more often depicted as dominant, whereas women, compared to men, were more likely to be sexualized. Contrary to our prediction, though, there was no statistically significant evidence that male or female characters are sexualized more frequently over time.

Limitations of the present research include chronological gaps in the sample, with only 37 years analyzed, due to resource and time constraints, as well as limited availability of some TV shows. Also, the sample size was small, with only one randomly selected show to represent each year. Our small sample size may have attenuated the power of our statistical analyses to detect support for our hypotheses. Additionally, we measured only three subcategories of the very broad construct of sexism. Future research could compile a broader sampling of TV shows and episodes, and extend the analyses to more recent years. Additionally, researchers could examine other indicators or subcategories of sexism, such as hypermasculinity, hyperfemininity, gender disparity in the provider role, and gender disparity of dialogue and screen time of female and male characters. Finally, the present study results yielded a small trend (not statistically significant) of possible increasing sexualization of men, which might be worth investigating further in a larger sample of episodes.

Acknowledgments

The authors of this article wish to thank Kent State University at Tuscarawas for supporting and funding this project. They would also like to thank the psychology undergraduate students Dakota Brown, David Ricklic, and Tessa Sanders for their assistance in transcribing and coding episodes, and Kacey Kamban and Lori Rogers for additional transcription.

About the Author

Breanna Sholtz is a 21-year-old Senior Psychology student at Kent State University at Tuscarawas, minoring in Justice Studies and Criminology and is a member of the National Society of Collegiate Scholars, Golden Key National Honor Society and the Ohio Psychological Association. She currently holds an Associate of Science degree through Kent State. She resides in New Philadelphia, where she works as a secretary, cheerleading coach and gymnastics instructor. She intends to continue on to graduate school, pursuing a career in family counseling.

References


Mental Health Concerns and Body Dissatisfaction within the Competitive Male Fitness Community: A Review

Valerie M Taton and Stephanie S. Judson
Cleveland State University

Abstract

Men involved in the fitness community are at greater risk of developing mental health issues in response to body dissatisfaction associated with competition. Minimal diagnostic criteria exist to apply to men in regard to body image related issues for this population. Existing mental health concerns that can affect this community are also explored. This review discusses the potential mental health concerns male fitness participants risk developing in the name of achieving a particular competitive goal. Further research and diagnostic modifications are encouraged in order to raise awareness of the issues affecting this unique population.

Men are exposed to specific societal ideals exemplified by strength and muscularity. In pursuit of these ideals and in order to achieve fitness goals, men may participate in fitness-related activities, such as powerlifting and bodybuilding. Participation in these activities competitively can encourage an overemphasis of self-image and self-esteem to be centered on performance, appearance, size and weight.

The nature of competitions and contests reinforces these body ideals and perceptions with scoring and judging based on physical appearance or performance. Amongst competitors, there can only be one winner, leaving satisfaction to come from how one’s perception of his body compares to his competition. When one experiences body dissatisfaction, physical appearance or performance carries a disproportional level of measure to one’s overall self-concept, thereby making the biggest, strongest and leanest man the best man overall. This dissatisfaction can lead to the development of several mental health concerns in response to feelings of low self-worth (Hallsworth, Wade, & Tiggemann, 2005; Hurst, Hale, Smith, & Collins, 2000; Skemp, Mikat, Schenck, & Krame, 2013).

BACKGROUND: COMPETITIVE MALE FITNESS COMMUNITY

Male bodybuilders exhibit more disordered eating and body image concerns than other men, including powerlifters. This can be attributed to the competitive focus of bodybuilding centering on aesthetics and appearance, as opposed to powerlifting which is judged on functional strength (Hallsworth et al., 2005). Elite-level bodybuilders display significantly more body dissatisfaction symptomatology than elite-level powerlifters immediately prior to competition, suggesting that bodybuilders may be more susceptible to body image disorders (Lantz, Rhea & Cornelius, 2002). Hale et al. (2010) suggests that type differences in research can occur due to participants self-selecting into a mutually exclusive lifting category, such as “bodybuilder” or “powerlifter.” Minimal, if any, background information verification is conducted on competitive history. Using level of body image dissatisfaction has been suggested as a potential solution.

MENTAL HEALTH CONCERNS

MUSCLE DYSMORPHIA
Muscle dysmorphia (MD) is defined as “a misconstrued body image” in which individuals view themselves as weak and/or small even though they appear fit or very muscular (Foster, Shorter, & Griffiths, 2015, p.1). MD symptomatology under the term “reverse anorexia,” with reported prevalence rates over 8% (Pope, Katz & Hudson, 1993). Behar and Molinari (2010) found rates of MD in over 13% of a weightlifting population. Weightlifters with MD exhibit a greater range of functional impairment and more pathology than normal lifters. They display significantly higher rates of comorbid disorders, such as mood, anxiety, and eating disorders, and have a greater prevalence of steroid use (Olivardia, Pope & Hudson, 2000).

EATING DISORDERS
The difficulty with identifying eating disorders within the competitive fitness community arises from the lack of applicable diagnostic criteria. Current diagnostic criteria fail to consider the unique demands of this population. Presently, diagnostic criteria for anorexia nervosa, bulimia nervosa and binge eating disorder only identify components of the fitness competitor’s dietary regimen. Further, seemingly “healthy” eating patterns common for the competitive fitness community do not appear outwardly harmful or dangerous. Pope et al. (1993) found that among bodybuilders, rates of anorexia nervosa were 14 times greater than the American average rate for men.

SUBSTANCE ABUSE
Within the scope of the fitness community, androgenic-anabolic steroids (AAS) are derivatives of the male hormone testosterone which have shown to increase strength, mass and muscular size. Low self-esteem and body dissatisfaction are potential predisposing factors to initial AAS use (Hartgens & Kuipers, 2004). Small studies have found prevalence rates of AAS use in over 50% of the competitive bodybuilding population (Tricker, O’Neill, & Cook, 1989), and rates of behavior consistent with substance dependence in one-third of respondents (Perry et al., 2005). Bodybuilders demonstrate higher rates of steroid use than other athletic groups. They report a more accepting view on steroid use, citing reasons such as a drive for muscle mass, to improve looks, and alleviate body dissatisfaction (Blouin & Goldfield, 1995). Several studies have suggested that the use of AAS and other fitness supplements (whose safety and functionality are not fully supported) may be correlated with the development of MD (McCreary, Hildebrandt, Heinberg, Boroughs, & Thompson 2007; Rohman, 2005).
EXERCISE DEPENDENCE

Exercise dependence can be defined as “a multidimensional maladaptive pattern of exercise, leading to clinically significant impairment or distress,” expanding on the DSM-5 criteria for addictive disorders (Hausenblas & Downs, 2000). No study to date has researched prevalence rates of exercise dependence within the competitive male fitness community alone (Hale et al., 2010). Hurst et al. (2000) found that “experienced” bodybuilders demonstrated more exercise dependence symptoms than powerlifters and “inexperienced” bodybuilders in order to exert mastery and control over their daily routines. Hale et al. (2010) supports previous theories that competitive lifters are significantly more likely to be exercise dependent than fitness lifters, but bodybuilders are more motivated by the “drive for muscularity” than powerlifters.

CLINICAL IMPLICATIONS

The lack of diagnostic consensus limits the clinician’s ability to accurately recognize, identify and measure symptomatology. Identifying impairment can occur only if the clinician is aware of the signs of a mental health concern. While it may be easier to understand the severity of malnutrition in a client with anorexia nervosa, for instance, it is not so simple to identify someone as “too in shape” or “too healthy.” Clinicians need to approach clients within the competitive fitness community with an awareness of social and gender influences, while maintaining an open environment for discussion and empathy. Current clinical approaches for treatment of men in this community parallel the treatment of eating disorders in women (Leone, Sedory & Gray, 2005).

FUTURE DIRECTIONS

With the revisions of the DSM-5 in place, it is important to investigate the unique circumstances and pressures in place for males within competitive fitness community. It is important to identify risk factors and potential mental health concerns not widely accepted or diagnostically identifiable in the psychological community that are unique to this particular demographic. Treatment specificity is necessary to address the social and sport pressures these men face.

References


Author Note

Correspondence concerning this article should be addressed to:
Valerie M. Taton
v.taton@vikes.csuohio.edu

About the Authors

Valerie M. Taton, MA, is a graduate of the Clinical Psychology program at Cleveland State University. Her research interests include substance abuse, addictive behaviors, body image disorders and gender differences within these fields of study. She is also participates in competitive powerlifting.

Dr. Stephanie S. Judson is a visiting assistant professor at Cleveland State University in the in the CASAL Department. Dr. Judson’s research focuses broadly on gender and most recently on the construct of gender microaggressions.
The Ohio Psychologist July 2015 - 32

The 2015 OP Quiz for Continuing Education

The articles selected in this issue are sponsored by the Ohio Psychological Association. OPA is approved by the American Psychological Association to provide CE for this home study. Complete this form in its entirety. A total of 80 percent of responses must be correct to receive 1.5 CE credit. Submit this form and payment (OPA members - $20; Non-members - $25) to OPA OP Home Study, 395 East Broad Street, Suite 310, Columbus, Ohio 43215. Pending successful completion of this quiz, you will receive a certificate of completion within 14 business days of receipt.

Name: ___________________________ License Number: ___________________________
Address: ___________________________________________________________________________________________________
City: ___________________________ State: __________ Zip: _____________ Email: ____________________________

PAYMENT INFORMATION:

☐ VISA / MC
☐ Check made payable to OPA
☐ Members $20  ☐ Non-Members $25
Credit Card Number: ________________________________________ 3-Digit Code: _______ Expiration Date: ________

Signature: ___________________________________________________________________________________________________________

By signing this form, I am stating that I have taken this test myself, without the help from any outside sources.

Article: Psychologists’ Perceptions of Obstacles (pg. 5)
1. In the Barriers to Accessing Mental Health Care Survey there was not a significant difference between the barriers reported by rural psychologists than those working in an urban setting. 
☐ TRUE ☐ FALSE
2. One of the limitations of this study was ________________.
   a. Sample size
   b. Defining what constitutes a “rural” setting
   c. Sample representation
   d. None of the above

Article: Self-Reflectiveness and the Underserved (pg. 9)
1. What term did DoVidio and his colleagues coin to describe people who are well intended and committed to equality but not immune from holding unconscious biases? ________________.
2. According to Banaji & Greenwald and Nosek et.al, what is one of the strongest and most consistent preferences amongst people in the United States?
   a. Women with family
   b. Men with careers
   c. Young vs. older adults
   d. White over black adults

Article: Maximizing your Teaching Effectiveness (pg. 12)
1. According to Standard 7.04 of the Principles of Psychologists and Code of Ethics (APA, 2010), programs and training facilities may require students to disclose personal information during in-course or program related activities, either orally or in writing, if they clearly identify this requirement in its admissions and program materials. 
☐ TRUE ☐ FALSE
2. Standard 7.03 of the Principles of Psychologists and Code of Ethics (APA, 2010), indicates that a balance needs to be struck between ________________ and ________________.
   a. Spontaneity and careful course planning
   b. Curriculum and assessments
   c. Hands-on activities and lectures
   d. None of the above

Article: Ethnic Minority College Students (pg. 24)
1. Which of the following variables were found to contribute to the prediction of career exploration:
   a. Stereotype threat
   b. Perception of barriers
   c. Career self-efficacy
   d. All of the above

Article: Medical Tourism (pg. 20)
1. Using an interpreter who is related to the patient is optimal. 
☐ TRUE ☐ FALSE
2. Which of the following best describes the recommendations for completing an assessment with patients from a different culture:
   a. Nonverbal
   b. Specific and concrete
   c. General and concrete
   d. None of the above

Article: Teaching Sexism to the Masses (pg. 27)
1. This study examined the presence of dominative paternalism present in the media. 
☐ TRUE ☐ FALSE

Article Body Dissatisfaction with Males (pg. 30)
1. The authors suggest the clinical implications with this population include all of the following EXCEPT:
   a. Eating Disorders
   b. Depression and/or Anxiety
   c. Exercise Dependence
   d. Substance Abuse
Scheduling & To Do Lists
Streamline your practice management and workflow. Past appointments are automatically added to your To Do List. Sync your calendar to your iPhone. Great multi-clinician scheduling features.

Patient Notes & EMR
Our form-based system makes it easy to keep up with your notes. Templates were designed specifically for mental health and therapists. Also upload any files to your patient records.

Electronic Billing
Easily submit claims electronically with TherapyNotes EDI! Track balances, view revenue reports, and generate CMS forms, superbills, and patient statements all from within TherapyNotes.

AND MANY MORE FEATURES!
Appointment Reminders
- Automatic text, phone, and email reminders
- Reduce no shows and decrease expenses

Fully Integrated Credit Card Processing
Swipe or enter patient credit cards

New Patient Portal!
Customers can request appointment times

“
My experience with TherapyNotes this past month has been fantastic!
Firstly, the system is easy to navigate, thorough, flexible, and extremely clinically intuitive. Secondly, technical and customer support has been efficient, fast, and very personal. I am leaving another EHR system for TherapyNotes... gladly. I’m very happy that you’ve created such a quality product. Thank you!
Dr. Christina Zampirrelli, PT, Licensed Clinical Psychologist

Just want to say that I truly love the system!
It takes all the guesswork out of tracking paperwork. Being able to schedule appointments and then have the system take over and track what is due for each client is wonderful.
Kathleen Bremer, PCC-S

Many more stories on TherapyNotes.com

Special Offer
Just For Ohio Psychological Association Members!
Receive Your First 2 Months Free!
Use Promo Code: 15OPS
Offer expires 9/1/2015

View Features and Sign Up Today at www.TherapyNotes.com
EMPLOYMENT OPPORTUNITIES

Associate Professor or Professor: WSU-SOPP is seeking outstanding candidates for a core faculty position at the Associate or Full Professor rank to start July 1, 2016 to teach and provide clinical supervision to doctoral-level students in our APA-accredited PsyD program in Clinical Psychology, and mentor/advise graduate students, direct doctoral dissertations, provide service to the doctoral program and university, engage in scholarship, and conduct clinical practice in the faculty practice plan. Required: A doctorate in clinical, counseling or a related field from an APA-accredited doctoral program; demonstrated ability to teach practitioner students, and be licensed in Ohio as a psychologist or be able to acquire licensure in Ohio within six months of appointment; have a commitment to the practitioner model of professional education. For information on additional requirements and to apply, go to http://jobs.wright.edu/postings/8916 by September 15, 2015 for first consideration. Review of applications will begin immediately and continue until the position is filled. For more details about our program, visit SOPP's website at http://psychology.wright.edu/. Wright State University: AA/EOE/M/F/Vet/Disability.

Postdoctoral Fellow/Instructor: The Wright State University, School of Professional Psychology seeks a Postdoctoral Fellow/Instructor for a one-year, full-time (renewable) position with a start date in Summer/Fall 2015 (to be determined based on candidate's availability) to provide psychotherapy and psychological assessment under the supervision of a staff psychologist. Required: Earned doctorate in clinical psychology, counseling psychology or a related field from an APA-accredited doctoral program. A letter certifying completion of all doctoral degree requirements is acceptable for persons whose degree will be conferred within three months after the start date. Must have assessment and intervention experience. Must be able to work some evening hours. Preferred: Post-doctoral seeking license; license eligible in Ohio as a psychologist. The ideal candidate will have experience conducting a broad range of assessments to include learning disabilities, ADHD, autism and developmental disabilities. Prefer candidates with adults and children as well as individual, family/couples and group intervention experience. Teaching experience and administrative skills are preferred. To apply, go to http://jobs.wright.edu/postings/8624. Wright State University, an equal opportunity/affirmative action employer, is committed to an inclusive environment and strongly encourages applications from minorities, females, veterans and individuals with disabilities.

Postdoctoral Fellow/Program Coordinator: The Wright State University, School of Professional Psychology seeks a Postdoctoral Fellow/Program Coordinator for a one-to-three year, full-time position beginning as early as July 1, 2015 to co-facilitate groups, supervise co-facilitators, and oversee a small scale research program which includes collecting and analyzing evaluation data and writing quarterly progress reports. Required: Earned doctorate in clinical psychology or counseling, or a related field from an APA-accredited doctoral program. A letter certifying completion of all doctoral degree requirements is acceptable for persons whose degree will be conferred within three months after the start date. The ideal candidate will have a strong background in working with Serious Emotional Disorders, preschoolers, adolescents, and families with court involvement; and familiarity with research designs and methods. Preferred: License eligible in Ohio as a psychologist. To apply, go to http://jobs.wright.edu/postings/8843. Wright State University, an equal opportunity/affirmative action employer, is committed to an inclusive environment and strongly encourages applications from minorities, females, veterans and individuals with disabilities.

OFFICE SPACE
NORTHWEST OHIO - Private Practice Opportunity in Perrysburg, OH. Furnished office space conveniently located near I-75. Reasonable rates/rent. Will consider independent contractors for full or part time. Prefer clinicians experienced working with children and families. Referral sources and billing services available if needed. Waiting room and administrative areas included. New career professionals are welcome. Contact Melissa Lanza, Ph.D. at 419-779-8198 or drlanza.phd@gmail.com for further information.