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Our mission as an association is to advance psychological knowledge in an effort to improve the lives of the people we serve in Ohio. This publication is one of the many ways we do that. It also demonstrates one of the methods that we use to communicate our knowledge and reveals the depth and breadth of the impact that psychologists across the state make.

Our theme this year is “the strength to lead, connect and heal.”

In “Intersections of Gender, Self-Care, and Burnout” Dr. Phillips, Miranda Villard and Brian Fitts examine professional burnout and focus on how this may be experienced differently for men, women, and transgender and gender nonconforming individuals. It is a good reminder about the importance of self-care as well as addressing the needs of all those in our profession. Dr. Swenson’s article “Ethical Issues in Dealing with an Online Reputation” examines an entirely different aspect of taking care of our professional lives. As psychologists, we understand that part of the strength to lead comes from making sure that we continue to connect and heal ourselves.

We also have two clinical articles which focus on very different populations. In Dr. Sweiss-Haddad’s article, “The Rhetoric of Psychologists who Lead, Connect, and Heal Families,” we examine a variety of solution-based interventions to utilize in working with young children. And perhaps one of the greatest opportunities to help people heal is around the issue of trauma. In “Trauma and the Question of Repressed Memories: A Brief Overview,” Dr. Reutter examines the complex issue of repressed memories.

As is tradition, students recognized at the OPA Annual Convention, are invited to publish their findings. We are fortunate to have articles from each of the winners this year. From Xavier University, Andrea Biel, Rachel Blain, Samantha Mathews and Dr. Gibson explore a measure used in positive psychology in the article “Can Our Strengths Make Us Feel Weak? Reactions to VIA Character Strengths and Social Comparison.” Also from Xavier University, Lauren Fredriksen shares her study, “The Effect of a Two-Week Delay on Radial Arm Maze Errors After 30 Days of Exercise in Adolescent Female Rats.” We also have a cohort from Wright State University, Eman Khwaja, Sarah Love, Manaal Sajid, Kathleen Griffin, Amy Sanders, and Drs. Ergun and Warfield. Their article “Fetal Alcohol Spectrum Disorder: Neuropsychological Implications and Overview of Evidence-Based Interventions” provides an overview of the assessment and treatment for children and adolescents. In “The Impact of Severe Childhood Illness on Parental Divorce: A Cross-cultural Exploration,” three students from Notre Dame College, Louisa Rygh, Jacqueline Corrigan and Stephanie Drscar explore the variables between childhood illness and parental divorce rates.

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 peers. I would like to extend my sincere appreciation to them for the hours they volunteered to review the manuscripts submitted for publication. As we look toward our next issue please be thinking about how you would like to contribute.

It has been an honor and my pleasure to serve as editor of this publication for a number of years. I leave this role with good memories of working with wonderful professionals and look forward to using my expertise in a new role in the community. I wish for each of you the strength to lead, people to connect with and space for healing within your own practices and lives.
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Intersections of Gender, Self-Care, and Burnout

Julia C. Phillips, PhD, Miranda Villard, and Brian R. Fitts
Cleveland State University

Abstract

This article examines the intersections of professional burnout and gender with a focus on unique issues for men, women, and transgender and gender nonconforming (TGNC) individuals. While female psychologists are more likely to experience emotional exhaustion and male psychologists are more likely to experience depersonalization, little is known about TGNC psychologists and burnout. Unique issues related to gender for male, female, and TGNC psychologists are discussed with emphasis on gender role conflict, conformity to gender norms, and societal oppression related to gender.

This article examines the intersections of professional burnout and gender with a focus on unique issues for men, women, and transgender and gender nonconforming (TGNC) individuals. Burnout is typically conceptualized using two of the three dimensions proposed by Maslach, Jackson, and Leiter (1996), that is, emotional exhaustion and depersonalization. Mental health professionals, by the nature of their work, are at a high risk to experience burnout (e.g., Gilroy, Carroll, & Murray, 2002; Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2012). In a literature review, Morse et al. reported burnout rates of 21-67% in mental health workers and concluded that burnout is associated with negative outcomes for the professionals themselves, their clients, and their organizations.

A rationale for examining gender and burnout lies in research findings that gender differences exist among male and female mental health professionals regarding burnout (e.g., Purvanova & Muros, 2010; Lim, Kim, Kim, Yang, & Lee, 2010). A meta-analysis by Purvanova and Muros indicated that men and women tend to report differing domains of burnout rather than differing rates, with men somewhat more frequently experiencing depersonalization and women slightly more frequently experiencing emotional exhaustion. While it is important to understand the nuances of gender differences in burnout, it is also critical to remember that there is much overlap with women experiencing depersonalization and men experiencing emotional exhaustion, as well. Research has also found gender differences between men and women in regards to the frequency of use and typology of self-care and career sustaining behaviors with women engaging in more self-care and career sustaining behaviors than men (e.g., Kramen-Kahn & Hansen, 1998; Rupert & Kent, 2007; Rupert & Morgan, 2005; Rupert, Stevanovic, & Hunley, 2009). Notably, transgender and gender nonconforming mental health professionals’ experiences and contributors of burnout are virtually absent in professional literature.

Examining these masculinity-related constructs may illuminate why men are more likely to experience depersonalization in their work as mental health professionals. Gender role conflict arises out of living in a patriarchal society and contributes to devaluation of others when they violate expected gender roles (O’Neil, 2015). In the burnout dimension of depersonalization, mental health practitioners also cynically devalue and objectify clients (Maslach et al., 1996). Although it may or may not be specific to their clients’ gender roles, the commonality is the devaluation.

Conformity to traditional male gender norms which emphasize emotional control (Mahalik et al., 2003) may increase the chance that men suppress affect and project onto others in a defensive fashion to manage negative feelings that may accompany work as a psychologist. Furthermore, male psychologists are more likely to report working more hours which is associated with increased levels of burnout (e.g., Rupert, Stevanovich, & Hunley, 2009) and an emphasis on the primacy of work and being the breadwinner is another aspect of male gender role conformity (Mahalik et al., 2003). Finally, men in countries with less progressive labor policies, including the U.S., were more likely to experience depersonalization (Purvanova & Muros, 2010), highlighting the important influence of social context on their work lives.

Burnout may be viewed as a mental health outcome and past research has identified self-care and career sustaining behaviors as predictors of burnout in male psychologists (e.g., Rupert & Kent, 2007). Masculinity-related constructs also influence self-care behaviors in men (e.g., Carpenter & Addis, 2000; Mahalik, Lagan, & Morrison, 2006) whereby men who experience less gender role conflict and conform less to traditional gender role norms are more likely to engage in more self-care behaviors, thus decreasing the risk for burnout. In fact, in a study of 76 male psychologists, Phillips & Fitts (2016) reported that the more participants engaged in career sustaining behaviors (e.g., consulting with colleagues, taking breaks between sessions), the less depersonalization and less emotional exhaustion was experienced. Interestingly in this study, centrality of masculine identity was also found to be positively related to the emotional exhaustion dimension of burnout. This study highlights the importance of male psychologists engaging in career sustaining behaviors to prevent burnout and considering the nature of their identities as men as they reflect on burnout prevention. Encouraging men to view their masculinity through a positive masculinity lens, which emphasizes strength, emotion, and virtues of masculinity, could help facilitate the use of career sustaining behaviors to prevent burnout (Isacco, Talovic, Chromik, & Yallum, 2012; Englar-Carlson & Kiselica, 2013). Additionally, men’s strengths in friendships whereby

Men

For all men, social context in the form of gender norm conformity, gender role conflict, and subjective gender stress are important to understanding mental and physical health outcomes (e.g., Carpenter & Addis, 2000; Wong, Shea, LaFollette, Hickman, Cruz, & Boghokian, 2011). Specifically, men are more likely to have negative outcomes when they experience gender role conflict (e.g., McCrery, Saucier, & Courtenay, 2005), subjective gender stress (e.g., Wong, Tsai, Liu, Zhu, & Wei, 2014), and gender norm conformity (e.g., Wong, Owen, & Shea, 2012). In a comprehensive literature review, these masculinity-related constructs were associated with increased stress, substance use, negative attitudes toward help-seeking, aggression, and health problems (O’Neil, 2012).
they tend to engage in shared activities (Vigil, 2007) may be a means of promoting self-care related to work – engaging in group activities at lunch or after work could also prevent burnout. Whether working out, biking, taking a martial arts class, golfing or bowling, the relational strengths of men can contribute to their health and well-being to further prevent burnout.

**WOMEN**

The context of women’s professional and personal lives likely affects their experiences of burnout at work, including in the field of psychology. In fact, a meta-analysis suggested that women in the U.S. experienced more emotional exhaustion at work than women in countries with more progressive labor policies (Purvanova & Muros, 2010), highlighting the importance of social context. Historically, the practice of psychology has been male dominated; however, numerically, females now hold more doctorates in psychology than men yet continue to be underrepresented in professional leadership and authorship, and they continue to experience a significant salary gap (e.g., King & Cubic, 2005; O’Shaughnessy & Burns, 2016). Literature suggests multiple factors contributing to this disparity, including individual and institutional sexism, and implicit attitudes about femininity and subtle stereotyping that leads people to view women as less competent (e.g., O’Shaughnessy & Burnes, 2016; Formanowicz & Szczesny, 2016). Similarly, a meta-analysis by Koenig, Eagly, Mitchell & Ristikari (2011) revealed perceptions of strong leadership as “decidedly masculine” (p. 634). Societal stressors related to sexism likely add to the strain that women feel at work and thus, to experiences of burnout.

Outside of work, research indicates family and domestic tasks are still overrepresented as female responsibility, both in assumption and in completion, further decreasing time, energy, and emotional capital available to women for professional advancement and leadership (e.g., Gregor & O’Brien 2015; Maltby, Hall, & Anderson, 2009; Sentell, et al., 2001). The field of psychology is not immune to these divergent expectations – in one study, 45% of female psychologists reported primary responsibility for domestic responsibilities compared with 13% of male psychologists (Rupert et al., 2009). Furthermore, for parents in this study, child care was the sole responsibility for 59% of women but only 3% of men. Thus, contextual influences related to gender role expectations also likely create additional strain on women’s coping and may influence their experience of burnout in the mental health fields.

Women psychologists are more likely to experience burnout as emotional exhaustion in their work lives, particularly when they are employed in agency settings as opposed to private practice (Rupert & Morgan, 2005; Rupert & Kent, 2007). It is hypothesized that private practice allows women more autonomy and flexibility to manage their work and family obligations than agency work and thus decreases the chance of burnout. It may also be that women become emotionally exhausted by the types of clients that are often seen in agencies and assigned to them by virtue of their gender – it is not unusual for clients to prefer or insist upon seeing a female therapist for issues related to trauma, for example. Identifying if such factors are contributing to higher proportions of burnout in an agency can give rise to organizational initiatives to reduce this possibility. Furthermore, women’s strengths in engaging in more self-care and career sustaining behaviors should be recognized and encouraged to decrease burnout. Because of these strengths, they may be well-suited for leadership positions and programs to reduce burnout among all therapists. Finally, women’s strengths with regard to preferred friendship styles that focus on emotionally supportive relationships (Vigil, 2007) may also be a means of promoting self-care among psychologists at work. Sharing feelings with coworkers can be a powerful means of decreasing the risk of burnout.

**TRANSGENDER AND GENDER NONCONFORMING INDIVIDUALS**

TGNC psychologists’ experiences of burnout are absent in professional literature. However, these psychologists face unique considerations and stressors in their work environments (APA, 2009). TGNC individuals are most likely similar to other groups that have been historically marginalized, including women. Complicating our understanding of this topic, TGNC individuals are a very diverse group with respect to their own identities and experiences. For example, the salience of a TGNC identity may be high for some individuals and low for others. Further, TGNC individuals may differ on the choices they make regarding disclosure of their identities and experiences. For example, the salience of a TGNC identity may be high for some individuals and low for others. Further, TGNC individuals may differ on the choices they make regarding disclosure of their identities and experiences, particularly at work. Most notably, there is little data to guide our understanding of burnout for TGNC psychologists.

A recent article on diverse early career psychologists notes some of the insidious ways non-dominant status creates additional stress, the first being the assumption that a TGNC clinician is the resident expert on all transgender issues (Pedrotti & Burns, 2016). This assumption may increase the clinician’s workload as they receive requests for information from colleagues and referrals to work with TGNC clients. Furthermore, TGNC psychologists may not have expertise on TGNC issues and may feel burdened by the expectations that they do. Additionally, TGNC issues are often conflated with sexual minority issues and implicit biases and microinvalidations from supervisors, administrators, and colleagues may also act as work stressors for TGNC psychologists (Pedrotti & Burns, 2016), thus increasing their potential for burnout. Finally, additional stressors related to advocacy
needs for basic human rights for transgender people in the U.S. likely increases the risk of burnout for TGNC psychologists. Clearly, research is needed for us to better understand the factors leading to burnout related to gender for TGNC psychologists.

In sum, it is recommended that psychologists self-reflect on issues related to gender that may add to their potential for burnout. Whether related to gender role conflict, constricting societal expectations related to gender, or discrimination and oppression, better understanding the intersections of gender and burnout for individual clinicians may aid in reducing the negative effects of burnout on ourselves and our clients. Orem (1971) notes the importance of self-care activities as being goal driven, with a specific outcome or target, self-awareness as key in identifying arising needs, and conscious and deliberate decision to engage in self-care activities. This approach will work for all psychologists, regardless of gender identity, and is consistent with research that suggests it is not necessarily the type of self-care practice that affects outcomes, but the increase in personal resources self-care practices provide (Colman, Echon, Lemay, MacDonald, Smith, Spencer, & Swift, 2016). Thus, specific recommendations for men, women, and TGNC psychologists are best focused on the unique individual and their particular coping style within their contextual lives. Finally, there are many resources available which can help psychologists further educate themselves on adequate self-care practices. Although a comprehensive review of self-care resources available to psychologists is beyond the scope of this article, there are many books available, such as Norcross and Guy’s Leaving it at the Office: A Guide to Psychotherapist Self-Care (2007) and The Resilient Practitioner: Burnout Prevention and Self-Care Strategies for Counselors, Therapists, Teachers, and Health Professionals by Skovholt and Trotter-Mathison (2011).

References


**Gender and Burnout**


**About the Authors**

**JULIA C. PHILLIPS** is an Associate Professor and Director of Doctoral Studies in the College of Education and Human Services at Cleveland State University. She is licensed as a psychologist in the State of Ohio and worked in university counseling centers for 21 years prior to joining the faculty at Cleveland State in 2013. Dr. Phillips is the President-Elect of the Council of Counseling Psychology Training Programs and a Fellow of the American Psychological Association. Her scholarly interests are in the intersecting areas of multicultural issues, clinical supervision and training, and leadership.

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Trauma and the Question of Repressed Memories: A Brief Overview
Kirby K. Reutter, PhD, LMHC, ICAADC, CADAC-IV, MAC

Abstract
According to the DSM-5, forgetting aspects of traumatic events can certainly be one sequela of trauma. However, the tendency to remember (and over-remember) traumatic events in various forms seems to cause more diagnostic issues than forgetting. While the repression and emergence of some memories may indeed be clinically valid, the preponderance of evidence does not suggest the primacy of these phenomena in trauma work. Furthermore, van der Kolk’s work seems to convincingly demonstrate that even when cognitive faculties forget traumatic events, “the body keeps the score.”

INTRODUCTION
Trauma clearly affects the full spectrum of human functioning. Ranging from physiological to psychological, cognitive to affective, intrapersonal to interpersonal, and somatic to spiritual, trauma seems to leave a deep, indelible imprint on all aspects of the human experience (Van der Kolk, 2014). This article will focus specifically on the effects of trauma on memory. In his book Remembering Trauma (2005), McNally provides a useful starting point for a well-researched exploration of this topic. McNally commences his work with three conclusions gleaned from reviewing hundreds of studies on the topic.

“First, people remember horrific experiences all too well…. Second, people sometimes do not think about disturbing events for long periods of time, only to be reminded of them later….Third, there is no reason to postulate a special mechanism of repression or dissociation to explain why people do not think about disturbing experiences for long periods” (p. 2).

To support these claims, McNally cites myriad studies which indicate that trauma is rarely categorically forgotten except in cases of actual neurological damage (McNally, 2005).

However, the Diagnostic and Statistical Manual, 5th Edition (DSM-5) clearly relates trauma to dissociative symptomology. Furthermore, various theorists over time (most notably starting with Freud) have insisted that chronic abuse can be “repressed” during childhood and “recovered” during therapy. Are McNally’s conclusions compatible with the DSM-5 or the speculations of other theorists? Before answering this question, let us first examine what both the DSM-5 and other theorists have to say on the matter.

THEORIES OF REPRESSION
At this point we have seen the DSM-5 correlation between trauma and dissociation. However, does this relationship suggest that traumatic memories can be categorically repressed for years on end, only to emerge later in therapy? McNally (2005) identifies a number of theories for traumatic repression which argue in the affirmative. According to Freud’s seduction theory, childhood victims of “seduction” (i.e., molestation) dissociate during the traumatic event, thus forcing the memories to be registered at unconscious levels. Freud further postulated that these repressed memories are only recoverable by means of psychoanalytic techniques, such as hypnosis, free association, and dream analysis. Eventually Freud updated his seduction theory by replacing the recovered memories of molestation with sexualized fantasies for parents of the opposite gender (Schimek, 1987). Regardless of why Freud abandoned his original speculation, most contemporary researchers do not believe that Freud ever “recovered” any “repressed” memories in the first place; rather, he most likely constructed false memories by resorting to highly suggestive techniques (McNally, 2005).

In addition, the DSM-5 overtly acknowledges the relationship between dissociative and traumatic pathology (APA, 2013). In fact, three of the trauma-related disorders (Acute Stress Disorder, Posttraumatic Stress Disorder, and Borderline Personality Disorder) include criteria for dissociative symptoms. For example, the criteria for both Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder make reference to “dissociative reactions (e.g., flashbacks)” as well as “dissociative amnesia”—i.e., the “inability to recall an important aspect of the traumatic event(s)” (pp. 271, 281). In addition, Borderline Personality Disorder references “transient, stress-related paranoid ideation or severe dissociative symptoms” (p. 663). These diagnoses concur with researchers such as Herman (2015), who contend that dissociation does indeed constitute part of the immediate, short-term, and long-term response to trauma.

DSM DIAGNOSES
According to the DSM-5 (APA, 2013), the Dissociative Disorders are characterized by a “disruption and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behavior” (p. 291). The DSM-5 currently posits three dissociative diagnoses: Dissociative Amnesia, Dissociative Identity Disorder, and Depersonalization / Derealization Disorder. Dissociative Amnesia is characterized by “an inability to recall important autobiographical information, usually of a traumatic or stressful nature” (p. 298). Dissociative Identity Disorder is characterized by “the presence of two or more distinct personality states” involving “recurrent gaps on the recall of everyday events, important personal information, and/or traumatic events” (p. 292). Finally, Depersonalization Disorder is characterized by “experiences of unreality or detachment” (p. 302) with regards to thoughts, feelings, sensations, perceptions, time, and surroundings.

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van der Kolk postulates four key premises. First, van der Kolk suggests addition to tenets of information-processing. In essence, van der Kolk’s modern masterpiece seems to be more attuned to the complexities of how trauma affects memory than the over-simplifications of previous models.

While children who have experienced repetitive, chronic trauma tend to forget the particulars of specific incidents, they do not tend to forget that the abuse itself has occurred. Thus, Terr’s underlying contention that “the more a child is abused, the less she will remember it” is not empirically justified. On the contrary, victims of childhood traumatization—whether “Type I” or “Type II”—seem to recall these events all too well (McNally, 2005).

Freyd presents yet another model for repressed memories (McNally, 2005). According to Freyd’s Betrayal Trauma Theory, memories of abuse committed by caregivers are more likely to be repressed than memories of abuse perpetrated by complete strangers. Freyd appeals to both evolutionary and attachment theory to explain her reasoning as an “analysis of evolutionary pressures and developmental needs suggests that victims of abuse may remain unaware of the abuse, not to reduce suffering, but rather to maintain an attachment with a figure vital to survival, development, and thriving” (p. 175). Responding to Terr’s Theory of Type I and Type II traumas, Freyd acknowledges the effects of trauma frequency upon memory repression, but argues that the identity of the perpetrator plays a greater role than the chronicity of the abuse. In fact, Freyd largely subsumes Terr’s theory under her own, “people forget repeated traumas because the traumas that are repeated are more likely to involve betrayal by a caretaker” (p. 175). However, Freyd’s work resembles Terr’s in that in both explanations appear to have reached erroneous conclusions. On the contrary, children who have been abused by their own parents once again seem to vividly recall these events, according to McNally (2005).

Van der Kolk (1994) advocated a more nuanced model for repressed memories. Van der Kolk’s theory is far more developed than the previous three and appeals to contemporary neuroscience in addition to tenets of information-processing. In essence, van der Kolk postulates four key premises. First, van der Kolk suggests that the memory of traumatic events (implicit, perceptual) is processed differently than the memory of innocuous events (declarative). Second, van der Kolk posits that “stress improves memory, but only up to a point, after which it impairs memory” (1994). Third, van der Kolk argues that the implicit, perceptual memory of trauma is highly “state-dependent” (1994). In other words, it is more difficult to retrieve because few subsequent contexts resemble the high-intensity traumatic milieu in which the memory was initially processed. Fourth, van der Kolk contends that traumatic memories are immutably fixed in contrast to their non-traumatic counterparts, which tend to evolve over time. This explanation seems to be more attuned to the complexities of how trauma affects memory than the over-simplifications of previous models.

**DISCUSSION**

The relationship between dissociation and trauma is well-documented. For example, both McNally and the DSM-5 affirm the connection between dissociative states and severe trauma. However, there seems to be a breach (with a paucity of intervening evidence) between dissociative responses and years of categorically repressed memory. Of the three trauma-specific diagnoses discussed above, dissociative symptoms are referenced as only one of multiple diagnostic possibilities, but not as the single, de facto, or overriding feature of trauma-based pathology.

Granted, PTSD identifies “an inability to recall an important aspect of the trauma” (APA, 2013, p. 271) as a possible symptom. However, this specification is still a far cry from “years of repressed memory” that some researchers have claimed. First, this criterion merely stipulates a failure to recall a single important aspect of a traumatic event—a “symptom” which most of us experience in the course of any ordinary event. Secondly, basic trauma theory teaches us that individuals subjected to extreme crisis frequently over-attend to the dynamics most germane to survival at the expense of less relevant details (Herman, 2015). Finally, the criteria for PTSD seem to emphasize involuntary acts of remembering the trauma more than involuntary acts of forgetting it. For example, the first symptom of Cluster B references “recurrent, involuntary, and intrusive distressing memories of the traumatic event(s)” while the second symptom from the same cluster references “recurrent distressing dreams ... related to the traumatic event(s)” (APA, p. 271). In fact, the DSM-5’s only reference to posttraumatic dissociation is used to describe flashbacks—which, ironically, represent an act of remembering, not forgetting!

**CONCLUSION**

According to the DSM-5, forgetting aspects of traumatic events can certainly be one sequela of trauma. However, the tendency to remember (and over-remember) traumatic events in various forms seems to cause more diagnostic issues than forgetting. The sensational claims of some therapists to have recovered the repressed memories of alien abductions (and the like) do not seem to help the argument for trauma-induced repression (McNally, 2005). While the repression and recovery of some memories may indeed be clinically valid (Pathis et al., 2013), the preponderance of evidence does not suggest the primacy of these phenomena in trauma work. Furthermore, van der Kolk’s modern masterpiece seems to convincingly demonstrate that even when cognitive faculties forget traumatic events, “the body keeps the score” (2014).
Trauma and the Question of Repressed Memories

**References**


**About the Author**

KIRBY REUTTER, PhD, LMHC, ICAADC, CAD-AC-IV, MAC, CCTP is a bilingual licensed psychologist, licensed mental health counselor, and internationally certified addictions therapist. Dr. Reutter has conducted his own international research on spiritual coping, which he presented at MIT in 2015. Most recently, Dr. Reutter was invited by the US Military Services Behavioral Health Branch to provide training on evidence-based approaches for treating trauma. Dr. Reutter specializes in working with residential populations, Spanish-speaking clients, and traumatized youth.
Abstract

Clients who are satisfied or dissatisfied by the service they receive from their psychologists may write an online review for a site such as Yelp or Healthgrades. This article discusses how to respond and how not to respond when the review is negative. The Principles of Psychologists and Code of Conduct (APA, 2010) are cited to show important ethical issues. Vignettes illustrate each relevant standard, covering ethical mistakes that might easily be made.

Consider the following vignette.

Kaja Tyler, PsyD has a psychotherapy practice. She specializes in treating adolescents and young adults with anxiety, depression and assorted adjustment problems to life transitions. She emphasizes mindfulness meditation and spirituality to all her professional interactions with patients. She has been in practice for 30 years. She feels that overall she has been highly successful. In a typical year she supervises three doctoral interns and periodically offers a workshop on spirituality in psychological healing.

Feeling particularly upbeat about her reputation in the community she decided to spend some time Googling her name. Although many comments and reviews were favorable, some were stunning. On Yelp one person who claimed to be a patient rated her as mediocre. Comments indicated that she was minimally competent, a poor listener and unable to relate meaningfully to patients. Several others echoed these sentiments, adding that she was never on time and did not seem to remember patients who missed a few weeks. What she read stung her ego. She felt threatened. She was alternately angry and vengeful. She perseverated over how to respond.

Koocher and Keith-Spiegel (2016, p. 368) reviewed online commentary sites for remarks about mental health professionals. Although many comments were favorable, those that were not fell into three general categories. These were statements about incompetence, lack of understanding/compassion, and financial abuse.

What guidance can we find in the Principles of Psychologists and Code of Conduct (APA, 2010)? When the Code went in to effect in 2003 there was little if any online disparagement. The updates in Standards 1.02 (Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority), 1.03 (Conflicts Between Ethics and Organizational Demands), and 3.04 (Avoiding Harm) since that time, were all in response to issues involving psychologists in the military. Generally the Code was intentionally designed to cover all professional activities of psychologists but without the specificity that would apply it directly to changing technology.

One possible response is the following, written by hypothetical psychologist Kaja Tyler, PsyD “It is obvious to me who wrote these remarks. Ms Nameless is a super morbidly obese individual who no one likes to work with. When her treatment is not immediately successful she joyfully defames her treating psychologist. These people with distorted bodies all behave like this.”

In this response to unfavorable online comments, the psychologist has attempted to find out who wrote the comments and to respond in kind or in person. A first impulse after getting slammed on line is to determine who wrote the comments and to try to rebut them or to correct them. But typically these comments are anonymous. Although it appears as though they were made by a former client there is no assurance that the writer was ever in the office or that she was the obvious client. In addition, if the psychologist is quite confident of the writer’s identity, a response directly at that person’s online entry might well violate Ethics Code Standard 4.01, Maintaining Confidentiality:

“Psychologists have a primary obligation and take reasonable precautions to protect confidential information obtained through or stored in any medium, recognizing that the extent and limits of confidentiality may be regulated by law or established by institutional rules or professional or scientific relationship.”

And depending on the comments that the psychologist might write about the reviewer, they could be harmful to both the reader and the writer. This would present a problem with Standard 3.04, Preventing Harm (a):

“Psychologists take reasonable steps to avoid harming their clients/patients, students, supervisees, research participants, organizational clients, and others with whom they work, and to minimize harm where it is foreseeable and unavoidable.”

Clearly it does not matter at this point that the psychologist was harmed by the review, as the Ethics Code only applies to psychologists, not to angry clients.
Another possibility is for Dr. Tyler herself to write several anonymous positive reviews. “Dr. Tyler is a wonderful psychologist.” “She is patient and understanding.” “Dr. G. gave me hope.” “Kaja had several ideas for activities I could work on between meetings.” “I felt better almost immediately.” “I just love Dr. Tyler. She is so concerned about me and her fee is just right.” There is something dishonest about writing fake reviews while pretending to be a happy patient. Could this be a problem with Standard 5.01 (a), Avoidance of False or Deceptive Statements?

“....Psychologists do not knowingly make public statements that are false, deceptive or fraudulent concerning their research, practice or other work activities or those of persons or organizations with which they are affiliated.”

Apparently the psychologist might not know that the review sites check IP addresses and would find out that several reviews originated on the same laptop and/or network.

Perhaps an associate or professor of Dr. Tyler could be asked to write a positive review instead. Zur (2015) notes that negative reviews, if they are not too numerous, might actually highlight the positive ones, so there should be some that are good. Consider these possibilities. “I was Dr. Tyler’s supervisor during her internship. I remember her as hardworking and a person who always puts her patients’ welfare first.” “Dr. Tyler and I are in the same group practice. Patients tell me that she is known to do a smashing good job with anxiety and depression.” “Clients are speaking out in the waiting room about Dr. G’s terrific work.” But now consider Standard 5.02 (a) Statements by Others.

“Psychologists who engage others to create or place public statements that promote their professional practice, products, or activities retain professional responsibility for such statements.”

This might work, but it appears likely that Yelp (2017) also has an algorithm that can distinguish true client reviews from others.

It seems as though the problems of writing an alternative review, or asking a colleague or friend to do so, could be resolved by just asking current clients, who seem to be doing well, to write reviews for the psychologist. This would be honest and genuine, and not involve the psychologist or her colleagues with constructing reviews of her service. But now consider Standard 5.05, Testimonials. “Psychologists do not solicit testimonials from current therapy clients/patients or other persons who because of their particular circumstances are vulnerable to undue influence.”

What are some more constructive ways to deal with online slamming? Here are a few.

1. Practice mindfulness meditation. Let it go. What has happened in the past is best left there. Take a deep breath and focus on today.
2. Think positively about whether there are any suggestions in the message(s) that might be used to improve ones practice and interpersonal relationships.
3. Cultivate an online presence that might produce links that lead to several affirmative sites about yourself. Write blogs or brief articles. Do some online advertising. (Swenson, 2014). Develop a web site. Populate the web with positive messages that are professional in nature.
4. Zur (2015) suggests posting on the review site words to the effect that you encourage a dissatisfied client to contact you to discuss the matter. This has to be done very carefully. Any public admission of substandard care opens the door to professional liability. Check with your professional liability carrier before trying this.
5. Depending on how thick ones skin is, another way to monitor online reviewing is to sign up for Google Alerts. This solution is not for everyone. For some, more negative reviews can be devastating.

This article discusses the problem of discovering difficult online reviews. Some suggestions are included for ways of coping with them that are consistent with the Ethics Code. The conclusion offers some ideas that might just work. More research is needed on the effect of online reviews on the therapeutic process.

References


About the Author

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Cognitive Behavioral Psychology has the strength to lead, connect, and heal because it is based on principles that are, at their core, logical and strategic. This paper examines seven different facets that can help facilitate good communication and positive behavioral change in families with young children (ages 3-12). By understanding the social milieu of the child and combining social cognitive behavioral techniques, we can “simplify behavioral formulas.” When families find it difficult to find solutions to their problems and “heal,” clinicians can help parents articulate and define exactly what they desire and assist them as they pursue goals strategically, methodically, over time in small steps. As psychologists who desire to help children change their maladaptive thoughts and behaviors, we need to examine some of the components of family intervention that are solution focused. For this reason, the Solution Focused Brief Therapy Association continues to update its manual with research supporting its methodology (Bavelas et al, 2013).

The seven components are primarily useful for understanding the social constructs that “set the stage” for behavioral interventions. They are not meant to discuss how positive or negative contingencies of reinforcement are delivered. The aim is to simply help us communicate to parents the social constructs surrounding a child; so that, they can begin to teach their children how to pursue meaningful and desirable ends using contingencies. Social learning theories emphasize that conditioning is a function of environmental consequences. It is therefore imperative to understand the family and school environment. Helping parents communicate expectations more clearly increases the child’s awareness of the rules and norms governing behaviors and their consequences.

First: CLEAR DEFINITIONS - In order for a child to make a behavioral choice, clear definitions of inappropriate and appropriate behaviors are necessary. Cognitive Behavioral Psychologists understand that for meaningful discourse to occur, individuals in a given community must agree on the definitions of words. For example, we must agree on definitions of problems and solutions. Confusion, inaction, and conflict are often the result of muddled definitions. As therapists, we help our clients connect with others by teaching them to “speak the same language” so that behavioral definitions are shared. We find constructive ways to help bridge the divide in communication. Table 1, modified from an earlier article (Sweis-Haddad, 2016), illustrates a few simple definitions of problems and solutions that parents may identify when discussing the problematic behaviors of their children in counseling.

TABLE 1: PROBLEM AND SOLUTION BEHAVIOR CHART

The juxtaposition of diametrically opposed behaviors creates a tension as the dichotomy and polarity of choices becomes strikingly clear and forces the child to make a choice toward one end or another. It should be noted that Verb phrases must be used to list problems and solutions rather than Adjective phrases since Adjectives are NOT active and dynamic and DO NOT delineate what specific action must be performed. Adjective phrases can be used be used AFTER an action occurs to describe the outcome of the action. For example, AFTER one cleans a room one is labeled “organized.” The descriptive label (“Character Quality”) is attached AFTER the work is completed. One may have an idea of what it means to be organized, but until the work is done it is simply a theoretical idea or goal. It is important to spell out the action that the child is expected to perform.

Second: SEQUENTIAL ORDER - Purposeful action by a child requires an understanding of logical pathways and orderly sequences in order to attain goals. Behavioral Flow Charts or Maps reflect order and sequences that are meaningful for purposeful action toward a given goal. This syntax is evidenced in grammar, mathematics, and logic. The term “operation” in mathematics implies action and action in grammar implies the use of verbs or verb phrases. Psychologists understand that actions involve reactions. However, the method of delivering contingencies and shaping behavior using reinforcers is not the focus of this paper. The goal is to first help parents understand some of the factors in the child’s social environment because that is where behaviors are birthed and eventually shaped.

When psychologists construct a diagram or a map for parents, we function as “cartographers” who facilitate meaningful and purposeful action (See previous article by Sweis-Haddad (2016) for example of a diagram). The efficacy of a map is in its utility when shared with others who desire to efficiently travel to a particular destination. Parents can create them to visually explain to a child how to get to a particular goal that the child has in mind. It makes clear the prerequisite behaviors necessary to obtain a reward or reach a certain destination. There is a linear sequence, a grammatical syntax, and a logic that expresses a formula for obtaining a desired effect. However, that formula or syntax is useless unless it is actually utilized for inaction is fruitless. Maps possess a certain foreknowledge based on past experiences and action. Purposeful action using information from maps is carried out with a pre-knowledge of the expected
The rhetoric of Psychologists

Parents are encouraged to reinforce behaviors that are successive with many stops between two end points. Psychologists recognize behaviors as simply visualized as the NYC green line on the "Subway Map" pathway with a vast spectrum of behaviors in between. (This may take place. Opposite behaviors simply represent points on a linear continuum. The black or white dichotomization recognizes that there is a vast gray expanse between the two poles where shaping can occur. Definition and valuation of behaviors need to be labeled and understood as either: socially desirable or undesirable, worthwhile or useless, fruitless or fruitful, "good" or "bad" at a given moment. Table 1 illustrates how particular behaviors are better understood with the passage of time.

Table 1: Problem and Solution Behavior Chart

<table>
<thead>
<tr>
<th>Identified Problem Behavior</th>
<th>Identified Solution Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fights with siblings and peers</td>
<td>Gets along with siblings and peers</td>
</tr>
<tr>
<td>Screams, yells, uses unkind &amp; mean words</td>
<td>Talks nicely to other</td>
</tr>
<tr>
<td>Hits, punches, kicks</td>
<td>Keeps hands and feet to self</td>
</tr>
<tr>
<td>Does not share or take turns</td>
<td>Shares, take turns</td>
</tr>
<tr>
<td>Does not play together</td>
<td>Agrees to play together</td>
</tr>
<tr>
<td>Does not pick-up after self</td>
<td>Picks-up after self</td>
</tr>
<tr>
<td>Will not put things away or make the bed</td>
<td>Puts things away, makes the bed</td>
</tr>
<tr>
<td>Leaves toys on the floor</td>
<td>Picks-up messes left on the floor</td>
</tr>
<tr>
<td>Needs frequent reminders</td>
<td>Remembers to do chores</td>
</tr>
<tr>
<td>Exhibits poor social skills</td>
<td>Exhibits good social skills</td>
</tr>
<tr>
<td>Does not look at person speaking</td>
<td>Looks at person who is speaking</td>
</tr>
<tr>
<td>Does not reply when spoken to</td>
<td>Replies when spoken to</td>
</tr>
<tr>
<td>Does not say hello or good bye</td>
<td>Says hello or good bye</td>
</tr>
<tr>
<td>Does not say please or thank you</td>
<td>Says please or thank you</td>
</tr>
<tr>
<td>Does not tell the truth</td>
<td>Tells the truth</td>
</tr>
<tr>
<td>Displays poor table manners</td>
<td>Displays good table manners</td>
</tr>
<tr>
<td>Does not stay seated &amp; fidgets excessively</td>
<td>Stays seated and eats quietly</td>
</tr>
<tr>
<td>Does not eat with utensils</td>
<td>Eats with utensils</td>
</tr>
<tr>
<td>Performs poorly academically</td>
<td>Performs well academically</td>
</tr>
<tr>
<td>Does not write down assignments</td>
<td>Writes down assignments</td>
</tr>
<tr>
<td>Does not bring home necessary books</td>
<td>Brings home necessary books</td>
</tr>
<tr>
<td>Does not do homework independently</td>
<td>Works independently</td>
</tr>
<tr>
<td>Does not return homework to school</td>
<td>Returns homework to school</td>
</tr>
<tr>
<td>Gives up easily on challenging tasks</td>
<td>Persists with challenging tasks</td>
</tr>
</tbody>
</table>

Table 1: Problem and Solution Behavior Chart

result. The action is not arbitrary (or accidental) but full of hopeful anticipation, even though it does not always materialize due to confounding variables.

Third: VALUE: A child’s behavior has an imputed value that is defined by his/her family culture and/or community. A child’s behavior needs to be labeled and understood as either: socially desirable or undesirable, worthwhile or useless, fruitless or fruitful, “good” or “bad” at a given moment. Table 1 illustrates how particular behaviors may be labeled (or valued) as either as problems or as solutions. These values can prompt children to make an “economic decision” whereby the practical “utility” of a particular choice, action, or effort is recognized by its outcome — a “cost benefit analysis” of sorts. The value of the outcome is generally a function of the child’s environment, particularly the child’s family culture or community.

Fourth: SPATIAL POSITION: A child’s behavior exists within a spatial context relative to other behaviors on a continuum that are diametrically opposed. Table 1 illustrates diametrically opposed behaviors, but these behaviors contain an infinite spectrum of behaviors between them. The black and white definitions and valuations of these tables suggest a multitude of choices between them, a “gray area” that is captured between these black and white definitions. Definition and valuation of specific problems or solutions serves to “anchor” or label points in space-time on a linear continuum. The black or white dichotomization recognizes that there is a vast gray expanse between the two poles where shaping can take place. Opposite behaviors simply represent points on a linear pathway with a vast spectrum of behaviors in between. (This may be simply visualized as the NYC green line on the “Subway Map” with many stops between two end points.) Psychologists recognize this gray area because that is where shaping takes place and where parents are encouraged to reinforce behaviors that are successive approximations of a particularly desirable behavior.

Fifth: CONTEXT: Any clearly defined behavior of a child needs to be contextually understood. Context is key. One may observe a child push his sister but not be aware that she just hit him, or broke his video game, or know that he was bullied at school, or realize that he was shoving her out of the way of the bus coming down the street. We lack omniscience and cannot assume we know what is happening until we examine the environment and as many antecedent behaviors as possible before delivering contingencies. The immediate history AND social history of the child are important.

Sixth: HISTORICAL NARRATIVE: Behavioral outcomes of a child are better understood with the passage of time. At any particular junction in time, a child may be closer or further to one particular end point or another (ie: unfinished homework or finished homework) on the continuum. Since behaviors are dynamic and fluid, they are expressed through action and allow us to perceive time.

Time laps photography is useful for understanding this process of change. A single photographic frame appears static and may suggest movement, but movement is not actually observed... unless a series of pictures is taken. The change observed between individual frames in an old fashion film real may or may not reveal significant change unless several frames are observed over a period of time. That is, an individual snapshot of a behavior is static; it does not necessarily reveal whether a specific action leans toward a “Problem” or a “Solution.”

Behavioral psychologists “lead” by helping clients discover the logic of semantic formulas that describe how work is rewarded and how choices are linked to consequences. Labor and harvest are both viewed as actions on a linear pathway. They are points that reflect an individual’s movement across time. In an old fashion film real, the gradual progression of movement, from sowing seeds to harvesting
The Rhetoric of Psychologists

plants is recorded. The camera captures some of these events, but not all of them, since it would need to snap at lightning speed to capture all of the events happening between point A and point B on a timeline. The faster the shutter snaps, the more information it captures. However, that information may seem inconsequential since the change between frames may appear small or non-existent. Einstein (1920) theorized that someone moving at the speed of light would observe everything at a standstill. It is difficult to see change if it is slow; but if change is fast, we perceive it more easily; however, we become less aware of the actual steps in that change process.

As psychologists, sometimes our task is to slow down and capture that process (or sequence); so that, clients can understand the components; while at other times, we speed up the process in order to illustrate the long term outcomes of current choices. In either case, movement is either toward or away from one of the extreme dichotomous poles identified earlier.

Seventh: OUTCOMES: A child’s behavior can have a number of different outcomes that are dependent upon a clear understanding of both context and culture. The word “outcome” suggests the passage of time and “IF/THEN” logic. It suggests an equation or formula that is understood by those who “speak the same language” and are of the same culture. For example, when Johnny lowers his eyes as he speaks to his elders, he is observed to show respect within his Asian culture, but he may be observed to lack self esteem by someone outside of his culture. In a consultation with well published linguist Habaka Feghali (2017), she underscored the importance of understanding language and behavioral outcomes in terms of both culture and context in order to draw appropriate conclusions and create adequate interventions.

TABLE 2: PROBLEM BEHAVIORS, CHARACTER QUALITIES, AND OUTCOMES CHART

<table>
<thead>
<tr>
<th>OBSEVED PROBLEM BEHAVIOR</th>
<th>NEGATIVE CHARACTER QUALITY SUGGESTED</th>
<th>POSSIBLE NEGATIVE OUTCOMES</th>
</tr>
</thead>
<tbody>
<tr>
<td>(dependent upon content and context)</td>
<td>(dependent upon content and context)</td>
<td>dependent upon content and context</td>
</tr>
<tr>
<td>Fights with siblings and peers</td>
<td>Unfriendly</td>
<td></td>
</tr>
<tr>
<td>Screams, yells, uses unkind &amp; mean words</td>
<td>Loud, Rude, a Bully</td>
<td>Stuck in Time-Out</td>
</tr>
<tr>
<td>Hits, punches, kicks</td>
<td>Aggressive</td>
<td>Does not have friends</td>
</tr>
<tr>
<td>Does not share or take turns</td>
<td>Anti-social</td>
<td>Not asked to play</td>
</tr>
<tr>
<td>Does not play together</td>
<td>Disagreeable, Ornery</td>
<td>Avoided and not liked by peers</td>
</tr>
<tr>
<td>Does not pick-up after self</td>
<td>Unkempt</td>
<td></td>
</tr>
<tr>
<td>Will not put things away or make the bed</td>
<td>Messy</td>
<td>Disorderly room</td>
</tr>
<tr>
<td>Leaves toys on the floor</td>
<td>Sloppy</td>
<td>Friends cannot come over to play</td>
</tr>
<tr>
<td>Needs frequent reminders</td>
<td>Forgetful, undependable</td>
<td>Does not enjoy privileges</td>
</tr>
<tr>
<td>Exhibits poor social skills</td>
<td>Antisocial</td>
<td></td>
</tr>
<tr>
<td>Does not look at person speaking</td>
<td>Aloof</td>
<td>Considered shy or anti-social</td>
</tr>
<tr>
<td>Does not reply when spoken to</td>
<td>Avoidant</td>
<td>Considered unfriendly</td>
</tr>
<tr>
<td>Does not say hello or good bye</td>
<td>Impolite</td>
<td>Does not make new friends</td>
</tr>
<tr>
<td>Does not say please or thank you</td>
<td>Rude</td>
<td>Considered ungrateful and impolite</td>
</tr>
<tr>
<td>Does not tell the truth</td>
<td>Dishonest, Lie</td>
<td>Not trusted</td>
</tr>
<tr>
<td>Displays poor table manners</td>
<td>Impolite</td>
<td></td>
</tr>
<tr>
<td>Does not stay seated &amp; fidgets excessively</td>
<td>Hyperactive, Fidgety</td>
<td>Considered to have poor self control</td>
</tr>
<tr>
<td>Does not eat with utensils</td>
<td>Clumsy, Uncoordinated</td>
<td>Considered impolite and a “baby”</td>
</tr>
<tr>
<td>Performs poorly academically</td>
<td>Poor Student</td>
<td></td>
</tr>
<tr>
<td>Does not write down assignments</td>
<td>Forgetful</td>
<td>Fails tests</td>
</tr>
<tr>
<td>Does not bring home necessary books</td>
<td>Disorganized</td>
<td>Cannot do homework</td>
</tr>
<tr>
<td>Does not do homework independently</td>
<td>Needs supervision, Pokey</td>
<td>Cannot work independently</td>
</tr>
<tr>
<td>Does not return homework to school</td>
<td>Slacker / Incompetent</td>
<td>Stays in for recess</td>
</tr>
<tr>
<td>Gives up easily on challenging tasks</td>
<td>Passive</td>
<td>Does not learn material</td>
</tr>
</tbody>
</table>

Family based interventions need to help parents assess and understand the social milieu of the child and the seven components that contribute to behavioral change. Behavior therapy shares many things in common with other therapies. First and foremost, it understands the importance for parents to articulate specific definitions of appropriate and inappropriate behaviors in terms of the social norms or rules of the home or school environment. Helping parents create behavior charts can be very useful for putting both parents and children on the same page. They are also helpful for creating therapeutic and measurable goals for counseling. See Tables 2 and 3.

TABLES 2 AND 3: PROBLEM AND SOLUTION BEHAVIORS, CHARACTER QUALITIES, AND OUTCOMES

Seven components that contribute to solution based behavioral interventions with families have been outlined. Psychologists can help families “heal” by “naming the dots” or “connecting the dots” along pathways that allow children to move from point A to point B. We must assist our clients as they move towards particular goals (or solutions) and away from identified problems. We must help clients realize that they must move through their own volition toward goals. As clinicians, we simply help clients “connect the dots” on the continuum of life choices. Yes, cognitive behavioral psychologists have the strength to lead, connect, and heal families through the facilitation of good communication and good rhetoric.
### TABLE 3: SOLUTION BEHAVIORS, CHARACTER QUALITIES, AND OUTCOMES

<table>
<thead>
<tr>
<th>OBSERVED SOLUTION BEHAVIOR</th>
<th>POSITIVE CHARACTER QUALITY SUGGESTED</th>
<th>POSSIBLE POSITIVE OUTCOMES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gets along with siblings and peers</td>
<td>Friendly</td>
<td></td>
</tr>
<tr>
<td>Talks nicely to others</td>
<td>Nice, Kind, Polite</td>
<td>Can play, not in Time out</td>
</tr>
<tr>
<td>Keeps hands and feet to self</td>
<td>Self controlled</td>
<td>Has friends</td>
</tr>
<tr>
<td>Shares, takes turns</td>
<td>Sociable</td>
<td>Peers ask child to play</td>
</tr>
<tr>
<td>Agrees to play together</td>
<td>Agreeable</td>
<td>Befriended and liked by peers</td>
</tr>
<tr>
<td>Picks-up after self</td>
<td>Neat</td>
<td></td>
</tr>
<tr>
<td>Puts things away in bedroom, Makes bed</td>
<td>Neat, Organized</td>
<td>Room is orderly</td>
</tr>
<tr>
<td>Picks up messes left on floor</td>
<td>Clean</td>
<td>Friends can come over to play</td>
</tr>
<tr>
<td>Remembers to do chores</td>
<td>Dependable</td>
<td>Enjoys privileges</td>
</tr>
<tr>
<td>Exhibits good social skills</td>
<td>Sociable</td>
<td></td>
</tr>
<tr>
<td>Looks at person who is speaking</td>
<td>Attentive</td>
<td>Considered engaging and attentive</td>
</tr>
<tr>
<td>Replies when spoken to</td>
<td>Engaging</td>
<td>Considered friendly</td>
</tr>
<tr>
<td>Says hello and good bye</td>
<td>Polite</td>
<td>Makes new friends</td>
</tr>
<tr>
<td>Says please or thank you</td>
<td>Polished</td>
<td>Considered grateful and polite</td>
</tr>
<tr>
<td>Tells the truth</td>
<td>Honest, Truthful</td>
<td>Trusted to do something</td>
</tr>
<tr>
<td>Displays good table manners</td>
<td>Polite</td>
<td></td>
</tr>
<tr>
<td>Stays seated and eats quietly</td>
<td>Self controlled</td>
<td>Finishes food</td>
</tr>
<tr>
<td>Eats with utensils</td>
<td>Coordinated</td>
<td>Polite and well mannered</td>
</tr>
<tr>
<td>Performs well academically</td>
<td>Good Student</td>
<td></td>
</tr>
<tr>
<td>Writes down assignments</td>
<td>Detail Oriented</td>
<td>Passes tests</td>
</tr>
<tr>
<td>Brings home necessary books</td>
<td>Dependable</td>
<td>Can do homework</td>
</tr>
<tr>
<td>Works independently</td>
<td>Independent</td>
<td>Can work alone</td>
</tr>
<tr>
<td>Returns homework to school</td>
<td>Organized/Competent</td>
<td>Plays at recess</td>
</tr>
<tr>
<td>Persists with challenging tasks</td>
<td>Persistent/Go-Getter</td>
<td>Learns to try again and succeed</td>
</tr>
</tbody>
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### References


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Abstract

Fetal Alcohol Spectrum Disorder (FASD) is an umbrella term that describes the continuum of prenatal alcohol exposure outcomes. Children and adolescents with FASD display intellectual, learning, memory, visual-spatial, and executive and motor functioning difficulties (Mattson, Crocker, & Nguyen, 2011). Problems within these areas adversely impact academic, adaptive, behavioral, emotional, and social functioning. Thus, interventions that target neurocognitive, behavioral, and social domains are essential for managing symptoms and improving treatment outcomes. This paper provides an overview of FASD, identifies neurocognitive strengths and weaknesses, and delineates evidence-based interventions for clinicians working with children and adolescents presenting with FASD. By implementing interventions that target recognized areas of difficulties, children and adolescents with FASD can receive targeted, appropriate, and efficacious treatment.

INTRODUCTION

FASD is an umbrella term used to describe the spectrum of prenatal alcohol exposure outcomes, which alter brain development and result in varying degrees of neuropsychological and behavioral difficulties (Mattson, Crocker, & Nguyen, 2011). The diagnoses associated with FASD are Fetal Alcohol Syndrome, Partial FAS, Alcohol Related Neurodevelopmental Disorder, and Alcohol Related Birth Defects. Approximately 2% to 5% of the United States population has FASD and an estimated 0.2 to 1.5 infants with FAS per 1000 live births are born each year (CDC, 2002; May et al, 2009; May et al, 2014).

NEUROPSYCHOLOGICAL IMPLICATIONS

The severity and impact of FASD depends upon the pattern, timing, and quantity of pattern and alcohol consumption prenatally. Prenatal alcohol exposure impacts general intelligence, executive functioning, problem-solving and planning, concept formation and set-shifting, fluency, inhibition, working memory, verbal and nonverbal learning and memory, language, visual-spatial skills, and motor function (Mattson, Crocker, & Nguyen, 2011). Alcohol’s impact on these domains results in academic, adaptive, behavioral, cognitive, emotional, and social difficulties. For example, children and adolescents may have difficulties following multi-step directions, paying attention in class, recalling their phone number and address, completing daily living skills, developing and maintaining friends, and comprehending language. Thus, it is crucial to select and implement interventions that target the neuropsychological domains affected by prenatal alcohol exposure.

OVERVIEW OF EVIDENCE-BASED INTERVENTIONS

Interventions for children and adolescents with FASD include those within the neurocognitive, cognitive, behavioral, and social domains. Neurocognitive interventions aim to increase awareness, improve executive functioning, and develop problem-solving skills. Thus, these interventions target attention and executive functioning skills, including inhibition, working memory, encoding, judgement, problem-solving, planning, fluency, and concept formation (Paley & O’Conner, 2011; Wells, Chasnoff, Schmidt, Telford, & Schwartz, 2012). Notably, repetition and repeated exposure of visual-verbal pairs and simple rehearsal strategies have promoted encoding and recall (Loomes, Rasmussen, Pei, Manji, & Andrew, 2008).

Specifically, Neurocognitive Habilitation builds on existing strengths and helps children and adolescents improve their self-regulation and executive functioning (Betrand, 2009; Wells et al, 2012). In addition, Cognitive Control Therapy helps increase awareness through body positioning, scanning and prioritizing of information, processing distracting stimuli, and categorizing and controlling for external information (Betrand, 2009). These strategies help children and adolescents with FASD acquire and organize information more efficiently.

Cognitive interventions seek to develop academic support and facilitate verbal development. Interventions aimed towards developing academic support involve evaluating the efficacy of programs designed to improve self-regulation skills and remediate executive functioning difficulties. These include Computerized Progressive Attention Training, Math Interactive Learning Experience, Rehearsal Training, and Language Literacy Training (Rasmussen, Pei, Manji, Loomes, & Andrew, 2009). Specifically, Math Interactive Learning Experience (MILE) is a cognitive rehabilitation program that was evaluated using pre-test and post-test data for its efficacy regarding mathematic difficulties in children with FASD (Kable, Coles, & Taddeo, 2007). Results indicated that children diagnosed with FASD in the mathematics treatment groups gained mathematics knowledge. That is academic psychoeducational components, addressed by the MILE program, remediated neurodevelopmental difficulties due to prenatal alcohol exposure (Betrand, 2009).
In addition, the implementation of early verbal interventions supports higher verbal language and executive functioning skills in children and adolescents with FASD (O’Connor, Frankel, Paley, Schonfeld, Carpenter, Laugeson, & Marqardt, 2006). Interventions target information processing, self-regulation, and verbal and visual learning and memory. Cognitive intervention strategies involve rehearsal with visual aids to increase verbal skills, visual- verbal paired associates to aid recall, and phonological coding to increase verbal skills (Rasmussen, Pei, Manji, Loomes, & Andrew, 2009).

Behavioral interventions aim to manage externalizing behaviors, set limits, and implement parent management training. Commonly, interventions are implemented through training programs and workshops that provide positive behavioral supports for parents and caregivers. Families Moving Forward (FMF) is a behavioral consultation program for families and children affected by FASD that provides psychoeducation and strategies to modify the home environment and reduce negative triggers (Paley & O’Conner, 2011). FMF interventions also modify parent and caregiver cognitions and attitudes, which can contribute to negative parenting response to negative behavioral problems. Results from the implementation of FMF demonstrated improved parenting techniques and reductions in problem behaviors (Paley & O’Conner, 2011).

Social skills interventions provide psychoeducation and promote appropriate initiation and development of relationships for children and adolescents with FASD. Notably, the Children’s Friendship Training (CFT) is the sole evidence-based social skills intervention for children with FASD (Frankel & Myatt, 2003; O’Conner, Frankel, Paley, Schonfeld, Carpenter, Laugeson, & Marqardt, 2006). CFT involves instruction, modeling, rehearsal, performance feedback, and homework assignments. These strategies have improved knowledge of and application of social skills, managed and reduced problem behaviors, and provided psychoeducation to parents and caregivers about the social skills their children are learning (Frankel & Myatt, 2003).

**DISCUSSION**

FASD is an umbrella term that denotes the set of conditions due to prenatal alcohol exposure. The pattern, timing, and quantity of alcohol consumption impact the physical and neurological development of the fetus prenatally. Specifically, alcohol impacts the cerebral hemispheres and development of brain structures, which results in specific neuropsychological difficulties. These consist of relative weaknesses in general intelligence, executive functioning, problem-solving and planning, concept formation and set-shifting, fluency, inhibition, working memory, verbal and nonverbal learning and memory, language, visual-spatial skills, and motor function (Mattson, Crocker, & Nguyen, 2011). The neuropsychological difficulties impact individuals’ academic, adaptive, behavioral, cognitive, emotional, and social functioning. Thus, it is important to plan interventions that build around an individual’s neurocognitive strengths and weaknesses and are evidence-based to ensure appropriate and efficacious treatment.

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**References**


FASD Implications and Interventions

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Can Our Strengths Make Us Feel Weak?
Reactions to VIA Character Strengths and Social Comparison
Andrea P. Biel, MA, Rachel C. Blain, MA, Samantha Mathews, MA, and Jennifer E. Gibson, PhD
Xavier University

Abstract
Positive psychology is a burgeoning field of scientific study that encompasses research and interventions focused on what people do well and what makes life worth living. Character strengths are one facet of scientific inquiry within this broad field. The Values in Action Inventory of Strengths (VIA-IS) is a popular measure used to determine an individual’s unique ranking of 24 character strengths. Because this inventory is widely available online and has been taken by over five million people to date, additional research is needed to understand how individuals respond to receiving their rankings of VIA character strengths. Furthermore, because character-based interventions are often used in group settings (e.g., in workplaces and schools), it is useful to know how engaging in social comparison may influence people’s perceptions of their own character strengths. A study was conducted to investigate the cognitive and affective responses to viewing and sharing VIA-IS results.

INTRODUCTION
Historically, mental health professionals have predominantly studied and treated psychiatric disorders with the goal of understanding and alleviating symptoms. The field of positive psychology transcends this practice and provides a more holistic picture of the human experience by studying positive emotion and character strengths (Seligman, Steen, Park, & Peterson, 2005). It has broadened the focus of psychology to the prevention of mental illness and promotion of what people do well, what makes them happy, and what makes life worth living (Seligman & Csikszentmihalyi, 2000).

One facet of positive psychology is the scientific study of positive character traits. In 2004, Peterson and Seligman established the Values in Action (VIA) classification of character strengths, a set of 24 positive traits possessed by everyone to varying degrees. In conjunction with this classification system, they developed the free, online VIA Inventory of Strengths (VIA-IS; Peterson & Park, 2009; Peterson & Seligman, 2004; www.viacharacter.org) for individuals to discover their unique ranking of character strengths. Use of the VIA-IS, and the VIA character strengths more broadly, has permeated professional and social domains as it has been integrated into schools, professional organizations, and psychotherapy. Knowledge and novel utilization of character strengths have been related to positive outcomes such as lower rates of depression (Huta & Hawley, 2010), higher rates of happiness (Ruch, Huber, Beer, & Proyer, 2007), improvements in life satisfaction (Proyer, Ruch, & Buschor, 2012), and better overall well-being (Korotkov & Godbout, 2014).

RATIONALE AND HYPOTHESES
Character strengths have been increasingly used in schools to promote positive education and growth in the classroom. In fact, we were first introduced to the VIA character strengths when a professor required us and fellow classmates in a graduate psychology course to complete the VIA-IS. Our personal experience with completing the measure and reviewing our results is the basis of the current study. Although we were all proud to review our top strengths on our VIA-IS reports, we overheard and observed disappointment being expressed when viewing the lower ranked strengths. We seemed to have a natural tendency to view our lower ranked strengths as weaknesses, which is not the intent of the VIA creators. Our disappointment continued, and subjectively increased, after we were encouraged to stand up and share our top three strengths with the class. We noted that we naturally compared our own top three strengths to others’ - a top strength like “judgment” no longer felt as desirable as a trait like “zest.” With the ease of accessing the VIA-IS results free, online, and across the globe, we wondered if what was supposed to be a positive intervention was potentially causing psychological distress.

In light of this personal experience, increased interest in positive psychology practices, and recognized gaps in the literature, we began formulating questions for further exploration. As part of a student-led, positive psychology research team within the School of Psychology at Xavier University, our goal was to develop a multifaceted study to answer various questions related to the VIA character strengths and the VIA-IS.

Broadly speaking, we aimed to study individuals’ cognitive and affective reactions to receiving their VIA-IS results. This included changes in positive and negative affect, self-esteem, and life satisfaction from before taking the VIA-IS to after viewing the results, as well as which strengths are most easily recalled. We also questioned how baseline depression and social comparison would affect said cognitive and affective reactions. In addition, we aimed to explore the relationships between VIA character strengths and prosocial behavior. Specifically, we asked the following research questions: 1) what are the immediate cognitive and affective responses after viewing a personalized VIA strengths report, 2) does knowing peers’ strengths change participants’ perceptions of and reactions to their own strengths, 3) are there correlations between VIA strengths and other traits (e.g., altruism), and 4) which strengths (i.e., top, middle, or bottom) are individuals most likely to recall?

In regard to our questions surrounding the immediate responses to VIA-IS results and the influence of social comparison, we predicted that following initial exposure to personal VIA-IS results, individuals’ would experience increases in positive affect and life satisfaction.
satisfaction, as well as decreases in negative affect. However, it was further hypothesized that positive affect and life satisfaction would subsequently decrease, and negative affect increase after participants engaged in social comparison of their strengths through an activity that required them to share their top strengths with a small group.

**METHODS**

We recruited undergraduate students (N = 300; 68.3% female, 72% White, average age 19.78 years) in psychology courses to participate in our study in exchange for partial course credit. After completing a brief orientation and informed consent documents, the participants completed self-report measures of self-esteem (Rosenberg Self-Esteem Scale; Rosenberg, 1965), depression (Center of Epidemiological Studies Depression Scale; Radloff, 1977), life satisfaction (Satisfaction with Life Scale; Diener, Emmons, Larsen, & Griffin, 1985), prosocial behavior (Self-Report Altruism Scale; Rushton, Chrisjohn, & Fekken, 1981), and positive and negative affect (Positive and Negative Affect Schedule; Watson, Clark, & Tellegen, 1988) online. Following these measures, the participants completed the VIA-IS and viewed their results for two minutes. Then, they minimized their VIA-IS results and wrote as many strengths as they could recall in 90 seconds. When that time had elapsed, the participants completed a second round of measures of self-esteem, life satisfaction, and positive and negative affect.

Next, we provided instructions for the manipulation, which was a group activity designed to evoke social comparison. In the experimental condition (N = 163, 54.3%) students shared their top three VIA-IS strengths with a small group of two to three peers. Participants in the control condition (N = 137, 45.7%) shared mundane information about themselves such as their birthday, favorite color, and the color of their shirt with a small group of two to three peers. Following the activity, participants filled out a final round of measures of self-esteem, life satisfaction, and positive and negative affect.

**RESULTS AND DISCUSSION**

Of the 285 participants who provided valid VIA-IS results, the strengths most commonly reported in participants’ top three strengths were honesty, fairness, and love. On the other hand, for these participants, the strengths least frequently reported in the top three strengths were zest, humility, and self-regulation (see Figure 1). These results are consistent with a previous study of college student character strength endorsement (Karris & Craighead, 2012).

Initial analyses of the experimental condition, found a significant decreases in negative affect across the three time points, $F(2, 256) = 51.33$, $p < .001$. Participants’ negative affect significantly decreased from baseline ($M = 17.29$, $SD = 6.44$) to after the receipt of their VIA-IS results ($M = 15.14$, $SD = 5.86$), $F(1, 128) = 39.59$, $p < .001$, and further decreased following social comparison of their VIA-IS strengths ($M = 14.44$, $SD = 5.88$), $F(1, 128) = 22.20$, $p < .001$. Additionally, individuals in the experimental condition experienced significant increases in life satisfaction after engaging in social comparison of their strengths, $F(1, 128) = 6.54$, $p = .012$. There were no significant changes in positive affect across any of the time points. Although these findings do not support our initial hypotheses based on our own experiences, these findings are consistent with the existing literature surrounding VIA character strengths, as knowledge and consideration of, as well as engagement with, one’s character strengths is related to positive psychological outcomes (Huta & Hawley, 2010; Korotkov & Godbout, 2014; Proyer et al., 2012; Ruch et al., 2007).

Integration of VIA character strength education into group settings appears to be a promising intervention tool. Therefore, given the ease of accessing and interpreting the VIA-IS, therapists, educators, administrators, and even parents, can capitalize on this resource and encourage discussion and utilization of character strengths among clients, students, employees, and peers. We continue to complete further analysis regarding immediate cognitive and affective reactions to VIA-IS results, and the influence of baseline self esteem and depression on these reactions. We also plan to examine how individuals attend to, encode, and recall character strengths based on their location on the VIA-IS report that they receive. To improve generalizability, additional research should examine social comparison of VIA strengths with different experimental groups that mimic real world groups in which the VIA-IS results would be shared, such as a group of individuals who know each other fairly well and a larger, classroom size group. Furthermore, due to the novel social comparison methodology created and implemented in this study, additional research could include replication or modification of the proposed social comparison manipulation.

**FIGURE 1:** Most and least commonly reported strengths in participants’ top three strengths.
Can Our Strengths Make Us Feel Weak?

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The Impact of Severe Childhood Illness on Parental Divorce: A Cross-cultural Exploration

Louisa Rygh, Jacqueline M. Corrigan, and Stephanie S.J. Drar, PhD
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Abstract

Childhood illness not only affects the diagnosed child, it also impacts their loved ones. The stress caused by severe childhood illness can affect the parent’s personal relationship, which may ultimately result in divorce. A review of the literature found that certain factors may relate to a greater likelihood of parental divorce (i.e., illness type, maternal education level) but that overall, severe childhood illness is not consistently correlated with an increased rate of parental divorce. The current literature review aims to unpack the variables that may mediate and moderate the link between severe childhood illness and parental divorce rates, with special attention to how cultural factors may play a role.

INTRODUCTION

Existing literature finds that pediatric cancer impacts parental stress levels (Vrijmoet-Wiersma, van Klink, Kolk, Koopman, Ball, & Egeler, 2008) however there is a dearth of longitudinal research that investigate such families to see if increased rates of divorce follow from increased stress levels or other factors. Some findings suggest a negative impact of childhood cancer on parental relationships, however, there is research that has found that some aspects of the relationship (i.e., communication and trust) tend to strengthen within couples with chronically ill children (Lavee & Mey-Dan, 2008). Syse, Loge, and Lyngstad’s (2010) longitudinal study regarding divorce rates and childhood cancer in Norway found that parents with a child diagnosed with any type of cancer at any time had a divorce rate similar to the parents of children without cancer. However, looking at the different types of cancer individually, the study uncovered increased divorce rates in some more severe forms of cancer such as Wilms tumor. The time of diagnosis and the type of treatment were also shown to have significant effect on parental divorce rates (Syse, Loge, & Lyngstad, 2010). Having to care of a sick child, as well as the other siblings and their own relationship can become a high stress factor in the day to day life which may cause increased family and relationship conflicts. Analyses also found an overall higher divorce rate in couples where the woman had an education beyond high school (Syse, Loge, & Lyngstad, 2010). Syse, Loge, and Lyngstad (2010) hypothesized that mothers were more likely to take on an increased caretaking role, making it more difficult for the mother to maintain work and social life.

Taking the role of primary caregiver for a severely ill child may lead to significant negative effects on various aspects of the parent’s mental health as well as causing conflict in the relationship. Consistent with the Norwegian sample, Syse, Loge, and Lyngstad (2010) found no significant overall relationship between childhood cancer and divorce rates. However, other studies have found that childhood illness can have a significant effect on parent’s relationship, which may lead to divorce (Reichman, Corman, & Noonan, 2004). Within samples of American families, some literature suggests that socioeconomic status may be a mediating factor for the effect of childhood cancer on parental divorce (Reichman, Corman, & Noonan, 2004). Research examining American families with a child diagnosed with cancer who had a low socioeconomic status or lower income were found to report higher risk of marital and relationship problems (Reichman, Corman, & Noonan, 2004). Studies also found that caregivers of children with health problems have shown to have more than twice the odds of reporting chronic conditions, activity limitations, and elevated depressive symptoms as well as greater odds of reporting poorer mental health (i.e., acute traumatic stress, depression, anxiety, and general stress symptoms) (Breault, J., Kohen, D., Garner, R., Miller, A., Lach, L., Klassen, A., & Rosenbaum, P., 2009; Muscara, F., McCarthy, M., Woolf, C., Hearps, S., Burke, K. & Anderson, V., 2008). Due to the varied findings regarding the relationship between childhood illness, socioeconomic status, divorce, and other factors, it is feasible that the availability of universal health care may moderate the relationship between childhood illness and parental divorce.

CORRELATES OF DIVORCE

Because of the lack of research specifically studying the relationship between childhood illness and parental divorce, a review of literature studying pediatric illness and correlates of divorce were necessary. Correlates of divorce include factors such as negative marital adjustment, marital distress, parent well-being, and marital role strain. Currie and Stable (2002) found that poor childhood health affected adult well-being directly through its effect on health, and indirectly through its effects on other forms of human capital accumulation (i.e., socioeconomic status). Another study examined parents of children with Cystic Fibrosis (CF) found that couples with a child diagnosed with CF reported greater role strain on measures of role conflict, child-care tasks, and exchanges of affection (Quittner, Espelage, Opipari, Carter, & Eid, 1998).

PARENTAL DIVORCE

In Norway in 2010, out of 168,110 couples who divorced 535 couples had a child diagnosed with cancer (Syse, Loge, & Lyngstad, 2010). Parents with a child diagnosed with any type of cancer had a similar rate as the parents of children without cancer, however when looking at CNS, renal, and endocrine cancer, Syse, Loge, & Lyngstad (2010) found a significant relationship with parental divorce. In the United States (US) on the other hand, three different studies using the Child Health Supplement of National Health Interview Survey found that married couples with a child diagnosed with congenital health problems had a higher chance of getting a divorce compared to other couples (Reichman, Corman, & Noonan, 2004; Corman & Kaestner 1992; Muldon 1992; Joesch & Smith 1997).
According to Canning, Harris, and Kelleher (1996) research, there is a relationship between family socioeconomic status and poor physical health, particularly in families with chronically ill children. Public health care is provided by the Norwegian state to all citizens, free of charge as well as leave of absence and financial help for parents of children diagnosed with severe illnesses (Syse, Loge, & Lyngstad, 2010). In the US, on the other hand, public health care is not provided by the American government and insurance is needed in order to help pay the full coverage of medical expenses. Leave of absence may not be available, however, financial help may be possible through different programs (i.e., American Cancer Society). Health insurance programs help narrow the socioeconomic gap in forms of medical care and health insurance among children. However, significant SES or related gaps remain even among children with common insurance (Currie & Stabile, 2002).

CONCLUSION

Overall, our review found that most studies that examine severe childhood illness and parental divorce rates find a non-significant relationship or only significant relationships under specific circumstances. In contrast, in some cases, marital satisfaction was found to increase after the child was diagnosed with a chronic illness. Based on this review the socioeconomic status, as influenced by the government’s health care system, may moderate and/or mediate the relationship between childhood illness and parental divorce. Looking at the two countries we can see a difference in both the healthcare system and the divorce rates. American families with a child diagnosed with cancer with lower income or a low SES demonstrate a higher risk of marital and relationship problems (Reichman, Corman, & Noonan, 2004). However, within a Norwegian sample, socioeconomic status was not shown to be a significant factor, potentially removing a factor that may increase divorce rates. The Norwegian public health care which is provided by the Norwegian state to all citizens, free of charge is postulated to be a mediating and moderating factor in the relationship between severe childhood illness and parental divorce. Further research should aim to better understand this relationship and the influence of healthcare on childhood illness and parental divorce.

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References


Abstract

There is evidence that acute bouts of exercise can have an immediate positive effect on working memory (Sibley & Beilock, 2007). Specifically, exercise has been shown to increase the number of immature neurons in rats’ hippocampal dentate gyrus (Patten et al., 2015). The study proposed tested whether 30 days of voluntary running would have an effect on working memory as tested in the radial arm maze (RAM) after a two-week delay in female, adolescent rats. Working memory was tested in an 8-arm Radial Arm Maze and double cortin positive cells were counted in the dentate gyrus of the hippocampus. There was no significant difference between the running and non-running groups, but the results of this study lead to many new ideas for future research topics.

Executive function is a higher mental process that is heavily involved in decision making, goal planning and choice behavior (Coles & Tomporowski, 2008). An important aspect of executive function is working memory, a process that allows for active use of information and possible consolidation of long term storage (Smith et al., 2013). There is evidence that acute bouts of exercise can have an immediate positive effect on working memory (Sibley & Beilock, 2007).

Sex differences have been reported in working memory studies using humans; when tested on spatial working memory, males responded faster than females after exercising (Soga, Shishido, & Nagatomi, 2015). These findings could be the result of innate differences in working memory or evidence that exercise affects each sex differently. Working memory has been researched using animals, but there is very little research focusing on female rats.

Adolescence presents a developmental period dominated by brain development, maturation, and neural plasticity (Hopkins, Niticki, & Bucc, 2011). There is limited research on the effects of exercise in adolescents; however, a study involving adolescents concluded that exercising during adolescence may capitalize on the neural plasticity that occurs at that age, leading to more durable effects of exercise on working memory (Hopkins et al., 2011).

The majority of rat research involving exercise has involved behavioral testing during or immediately after the exercise paradigm has ended. Hopkins et al. (2011) tested the idea that a delay between the exercise and behavioral testing would affect the rat’s working memory. This study used a two-week delay between exercise and behavioral testing. The results showed that after the two-week delay, rats performed better on the behavioral test than they did immediately after the running ended. These results provide evidence that the effects of exercise last at least two weeks after the running ends in and that the effects increase over time (Hopkins et al., 2011).

HYPOTHESIS

The study proposed tested whether 30 days of voluntary running would influence working memory as tested in the radial arm maze (RAM) after a two-week delay in female, adolescent rats. It was hypothesized that rats in the running group would perform better in the RAM than those that did not run. It was also hypothesized that animals in the running group would experience more neurogenesis in the dentate gyrus, as indicated by enhanced expression of double cortin, than the animals in the non-running group.

METHOD

RATS

A group of sixteen sixty day-old female Long-Evans rats were used. The rats were single-housed in standard plastic tubs with wire-topped cages filled with corn cob bedding. Water and food was available ad libitum until 2 weeks prior to behavioral testing. The non-running group (n=8) remained in the standard housing for the entire study. The running group (n=8) was housed in cages with running wheels attached and had 24-hour access.
STUDY

Once 30 days had passed, the rats housed with a running wheel where moved to the standard cages (see above). Food restriction
started for all rats to reduce their body-weights to 85% of their free-
feeding body weight and were maintained until the end of the study.

RAM TRAINING AND TESTING

Twelve days after the onset of food restriction, rats were habituated
to an eight arm RAM. The rats were placed in the center of the RAM
maze with four of the eight arms open and allowed to move around
freely for 15 minutes. The next day was the training phase: each rat
was placed in the center of the maze for three, 5-minute blocks (15
minutes total). During the first 5 minutes, fruit loops were placed
around the maze, and the rat was free to move around. For the
second 5-minute phase, fruit loops were placed in only one arm of the
maze. The last 5 minutes, a fruit loop was only placed at the end of
one arm of the maze. Fruit loops were replaced as they were eaten.

Next, the RAM testing began. Rats were placed in the center of the
maze to begin and only four of the eight arms were baited with a
fruit loop at the end. The trial finished when the animal collected all
4 fruit loops or 10 minutes had passed (Ren et al., 2011). The number
and type of arm entry was recorded. A working memory error was
recorded when the rat re-entered an arm from which they had
already retrieved the fruit loop (Ren et al., 2011). Reference memory
errors occurred when the rat entered an arm in the maze without bait
(Ren et al., 2011). A working/reference memory error was recorded
when the rat re-entered an arm without bait (Ren et al., 2011). Testing
continued for 10 consecutive days.

IMMUNOHISTOCHEMISTRY

Rat brains were cryoprotected in a glucose solution, frozen, and
sliced at 60μm using a microtome. Then a double cortin stain
was used on the slides to identify cells that had gone through
neurogenesis (Maisonnave & Garcia-Cairasco, 2007).

RESULTS

RAM TESTING

There was not a statistically significant effect of group on working
memory errors as indicated by a one-way repeated measures ANOVA,
\( F(4,9) = 2.412, p = .067 \), and non-significant main effect of group,
\( F(1,1) = .807, p = .384 \) (Figure 1).

FIGURE 1: The Results of a Repeated Measures Between Subjects
ANOVA on Working Memory Errors an Group Across Testing Day

There was not a statistically significant effect of group on reference
memory errors as indicated by a one-way, repeated measures
ANOVA, \( F(4,9) = 1.605, p = .203 \), and non-significant main effect of
group, \( F(1,1) = 1.774, p = .204 \) (Figure 2).

FIGURE 2: The Results of a Repeated Measures Between Subjects
ANOVA on Reference Memory Errors an Group Across Testing Day

There was not a statistically significant effect of group of working/
reference memory errors as indicated by a one-way repeated
measures ANOVA, \( F(4,9) = 2.389, p = .063 \), and non-significant main
effect of group, \( F(1,1) = .849, p = .372 \) (Figure 3).

FIGURE 3: The Results of a Repeated Measures Between Subjects
ANOVA on Working/Reference Memory Errors an Group Across
Testing Day
There was not a statistically significant effect of group on total number of arm entries as indicated by a one-way, repeated measures ANOVA, \( F(4,9) = 2.766, p = .035 \), and non-significant main effect of group, \( F(1,1) = 1.195, p = .293 \) (Figure 4).

**FIGURE 4: The Results of a Repeated Measures Between Subjects ANOVA on Total Trials and Group Across Testing Day**

<table>
<thead>
<tr>
<th>Testing Day</th>
<th>Running</th>
<th>Nonrunning</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
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</table>

(mean±SEM)

**DISCUSSION**

The results of this study found no significant differences between the groups on any of the types of errors. Also, the number of double cortin positive cells in the dentate gyrus of the hippocampus did not significantly differ between the groups. Power analysis suggests that double the number of rats in each group are needed in order to see a significant effect.

While there was not a statistically significant effect of running on neurogenesis, there was a very interesting trend that may lead to future research directions. A general down regulation of the double cortin cells was seen in the running group, an effect opposite of that hypothesized. Several studies suggest exercise enhances double cortin expression, whereas the current results could be due to the removal of access to the running wheels and the delay between the running treatment and the working memory testing (Patten et al., 2015; Kim & Seo, 2013). In another study, Neese et al. (2013) found that over the first five days of testing a decrease in performance was measured in female rats given access to a running wheel as compared to rats who were not giving running wheel access. The decrease in performance was not apparent for the second 5 days of testing (Neese et al., 2013). Double cortin cells take time to mature and could have affected the behavioral outcomes in this study as seen by the lower number of errors in the running group on Day 1. Specifically, the cells counted from the animals would not have matured enough to affect behavior and of cells counted could have formed during the two weeks when the animals were not running. There also could have been a decrease in double cortin cells even though exercise is proven to increase neurogenesis because of the effects of stress. Stress can impact the number of double cortin cells in the dentate gyrus (Epp, Barker & Galea, 2009). In this study, stress from not being able to run could have resulted in down regulation of double cortin following exercise (Epp, Barker & Galea, 2009).

Some limitations of the research conducted were due to the constraints of working in a shared lab. While many steps were taken to avoid confounds, there could be additional variables, including individual working memory differences among rats in the control group, or the stress of changing cages for the running group that prevented the researchers from finding significant results. Future research should first focus on adding rats to each testing group. This would provide the necessary statistical power for seeing if there is a real effect of exercise on working memory. Future research should also involve changing the length of the delay between exercise and testing and the inclusion of a third group that continued to run throughout testing, acting as a positive control.

**NEUROGENESIS**

Immunohistochemical staining failed to reveal significant differences in the presence of double cortin labeled neurons in the dentate gyrus as indicated by a non-significant ANOVA, \( F(1,2) = 1.252, p = .28 \) (Figure 5).

**FIGURE 5: The Results of a Repeated Measures Between Subjects ANOVA on Number of Double Cortin Positive Cells and Group**

<table>
<thead>
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<th>Nonrunning</th>
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</thead>
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</tr>
</tbody>
</table>

(mean±SEM)

**REFERENCES**


Working Memory and Exercise in Rats


About the Author

LAUREN FREDRIKSEN completed her bachelor’s in science at Baldwin Wallace University. She is currently a graduate student at Xavier University in the PsyD program.
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Article: Intersections of Gender, Self-Care, and Burnout (pg. 4)
1. Transgender and gender nonconforming (TGNC) psychologists...
   a) are not a well-researched population in the area of burnout
   b) are a diverse group of individuals with respect to their identities
   c) may be additionally stressed by others’ assumptions that they are resident experts on TGNC issues
   d) all of the above
2. Which of the following is FALSE about psychologist’s self-care in the context of gender?
   a) Men who experience less gender role conflict engage in more self-care behaviors.
   b) Women and men are equal in the number of self-care and career sustaining behaviors.
   c) Women report more self-care and career sustaining behaviors than men.
   d) Women’s self-care may be hindered by greater family and domestic responsibilities

Article: Trauma and the Question of Repressed Memories (pg. 9)
1. Which of the following statements best reflects Terr’s theory of repressed memories? People tend to remember...
   a) repeated abuse but are likely to forget isolated events.
   b) isolated events but are likely to forget repeated abuse.
   c) abuse from a stranger but are likely to forget trauma inflicted by a caregiver.
   d) abuse from a caregiver but are likely to forget trauma inflicted by a stranger.
2. Which of the following statements best reflects the DMS-5 description of PTSD?
   a) Remembering trauma is emphasized more than forgetting trauma.
   b) Forgetting trauma is emphasized more than remembering trauma.
   c) Neither forgetting trauma nor remembering trauma are strongly emphasized.
   d) PTSD was removed from the DSM-5 for political reasons.

Article: Ethical Issues in Dealing with an Online Reputation (pg. 12)
1. Which of the following is not one of the major types of online reputation disparagement?
   a) Comments over abusive pricing
   b) Lack of compassion
   c) Incompetence
   d) All of the above are major types
2. What is one of the best ways to handle an online assault on a reputation?
   a) Write back a justification for the psychologist’s behavior
   b) Attack the writer in a similar style.
   c) Ignore the negative comments.
   d) Expose the writer for having a severe personality disorder.

Article: The Rhetoric of Psychologists (pg. 14)
1. If Life is rarely Black or White, but often GREY, why is it helpful to create clear dichotomous choices for children? It helps children assess whether...
   a) their choice moves them in the direction of an identified solution or problem.
   b) they are closer or further from an identified solution or goal.
   c) they are close to meeting a goal and earning a reward.
   d) or not their behavior will receive a negative contingency or negative consequence because they know what is expected.
   e) All of the above
2. If children’s choices are often in a GREY area, how do we know whether the child is actually improving/moving in the direction of positive goals?
   a) Comparison to the child’s baseline performance shows either an increase or decrease of specific positive behaviors.
   b) Change is difficult to see. It is only through the passage of time that we can see if there is any perceptible change.
   c) We cannot ever know whether there is improvement.
   d) The child and/or parent will report precisely what they are doing correctly based on clearly delineated expectations presented by parents or by the positive contingencies that the child reports they have earned.
   e) A, B, and D are correct.

Article: The Effect of a Two-week delay on Radial Arm Maze Errors (pg.27)
1. Exercise has been show in other studies to increase double cordin expression in the hippocampus.
   a) True    b) False
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