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Letter from the Editor: Keelan Quinn, PhD

Call for Papers: 2022 Ohio Psychologist

Interprofessionalism as a Cross-Cutting Skill: A Perspective on Transitioning from Academic Medicine to Community Behavioral Health
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Summa Health Family Medicine Center

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(Since the submission of this article, the author has completed her doctoral degree in Clinical Psychology at Bowling Green State University)

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Sheresa Wilson-DeVries, MS, MA, PA-C

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Montefiore Medical Center, Bronx, New York

2021 OPA P.O.D.cast Winner | Undergraduate Student - Empirical Award
The Effect of Beliefs about Effort on Empathic Effort
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2021 OPA P.O.D.cast Award Winner | Graduate Student - Empirical Award
Prevention and Management of Falls in Older Adults with Chronic Musculoskeletal Pain: A Look at the Literature
Written by: Ashley E. Murphy, BS, Doctoral Trainee
Julie L. Williams, PsyD, ABPP, Professor and Clinical Psychologist
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Ohio Psychologist Continuing Education Quiz

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The Ohio Psychologist 2021 | 1
The past year sure has flown by. It has been another difficult year to manage with a number of changes, continued increases in violence and deadly shootings, and, of course, the continued fight against Coronavirus Disease 2019 (COVID-19) and its new variants. However, there has also been a great deal of good during this past year. Vaccinations to fight the virus were developed and distributed to almost half of Ohio. Many businesses have returned to work in-person in some sort of capacity. Schools are soon to begin in face-to-face settings as well. Although we continue fighting COVID, there does seem to be somewhat of a return to a “new normal.” This new normal, however, is ever changing and no day seems to be the same as the last. Each and every one of us has had to learn to be flexible and patient. We, along with our clients, now wait each day for the next announcement, the next tragedy, the next change without knowing what to expect. No matter what comes at us, though, we will persist. The field of psychology will do as it has for the past almost century and a half to do the same—persist through these times of change.

This new normal has taught each of us how important it is to have support from others in both our personal and professional lives. If the quarantine and isolation reinforced any well known wisdom, it is that we need others to survive and succeed mentally, emotionally, and, in some circumstances, physically. If it’s a skill we’ve not previously honed, we have learned how to ask for and give help, even when it is not directly requested. Whether it is in the form of picking up a neighbor’s groceries, offering a coworker a ride, donating to a charitable cause, or helping a colleague complete the never-ending administrative duties of psychology because he/she is too burned out. Helping others is natural for us psychologists, but seeing our surrounding communities come together to help those in need has been exactly what the world needs to persist.

This year’s theme of Interprofessional Alliances to Promote Growth in Times of Change illustrates exactly what the field needs at this time. Examples of interprofessionalism are illustrated in many of this year’s articles including Dr. Katherine Lamparyk’s Interprofessionalism as a Cross-Cutting Skill: A perspective on transitioning from Academic Medicine to Community Behavioral Health; Drs. Shannon Perkins and Brooke Babyak’s Medical-Legal Partnership: An interprofessional approach to addressing social problems that impact health; Elizabeth Emely’s Coming Together to Address Social Determinants of Health; and Dr. Christopher Modica and Maria Alonso’s Ethical Considerations in Supervising Undergraduate Internships Across Professions: Issues of Competence. These articles provided perspectives and examples of how psychologists have joined with other professions and groups to promote positive change.

This year’s publication continues to feature articles that support various populations. Abigail Hollowell and Dr. Richard VanVoorhis provide information about Females diagnosed with Autism Spectrum Disorder in ASD in Females: Inter-Professional Diagnostic, Classification, and Practical Considerations. Ashley Murphy and Dr. Julie Williams review information for older adults who experience chronic musculoskeletal pain In Prevention and Management of Falls in Older Adults with Chronic Musculoskeletal Pain: A Look at the Literature. Furthermore, Dr. Anna Hayburn discusses opioid abuse among the LGBT+ population in Opioid Abuse in the LGBT+ Population: Contributing Factors and Treatment Recommendations. Each of these articles discusses the unique needs of these populations that will help those working with them advocate for what they need.
Treatment methods is another area from which our readers benefit. Michell Sanchez, Dr. Kirby Reutter, and Sheresa Wilson-DeVries discuss the benefits of therapeutic art in *Therapeutic Art as Effective Intervention to Provide Trauma Informed Care: An Appeal to the Polyvagal System*. Dr. Alan Dubro provides a description of how antipsychotic medications were developed and how they are used by client in *Psychopharmacology of Schizophrenia*. Finally, Keegan Early discusses a relationship between effort and empathy in *The Effect of Beliefs about Effort on Empathic Effort*.

Without knowing what the future holds in this “new normal,” we psychologists will continue doing what the rest of the world does—take each day as it comes with patience and flexibility. As we do, we will continue acting as helping professionals, assisting clients process and work through their own crises, and advocating for positive change and positivity. Most importantly, we will continue fighting together until we persist through the unknown.

**Call for Papers: 2022 Ohio Psychologist**

The OPA Communication & Technology Committee is calling for manuscripts to review for the 2022 Ohio Psychologist, a peer-reviewed journal which is published once a year by the Ohio Psychological Association.

**The following types of articles may be submitted:**
- Empirical
  - Quantitative
  - Qualitative
  - Mixed Methods
  - Meta-analyses
- Literature reviews
- Theoretical
- Methodological
- Perspective essays

**The focus of articles can be:**
- Scientifically research-based
- Advocacy related to the profession
- Practice related
- Current use of technology practices in psychology

**Instructions for authors:**
1. Articles should relate to the 2022 theme, “A New Social Consciousness Informing our Research and Practice” and follow the guidelines set within the APA’s publication Manual (7th edition).
2. Articles are to be no longer than 1,600 words (not including APA abstract, references or biography). Articles exceeding this length will be returned to the author without being reviewed.
3. Each article must contain a 100-150 APA Abstract.
4. All papers must have references and be written in APA format.
5. Perspective essays may be based upon clinical or practical experiences, and do not need to be research or academic based, however, they must still be written in a professional tone and use APA formatting.
6. Please notify Keelan Quinn (ohpsycheditor@gmail.com), Editor, your intent to submit an article.
7. Authors will email articles for review to Keelan Quinn in a Microsoft Word document no later than May 6, 2022. Art work, tables, charts or photos are desirable, but must be submitted in a separate high-resolution pdf or jpeg format, not embedded within the paper. The use of images is at the discretion of the managing editor on the basis of space and article significance.
8. Articles considered for publication will be independently reviewed by at least two different anonymous reviewers. Written comments and recommendations from reviewers will be shared with authors.
9. Each leading author will be contacted as to the status of the article after the peer review is complete.
10. Accepted authors will provide a brief biography of themselves, along with a high-resolution photograph.
11. Authors will receive three copies of the magazine, and more can be supplied upon request.
12. Any questions regarding this process should be directed to Keelan Quinn (ohpsycheditor@gmail.com), Editor of the Ohio Psychologist.
Interprofessionalism as a Cross-Cutting Skill: A perspective on transitioning from Academic Medicine to Community Behavioral Health

Katherine L. Lamparyk, PsyD
Director of Clinical Training and Development, OhioGuidestone
Fellow, Institute of Family and Community Impact

Abstract

This perspective essay describes the utility of interprofessional skills in two distinct practice settings: academic medicine and community behavioral healthcare. The necessity and utility of interprofessional alliances are discussed in each of these contexts. Core similarities in the applicability of this skill-set are described in the context of the global definition of health including mental, physical and social well-being and the translational function of psychological work. Current standards and definitions of healthcare interprofessional collaboration are discussed as essential and transcendent skills for health service psychologists. The manuscript calls for creativity and motivation in improving interprofessional alliances within the field of psychology.

Other than the obvious focus on health service psychology (HSP), what is one of the biggest similarities between academic medicine and community behavioral healthcare (CBH)? At first glance, the vast differences are easier to identify; emphasizing different models of treatment, with largely different demographic make-ups, and generally a different focus of presenting problems. Academic medicine and community behavioral health also place a different emphasis on research, teaching, advocacy, and direct clinical care. Transitioning from a longstanding career in academic medicine, strongly identifying as a Health (Pediatric) Psychologist, to a leadership role in a CBH organization, I discovered that the largest similarity between these practice settings was the cross-cutting skill of building interpersonal alliances.

As a pediatric psychologist, I was professionally “raised” in developing interprofessional skills. This resulted in me putting a high value on interprofessional collaboration. Learning how to collaborate with medical professionals and understand the patient (client) from a multi-factored and dynamic (biopsychosocial) perspective was essential to the role of a pediatric psychologist. The direct inclusion of interprofessional skills as a core competency in psychology training (APA, 2015) was particularly validating, formally recognizing a core skillset that is so profound in healthcare. However, I recall overhearing comments in the Association of Psychology Postdoctoral and Internship Centers (APPIC) 2018 Membership Conference that this new competency was, at times, challenging to meet in other settings. This seemed particularly true for CBH settings, in which psychologists primarily interact with other behavioral health professionals and provide services for primarily DSM-5 diagnosis. At the time, I agreed that interprofessional skills and competencies would not only be more difficult to train but also potentially less necessary depending on the practice setting (read: “non-medical” in my previously narrow worldview of HSP). Therefore, it was an eye-opening experience to find myself relying on this skill-set more than any other in my transition to CBH. I have concluded that this is due to two primary reasons; 1) mental healthcare is just one piece of overall healthcare, and 2) interprofessional skills transcend direct care responsibilities to the other roles of professional psychologists.

IT IS ALL HEALTHCARE

The World Health Organization (1946) defines health as a “state of complete physical, mental, and social well-being,” which notably does not distinguish between these domains and underscores the interconnectivity of these factors. As experts in the domain of mental health, psychologists cannot do justice to the people we serve in our field without attending to the other health domains. And as most psychologists are presumably not experts in domains of physical and/or social well-being, interprofessional collaboration is fundamental to the ultimate mission in our field of improving healthcare (National Registrar, n.d.) and benefiting our society and improving people’s lives (APA, 2015).

Academic medicine has historically focused on the physical domain while CBH has focused on the mental domain, and both have had the propensity to be overly focused on these respective domains while neglecting the others. In the academic medical center, as the minority provider focused on the mental-health domain, it was easy for me to understand the role of interprofessional collaboration in treating the entire individual that was presenting for care and to advocate for this definition of health. Conversely, in CBH, surrounded by other like-minded mental health professionals, it may be easier to lose sight of this definition and the importance of
attending to the totality of a person’s health; however, it is no less important or vital to do so.

When our clients present with mental health concerns, it is our due justice to identify and understand their health status in entirety because the mental-physical-social domains interact inherently. Depression could be the result of low vitamin D levels or an underlying thyroid condition (Anglin et al., 2013; Bauer et al., 2008). These causes would not be identified by the mental health provider but would nonetheless significantly alter the mental health treatment plan. An individual with a chronic disease and elevated anxiety may be appropriately warranted in their worries and require supportive and validative interventions. Alternatively, their fears and anxiety may be exacerbated for a variety of reasons, and they would benefit better from trauma-informed cognitive restructuring or behavioral activation. More likely, the answer is a constantly evolving combination of both options. Without a thorough understanding of their diagnosis and prognosis, providing an accurate conceptualization and corresponding treatment plan will not be possible and could easily do more harm than good.

It is important to note that diagnosis and prognosis are distinct concepts. While the diagnosis may be something that can be learned through independent research, especially with the proliferation of valid internet sources, a person’s individual prognosis within that diagnosis can vary significantly and change over time. Without additional information, we have an inherent tendency to apply our own narrow history to the understanding and judgement of others (Meehl, 1973). “My aunt had breast cancer and worked throughout her treatment so my client should be more active and stop lying around all day,” or “My cousin died within a few months of his cancer diagnosis, so we should really be processing mortality and end-of-life conversations instead of going about daily routines as if in denial.” Interprofessional collaboration is the best strategy to obtain this vital information and inform best practices.

**IT IS ALL TRANSLATIONAL**

The Interprofessional Education Collaborative (2016) defines four primary competencies for interprofessional practice: 1) Values/Ethics, 2) Roles/responsibilities, 3) Interprofessional Communication, and 4) Teams/Teamwork. Much of the specifics of these competencies rely on the understanding of our role as psychologists, the role of other professional we are collaborating with, and the ability to effectively communicate between these two roles. For example, the first competency includes the ability to “Work with individuals of other professions to maintain a climate of mutual respect and shared values.” This may be demonstrated in navigating the slight but inherently different values between medicine and psychology or navigating the competing interests of psychology ethics and business practices or economic realities. It turns out, the ability to translate our psychological knowledge, ethics, and interpersonal skills is also a cross-cutting leadership skill.

Interprofessional alliances transcend direct patient-care to our broader role as psychological advocates, leaders, and business professionals. This has become evident with each interaction I have had in my new leadership role. Conversations with statisticians, compliance officers, and human resource personnel tap into the same skill-set that previously allowed for successful collaboration with physicians, nurses, and child-life specialists. In each situation, it is essential for me to understand my unique identity and skill-set as a psychologist, the general ethos and motivations of their role, and how to effectively communicate in order to bridge these two perspectives to a mutually beneficial outcome. This mutual translation of interprofessional knowledge is no doubt effective in other professional contexts as well, including advocacy, public education, and industry ventures. The applicability of interprofessional skills is likely limited only by our own creativity.

The skills and values of a psychologist make us uniquely primed for leadership and advocacy efforts outside the direct clinical work we have been trained for. Self-awareness, empathy, and enhancing motivation and behavior change are just a few skills, inherent to psychologists, applicable in forming interprofessional alliances. In fact, most of IPEC competencies (2016) are also fundamental to being an effective psychologist. Rather, as I have come to learn through my career transition, the key missing link in furthering interprofessional alliances in psychology is the creativity and motivation to apply these skills outside our inherent comfort zones. If psychologists are to fulfill our mission in improving healthcare and benefiting our society, then stepping outside our comfort zone and tapping into our interprofessional creativity is every bit a part of our role. Personally, interprofessionalism is how I have maintained the common thread to my professional identity in shifting from a Pediatric/Health Psychologist to a Community Behavioral Health Psychologist, ultimately asserting myself as an Interprofessional Collaborative Psychologist.
Interprofessionalism as a Cross-Cutting Skill

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About the Author

KATHERINE LAMPARYK, PSYD, is a clinical psychologist practicing in the area of child clinical and health psychology for the first decade of her career at Cleveland Clinic. In this role, she developed a comprehensive and integrated behavioral health program embedded within the Pediatric Gastroenterology Department as well as led the development of the now APA-accredited predoctoral internship program in pediatric psychology, serving as the training director for the inaugural five years of the program. She has recently transitioned into a role as Director of Clinical Training and Development at OhioGuidestone, where she leads the clinical training orientation and ongoing education initiatives throughout the agency, focused on improving the quality of education and training to drive clinical outcomes. She maintains a small private practice to sustain her clinical specialization in treating disorders of the brain-gut-axis. Her work in these areas has been presented nationally and internationally, and published in both medical and psychological peer-reviewed journals.

Author Note:
There are no conflicts of interests to disclose.
Correspondence concerning this article should be addressed to :
Katherine Lamparyk | 345 W. Bagley Road | Berea Ohio, 44107.
Email: Katherine.Lamparyk@ohioguidestone.org

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Medical-Legal Partnership: An interprofessional approach to addressing social problems that impact health

Shannon Perkins, PhD and Brooke Babyak, MD | Summa Health Family Medicine Center

Abstract

Psychologists often confront barriers when attempting to treat patients whose mental and physical health is negatively impacted by social factors. Medical-Legal Partnerships (MLPs) help health care providers address “health-harming legal needs” such as eviction, unsafe housing, and domestic violence. The authors recently completed a legal needs screening process prior to implementing an MLP in the Summa Family Medicine Center. Three hundred sixty patients completed the screening questionnaire. Eighty-seven percent of respondents endorsed at least one health-harming legal need and sixty-three percent said they would be interested in using free Community Legal Aid services. Since the MLP program was implemented, we have referred thirty-three patients for free legal assistance. Housing issues such as pending eviction and unsafe housing conditions are the most common reasons for referral. Next steps include securing ongoing funding and defining formal research outcomes.

Frequently, when patients are referred to psychologists for behavioral health treatment, there are underlying social issues that need to be addressed before treatment success can be achieved. These social issues may have a greater impact on patients with limited financial resources. For example, Gina is a 34-year-old woman who was referred to the first author by her primary care physician (PCP) for treatment of depression and Post Traumatic Stress Disorder. At her first behavioral health visit, Gina reported that she was worried about being evicted from her apartment with her two school-aged children. She had been terminated from her job while on medical leave and had gotten behind on her rent payments. With these threats to her safety and security, Gina was unable to focus on learning cognitive behavioral skills to help her cope with her mood symptoms. While her treatment team included a physician, psychologist and a social worker, they were unable to help Gina with the problem most significantly harming her behavioral and physical health, a pending eviction.

An effective solution to address social problems that impact health is a Medical Legal Partnership (MLP; McCabe & Kinney, 2010). MLPs bring an attorney onto the health care team to help address the social determinants of health. According to the World Health Organization (2021), “The social determinants of health (SDH) are the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems. The SDH have an important influence on health inequities - the unfair and avoidable differences in health status seen within and between countries. In countries at all levels of income, health and illness follow a social gradient: the lower the socioeconomic position, the worse the health.”

MLPs have been proven to have a significant impact on social determinants of health, including: decreased stress and improved wellbeing (e.g., Ryan et al, 2012); increased access to income supports (e.g., Sege, et al, 2015); improved adherence to treatment for chronic illness (e.g., Fleisman, 2006); safer and more stable housing (e.g., Hernández, 2016); improved access to ADA accommodations for patients with disabilities (Matthew, 2017); improved access to primary care services for transgender patients (Marple, 2014); improved workplace safety for immigrant workers (Matthew, 2017); and increased access to protection orders against a violent partner (Edouard, 2010), among many other positive benefits.

The authors recently completed a legal needs screening process prior to implementing an MLP in the Summa Family Medicine Center (FMC). The FMC is an urban family residency training practice serving a diverse population of patients, many of whom have limited financial resources. Before beginning the program, we screened our patient population for “health-harming legal needs,” defined as social problems which negatively impact a person’s health or access to healthcare (Matthews, 2017). Three hundred sixty patients participated in the screening. Fifty-seven percent of respondents were White, 31% were Black, and 12% were Asian, multiracial or “other.” Sixty-three percent of respondents said they would use free Community Legal Aid Services and 87% endorsed at least one health-harming legal need. Twenty-one percent of respondents endorsed concerns about housing, such as pending eviction or foreclosure, denial of application for public housing, and unsafe or unsanitary housing conditions. Twelve percent reported recent termination of food stamp benefits or Medicaid. Eleven percent reported having criminal records needing expungement and 9% reported needing to file for bankruptcy.
We began accepting referrals for our MLP on 3/1/21. As of 7/23/21, we have referred 33 patients to the program. Housing issues are the most prevalent health-harming legal need our program has identified, with twelve patients seeking assistance for problems in this area. Examples of housing issues for which our patients have sought help include pending or threatened eviction, unsafe or unsanitary housing conditions, such as lead paint or mold, and illegal rent increases in government-sponsored housing. In one case, an elderly woman with end-stage kidney failure was being evicted from her home without cause. The attorneys from Community Legal Aid were able to communicate with her landlord and request a “reasonable accommodation” for her health condition, and the patient will now be able to stay in her housing for the remainder of her life if she chooses. Patients in our clinic have sought help for numerous other concerns such as: IRS disputes preventing them from receiving stimulus checks, child support and custody issues, domestic violence, divorce, and expungement of criminal records.

We are currently working on finding additional sources of funding in order to ensure the sustainability of this program. This is currently a pilot quality improvement project. At the end of this year, we will review data and decide on outcomes to investigate for research. Possible outcomes are patient stress and perceived well-being, financial benefits to patients, hospitalization rates and adherence to medical treatment. We hope to inspire other clinics and hospitals serving disadvantaged populations in Ohio and across the country to create MLPs to better serve the needs of their patients.

References


About the Authors

SHANNON PERKINS, PHD graduated from Kent State University with a BA in psychology in 1995. She completed her PhD in clinical psychology at St. Louis University in 2001. She did her internship in clinical health psychology at the University of Florida Health Sciences Center. She completed a post-doctoral fellowship at Cleveland Clinic Foundation. Dr. Perkins has worked at Summa since 2009, and since 2017 has served as the Director of Behavioral Science and Associate Director of the Summa Family Medicine Residency Program.

BROOK BABYAK, MD, a Northeast Ohio native, is a Kent State University graduate and completed her medical degree and a Certificate in Bioethics at Northeast Ohio Medical University in 2014. She completed her Family Medicine residency at Summa Akron City Hospital in 2017. In 2018, she completed the Integrated Community Psychiatry and Primary Care Fellowship through NEOMED. She is currently the Associate Program Director at Summa Health Family Medicine Program-Akron Campus. Her areas of clinical interest include integration of primary care and behavioral health in practice, academic medicine, inpatient medicine, medication-assisted therapy (MAT), and global health.
Coming Together to Address Social Determinants of Health

Elizabeth Emley, MA | Bowling Green State University
(Since the submission of this article, the author has completed her doctoral degree in Clinical Psychology at Bowling Green State University)

Abstract

Across the globe, good health is not evenly distributed. The United States has one of the greatest inequality gaps, perpetuating an array of disparities between those with the most and those with the least. Of particular note to psychologists, social determinants of health are a formidable problem we face in our work to reduce human suffering. Thus, it is imperative that we work to dismantle these disparities in the many roles we hold, including our work with clients, our ability to effectively consult and work with other helping and health professionals, our knowledge of the communities we serve, and our engagement in public advocacy. Through these efforts, we can continue to promote a more equitable and thriving society.

INTRODUCTION

It is well known that good health is not evenly distributed amongst the people of the world. When it comes to rates of morbidity and mortality, those at the bottom of the socioeconomic ladder fair far worse than those at the top (Chetty et al., 2016). These disparities are particularly wide within developed countries, like the United States, where inequality gaps have grown substantially over the past century (Saez, 2018; Wilkinson, 2005).

In helping professions, an especially salient topic is that of social determinants of health (SDoH), defined as “conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes” (CDC, 2021). Through the Healthy People initiative, the Office of Disease Prevention and Health Promotion outlines five key domains of SDoH: economic stability, social and community context, neighborhood and built environment, education access and quality, and healthcare access and quality (ODPHP, 2021). These factors are primary drivers of health behaviors and outcomes through issues such as income and job opportunities and access to nutritious foods. Disparities within these domains are perpetuated by economic, social, and political structures that alter the availability of resources to certain populations, making policy an essential aspect of this topic (Marmot, Friel, Bell, Houweling, & Taylor, 2008).

Furthermore, it is crucial to note that systemic racism and other forms of discrimination underly all SDoH, with public practices such as social segregation and immigration policy directly influencing who in our society is more likely to experience socioeconomic disadvantage (Gee & Ford, 2011). For example, Black, Latinx, and Native American individuals are two to three times more likely than white individuals to live at or below the poverty line (Carlo, Crockett, Carranza, & Martinez, 2010). To address social health inequities, we must also acknowledge the roles that racism and intersectionality (the interconnected nature of a person’s social and political identities) play in discrimination and privilege, and work to dismantle these injustices.

On the individual level, a key challenge associated with SDoH is the accompanying sense of powerlessness experienced by people facing inequity. Living in a situation where social and economic resources are not available or easily accessible can contribute to one’s sense of helplessness to be able to achieve the life one wants and to engage in behaviors that can improve one’s overall wellbeing (Prilleltensky, 2012; Wallerstein, 1992). Furthermore, the chronic stress accompanying the enduring experience of living in adversity is well known to cause and/or perpetuate a vast array of physical and mental health concerns (Sapolsky, 2004).

PSYCHOLOGY AND SOCIAL JUSTICE

In the field of psychology, we have witnessed an emerging focus on social justice over the past several decades and the consequent challenges this brings (Vasquez, 2012). The roles and responsibilities we hold as clinicians, researchers, consultants, and more provide many opportunities to address social and health inequities on individual, community, and systemic levels. Addressing SDoH in our work is highly aligned with our compassion for helping others in need, and by harnessing our unique privileges and skillsets we can strive to do so in many ways.

Clinically, many therapeutic approaches can acknowledge and address social disparities. Feminist therapy theory, which explicitly emphasizes the political realities of psychotherapy (Brown, 2006), as well as multicultural and systemic theories that emphasize the sociocultural context, provide direction in facilitating clients’ awareness of the inequities that impact their mental health and build empowerment toward creating social change. Person-centered and existential-oriented techniques can promote self-awareness, acceptance, and confidence to counteract the messages often internalized amongst individuals facing disadvantages.

Assessing SDoH with clients can itself be an act of increasing awareness, empowerment, and action. In intake appointments, we can assess for various social traumas and stressors like food insecurity to enhance our treatment of
Our heightened knowledge of the psychological and social injustices in practice.

## INTERPROFESSIONAL ACTIVITIES

Interprofessional activities are another vital component of our role as psychologists in reducing health disparities. Our heightened knowledge of the psychological and social influences on behavior affords us the opportunity to inform other professionals about these influences in their work with clients.

For example, educating medical professionals on the benefits of motivational interviewing, a psychotherapy approach designed to assist those who are ambivalent to change health behavior, can be one avenue to discuss the external and internalized barriers individuals face in adhering to medical guidance. We can consult with nutritionists, integrative medicine doctors, or other holistic health professionals to support clients in prevention efforts of which they may be unaware and support other health professionals in their efforts to problem-solve with clients facing adversity. We can also learn from other professionals how they understand and address social inequities in their work, which can increase our awareness of other systems’ efforts and provide us with new perspectives and areas to explore in our own systems.

Regarding research activities, conducting needs assessments for service and health organizations can improve their ability to tackle SDoH, and finding creative ways to increase the accessibility of our research can advance both providers’ and consumers’ awareness of our contributions to these issues.

Consulting with health professionals on SDoH as they relate to the work we do with clients and their unique life experiences will increase the efficacy of the client’s overall treatment and, ideally, increase the client’s felt sense of support and empowerment in their journey of seeking help. To address broader barriers within larger healthcare systems, we can advocate with and for our clients and work alongside other healthcare professionals to achieve collective goals to improve client’s experiences of their care (e.g., “UBC Health Advocacy Framework,” Hubinette, Dobson, Scott, & Sherbino, 2017).

## COMMUNITY INVOLVEMENT AND WORK

Underpinning these clinical and academic goals is our knowledge of the communities we serve. First, this knowledge increases our ability to connect our clients with a range of beneficial resources where we live to help them target health concerns from many angles. Second, it allows us the opportunity to understand where the major disparities and gaps exist in our unique community, thus guiding where to put forth our efforts most effectively. This could include finding ways to connect and consult with important community resources or pursue relevant research. Additionally, expanding our interprofessional networks can increase our own sense of empowerment as we work to address difficult social problems.

Finally, it is our responsibility as professionals with power and privilege to humbly engage in public advocacy to address the systemic factors that perpetuate the inequities many of us see daily yet are ourselves protected from. In our communities, we can participate in service activities to support and be supported by professionals in other important areas like food pantries or sexual assault and domestic violence centers. We can advocate for legislation that promotes health and social equity by speaking with our representatives or joining professional groups like OPA who do this incredible work. For example, supporting “Health in All Policies” initiatives, which target SDoH through integrated policy response, could have an impact on our own work and the work of other healthcare professionals our clients utilize (Donkin, Goldblatt, Allen, Nathanson, & Marmot, 2018). Finding ways to get our research on such topics to the officials who make city, state, and federal policy is another powerful avenue we can take. Furthermore, we need interprofessional activism to accomplish a task of such grand scale, including professionals from healthcare, academic, policy, and advocacy backgrounds (Fisher & Baum, 2010; Marmot, Friel, Bell, Houweling, & Taylor, 2008). There is much we can accomplish with our knowledge and expertise if we are willing to make the effort to do so.

## CONCLUSIVE WORDS: PERSONAL WORK AND SELF-CARE

As we work to help those around us, whether they be clients, research participants, or the general population, we must ask ourselves how we can do similar work within ourselves. Connecting with our values and having compassion for ourselves are essential tasks to work toward such challenging but vital social change. We must also remember that it is acceptable to make mistakes; what matters is how we respond to ourselves and those around us when we do. With these concepts in mind, I ask us to consider the spaces in our work and our lives where we could make one step toward social change right now. Perhaps one example is reviewing some of the models and frameworks referenced here that are particularly relevant to your work setting and activities. As social and health inequities rise and become increasingly complex, the time to act is always now. These are the actions that will propel us forward into the more equitable, thriving world we hope for and desperately need.
References


About the Author

ELIZABETH EMLEY (she/her) is a doctoral candidate of Bowling Green State University’s clinical psychology program. She recently completed her internship at the University of Akron’s Counseling and Testing Center and will soon be engaged in postdoctoral training at Kent Psychological Associates, furthering her skills in providing behavioral medicine assessments and interventions. She is passionate about effective consultation with other professionals to improve clients’ holistic well-being and specializes in clinical work around issues of psychosocial trauma and behavioral health.

Since the submission of this article, the author has completed her doctoral degree in Clinical Psychology at Bowling Green State University.
Ethical Considerations in Supervising Undergraduate Internships Across Professions: Issues of Competence

Christopher A. Modica, PhD | Ohio Wesleyan University
Maria G. Alonso | Santo Domingo, Dominican Republic

Abstract

Undergraduate internships in psychology can be highly formative experiences for students. Commonly, students locate internships in agencies outside of a university; often in professions and clinical domains outside the expertise of a supervising psychology professor. These arrangements often necessitate interprofessional alliances and collaborations and, consequently, give rise to ethical questions regarding competency. Further, there exists a paucity of literature on ethical considerations of undergraduate internships in psychology and existing ethical and legal standards do not easily translate or apply to such internships. In response to these issues, this article presents a brief internship vignette, followed by a discussion of three issues of competency of parties involved. Although in several cases existing ethical standards and Ohio laws do not specifically apply to undergraduate internships, this article draws upon the ideals contained in relevant standards/laws to help the psychology faculty evaluate whether a particular internship arrangement is appropriate and prudent.

INTRODUCTION

Helping undergraduate students obtain internships or preliminary experience in a specific work setting, separate from their formal academic studies, has emerged as a prominent initiative in higher education and is encouraged within the American Psychological Association’s (APA) “Principles for Quality Undergraduate Education in Psychology” (APA, 2013). Internship experiences in prospective work settings, in particular psychology settings, can be some of the most formative educational experiences that influence a student’s career development and personal growth and may cultivate a more thoughtful consideration of how their interests, skills, and personality fit with a particular career path (Barber & Bailey, 2015; Reddy & Moores, 2006).

Below is a vignette that illustrates a common internship arrangement:

Ms. Smith is a 21-year-old undergraduate senior majoring in psychology at a small liberal arts university. She is hoping to complete an internship in her last semester of her education and planning on attending graduate school in clinical psychology. Knowing she needs a psychology professor to approve and supervise her internship to obtain credit, she met with Dr. Burns, a professor in the psychology department, to discuss the process of obtaining internships, supervision, and her interests in gerontology and mental health. Ms. Smith then contacted a local agency that serves elderly individuals with mental health concerns and the director there (Mrs. Nelson), a licensed social worker also trained in supervision, has agreed to supervise Ms. Smith. Ms. Smith’s internship would consist of shadowing Mrs. Nelson as she conducts home visits for elderly individuals and co-presenting community education seminars. Dr. Burns is a licensed psychologist with minimal training in gerontological issues (an area he is aware of his lack of competence), who will be Ms. Smith’s faculty supervisor. Dr. Burns and Mrs. Nelson have never met.

In one way, the collaboration between Dr. Burns (a psychologist) and Mrs. Nelson (a social worker) to provide an internship for Ms. Smith illustrates an interprofessional alliance. As defined by Green & Johnson (2015) these occur when two or more professionals from different areas work collaboratively in a mutually beneficial way to achieve a shared goal. Such alliances involve teamwork, interdependency, collaboration, and sharing (D’Amour et al., 2005). In the context of undergraduate internships, interprofessional work is not only relevant but, at times, the only way to provide students with opportunities to explore their interests. However, while such alliances are perhaps necessary they often involve the following nuanced ethical issues:

1. Given diversity in student interest and available opportunities in a given community, psychology faculty often find themselves being asked to supervise interns working across disciplines, professions, and in areas they do not have expertise.
2. At the undergraduate level, students often have a “site supervisor” who is the content and practice expert responsible for overseeing the work or experiences of the student at the internship (Barber & Bailey, 2015). Instead, psychology faculty often serve as a “faculty supervisor” who helps the student process and reflect on their experiences and consider how these inform career decisions through regular meetings.
3. As an agent of the university, psychology faculty often approve an internship and serve as a liaison between the student, internship site, site supervisor, and university (See Dunn et al., 2020).

4. Translating existing laws or ethical codes to an undergraduate internship is often not appropriate or straightforward. For example, in Ohio law supervising an undergraduate intern does not fit within codified types of supervision, and within the APA Ethics Code (APA, 2017) it is unclear if specific standards apply to undergraduate internships.

It is reasonable that Dr. Burns has ethical concerns of being a part of this alliance that center on the area of competence, and the paucity of literature on the ethics of undergraduate internships further complicates Dr. Burns’s considerations. Is Dr. Burns competent to be Ms. Smith’s faculty supervisor? Is Ms. Smith competent to be an intern at this agency? Is Mrs. Nelson competent to supervise Ms. Smith? Given these questions, the aim of this article is to draw upon the standards regarding competence from the APA Ethics Code (APA, 2017), APA’s Clinical Supervision Guidelines (APA, 2014), and relevant Ohio laws for psychologists and apply them to the vignette of Ms. Smith. Before this undertaking, an important acknowledgment should also be made; in several cases it is possible that a standard or statute discussed does not actually apply to undergraduate internships. However, we propose that the ideals contained within such standards/statutes might still serve as a professional compass, to encourage a consideration of more broad ethical principles to ensure an appropriate experience for students.

**DR. BURN’S BOUNDARIES OF COMPETENCE**

The APA Ethics Code (i.e., Standard 2.01) states that “psychologists provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence” (APA, 2017, p. 5). Ohio law (i.e., ORC 4732-13-04 C.3) and the APA’s Clinical Supervision Guidelines (i.e., Domain A.1) contain similar standards, though they likely apply to specific forms of graduate-level clinical supervision (e.g., “psychological training supervision”). If this were a situation of psychological training supervision for licensure in Ohio, Dr. Burns would most likely be obliged to not engage in supervision. However, in this situation a) Dr. Burns will not be responsible for the on-site work of Ms. Smith, b) Ms. Smith is not a graduate trainee providing clinical services, and c) Ms. Nelson is competent within her respective profession to engage in and supervise such work. Instead, Dr. Burns’ role will be to meet with Ms. Smith to help her process her experiences and integrate these with previous learning.

Ultimately, even though Dr. Burns would not provide training supervision, his interactions with Ms. Smith could reasonably be considered “teaching,” making Standard 2.01 still relevant. The issue perhaps then becomes whether Dr. Burns is competent to provide process-experiential discussions with Ms. Smith concerning older adult mental health care. In the end, some faculty may emphasize this process-experiential/educational role in this situation and conclude that this arrangement is appropriate. However, others may feel quite uncomfortable given the population served being outside of their competence, that they refrain. Both decisions may be justifiable and faculty are encouraged to thoughtfully self-evaluate their comfort level with such arrangements before an agreement with Ms. Smith is made.

**MS. SMITH’S COMPETENCE**

Although in most cases graduate supervisees are not competent to independently practice, supervisors must still ensure that a supervisee is performing work within their scope of competence. Such mandates are contained in Ohio law (4732-13-02 C & D; 4732-13-04 B.9) and echoed in literature (Bernard & Goodyear, 2004; Saccuzo, 1997). No such standards exist for undergraduate psychology interns. Even though Ms. Smith will not be rendering services, this issue is nonetheless still important since she will have contact with those served by the agency.

Given the lack of guidance on this issue from the relevant codes above, it is nonetheless wise for both Dr. Burns and Mrs.
Nelson to gauge whether Ms. Smith is ready to complete an internship. Preliminary meetings between Dr. Burns and Ms. Smith as well as Ms. Smith and Mrs. Nelson should be used to gauge Ms. Smith’s readiness. Ultimately, in this decision, the psychology professor will need to consider (among many other things) the student’s skills and maturity, past classes, amount of face-to-face contact with clients, the emotional impact of seeing individuals who may be experiencing distress, amount of independence she may have, and the ability and willingness of Mrs. Nelson to monitor or mentor Ms. Smith. Barring any significant concerns in these areas, it seems reasonable to proceed with Ms. Smith’s internship.

MRS. NELSON’S COMPETENCE TO SUPERVISE?
A last consideration is whether Mrs. Nelson is competent to supervise Ms. Smith. Commonly in undergraduate internships, students arrange their own internships and may find agencies with formal internship programs or agencies that allow them to informally “volunteer.” Particularly with the latter, it is important that the psychology faculty investigate whether the proposed site-supervisor is willing and able to give appropriate oversight, understands the developmental level of the student, and has the same understanding of “supervision.” The case above is challenging because a) Dr. Burns does not know Mrs. Nelson, b) Dr. Burns may be unfamiliar with state laws and ethics codes of social work, and c) asking about the competence of another professional might be inappropriate. However, it seems advisable to initiate a discussion of supervision standards of a site-supervisor’s profession, if any exist. In this case, the social work ethics code indeed contains ethical standards regarding supervision competence (i.e., Standard 301a) (National Association of Social Workers, 2008). All things considered, if Mrs. Nelson and Dr. Burns agree on what on-site supervision will entail it seems reasonable to proceed with the internship.

CONCLUSION
Undergraduate internships can be incredibly enriching for students in the process of finding their desired fit within a particular field. Through these unique opportunities, students can gain valuable knowledge germane to their future endeavors. While undergraduate internships may not be required, there nonetheless exists a lack of guidance regarding the ethical implications of supervising a student pursuing an internship outside a psychology professor’s scope of competence. Hence, before proceeding with internship arrangements psychologists should consider issues of competence of all parties involved. While existing ethical standards and laws may not always apply to undergraduate internships, adhering to the spirit of such standards as applied to undergraduate internships is still prudent. As is common with many ethical principles, there are no clear-cut answers about how to approach the numerous issues that may arise when finding internship placements for students; however, it is essential to be thoughtful about such decisions given their potential significance for students.

Footnotes
1 Supervising a psychology undergraduate student in a psychology-oriented internship is not supervision, as defined by Ohio law (i.e., in ORC 4732-13-03). Consequently, one might argue that in Ohio any supervisory laws/standards simply do not apply.
2 The APA Ethics Code also does not explicitly contain standards concerning graduate-student supervisee competence. The standards regarding “delegation of work” (APA Ethics Code, Standard 2.05), “design of educational and training programs” (APA Ethics Code, Standard 7.01) are related but do not fully apply.

About the Authors

CHRISTOPHER MODICA is an Assistant Professor of Psychology at Ohio Wesleyan University, where he teaches classes in Abnormal Psychology, Psychology and Law, and an Internship class designed for Junior and Senior students. He is also a licensed psychologist in Ohio and Indiana. His research primarily focuses on the topics of body image, eating behaviors, sexual objectification, and social media.

Author Note:
Christopher A. Modica, PhD, Department of Psychology, Ohio Wesleyan University, 61 S. Sandusky St., Phillips Hall 52, Delaware, OH, 43015, camodica@owu.edu.

MARIA ALONSO is a recent graduate of Ohio Wesleyan University. She double majored in Psychology and Spanish, and will start graduate school this Fall at the University of Central Florida to earn her M.A. in Clinical Psychology. She has been involved in research since her junior year of college, and would ultimately like to become a licensed psychologist.

Author Note:
Maria G. Alonso, Santo Domingo, Dominican Republic; maria.alonso.2020@owu.edu
Undergraduate Internships

References


Autism Spectrum Disorder in Females: Inter-Professional Diagnostic, Classification, and Practical Considerations

Abigail Hollowell and Richard VanVoorhis, DEd, NCSP | Youngstown State University

Abstract

Many educational and mental health professionals are aware that Autism Spectrum Disorder (ASD) is more prevalent in males. Recently, it has been questioned if this is due to the actual increased prevalence rates in males or if diagnostic guidelines and practices are less effective for diagnosing females. Today, more adult females seek an ASD diagnosis due to recent changes in diagnostic criteria, professional practice issues, and awareness that ASD presentation may appear somewhat different for males and females. This implies that females with ASD may endure their primary school years without the supports they need. This paper provides a more comprehensive understanding of the under-diagnosis or misdiagnosis of females with ASD by exploring characteristic differences between males and females and diagnostic ambiguity for professional practice. Implications for females who struggle with ASD symptoms are shared, along with potential recommendations for future research and practice.

Recent research contributions have demonstrated that Autism Spectrum Disorder (ASD) may present differently in males and females (Myles et al., 2019). These authors note that the differences may be partially explained by the historic use of predominantly male samples in autism research. This may have overshadowed the understanding of the presentation of ASD in females. Also, it has been reported that many females with autism may be more skilled in ‘masking’ or ‘camouflaging’ their ASD symptoms into more socially acceptable mannerisms (Myles et al., 2019). Females may be better able to ‘blend in’ by using learned strategies to hide their social difficulties (Stark, 2019). Finally, there appear to be ASD diagnostic and school-based classification language inconsistencies involved, which require further exploration. This paper aims to share these factors related to ASD diagnostic considerations for females and share practical examples of how school and clinical/community-based providers can address these diagnostic and classification issues in practice.

STATEMENT OF THE PROBLEM

Females with significant ASD characteristics may not receive an ASD diagnosis due to a missed referral or false negative diagnosis. This can lead to experiences of social isolation, limited access to resources, mental health difficulties, and difficulties understanding social cues (Stark, 2019). Stark (2019) experienced these struggles firsthand as she was not diagnosed with ASD until she was twenty-seven years old. This led to many difficulties throughout her life that many other females with ASD have similarly experienced. Myles et al. (2019) conducted interviews with school-age females with ASD. Key elements that emerged from the student interviews were the value and struggles of achieving peer acceptance, friendship, and social competence. While female students diagnosed with ASD still experienced difficulties, these struggles increased when support was not offered or available.

Huang et al. (2020) offered insight into the struggles an individual faces when ASD diagnosis is not made until later in life. Huang et al. (2020) indicated that more adults with autism seek out an evaluation for ASD because of recent changes in diagnostic criteria, awareness, and professional practices. Many of these adults are females who were overlooked during their childhood because of their masking abilities. The author explained that females with autism have trouble finding knowledgeable specialists. Females with ASD are also more at risk for sexual victimization because they struggle with social cues and receive less support and fewer resources when they lack a diagnosis (Huang et al., 2020). This lack of support is a concern, because it can lead to female adults with ASD developing emotional difficulties, employment troubles, and mental health issues. Another important finding from Huang et al. (2020) is the ratio of identified males with ASD compared to identified females with ASD is approximately 4.1. In time, this gender gap narrows to about 2.5 males to 1 female in the adult population. The indication of this wider gap for younger populations implores the exploration of ASD diagnostic criteria and practices especially relative to younger females.

HISTORICAL ASPECTS OF ASD DIAGNOSTIC CONSIDERATIONS

Grant and Nozyce (2013) indicated that ASD is characterized by atypical social, behavioral, and communication functioning. ASD is diagnosed after a thorough evaluation of various areas, including social interaction, communication, and restricted and repetitive behaviors. The disorder is defined as a spectrum because characteristics and behaviors can vary considerably from person to person diagnosed with ASD. As explained, alongside the individual presentation differences of ASD, there is a well-documented increased prevalence of diagnosed ASD in males. In more recent years, it has been questioned if this is due to the actual increased prevalence of ASD in males or if ASD diagnostic practices, criteria, and materials are less effective for diagnosing females. As Stark (2019) explained, much of the ASD foundational research by Leo Kanner and Hans Asperger was established utilizing male subjects. Both Kanner and Asperger acknowledged that autism seemed to present differently in girls and boys, but they did not provide further
explanation through their research. Consequently, this may have led to a misunderstanding that ASD was a predominantly male condition. Subsequent research and diagnostic practices and materials also heavily focused on the characteristics of ASD typically presented by males, and these likely also overlooked characteristics of ASD in females.

**ASD PRESENTATION DIFFERENCES IN MALES & FEMALES**

Matheis et al. (2019) explained that research has consistently demonstrated that females with ASD show stronger social and play skills than males with ASD. Also, females with ASD tend to exhibit less repetitive use of objects, preoccupation with parts of objects, and adherence to rituals compared to males with ASD (Matheis et al. 2019). Upon understanding these differences found by previous research, Matheis et al. (2019) further examined gender differences in ASD symptoms and developmental functioning to explain these differences more precisely and in greater detail. Their findings indicated little difference among males and females who have ASD accompanied by cognitive delay. In other words, there were fewer gender differences within lower-functioning ASD populations. However, when comparing higher functioning samples of males and females, females had fewer difficulties with communication but more significant challenges with motor skills (Matheis et al. 2019). The findings suggested that females with ASD may have stronger masking abilities, even at a young age.

Halladay et al. (2015) explained essential aspects to consider when evaluating females with suspected ASD. Researchers cautioned that although research has shown that females tend to exhibit fewer repetitive behaviors than males within the ASD population, there is a chance that these behaviors are often overlooked in the evaluation process due to societal perceptions. For example, females with autism may present an increased interest in books, dolls, or babies. Although these may be actual restrictive behaviors, some misinterpret this as pretend play and miss these signs due to societal expectations of females (Halladay et al., 2015). On the other hand, males tend to be more quickly referred for evaluation due to pervasive and overt symptoms such as aggression, hyperactivity, or social isolation (Halladay et al., 2015). Thus, it is essential for practitioners to understand how gender expectations and possible biases may lead to inaccurate diagnostic conclusions. As Halladay et al. (2015) explained, many methodologies for identifying autism are primarily based on a male-focused model, which has likely led to underdiagnosis of ASD in females.

**DIAGNOSTIC LANGUAGE CONSIDERATIONS FOR ASD**

According to a study conducted by Safer-Lichtenstein and McIntyre (2020), identifying students with ASD varies upon the setting and the time-period of the diagnosis. For example, when individuals with ASD attain a medical diagnosis, it is based on specific criteria defined in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5). The authors indicated that the DSM-5 definition of ASD requires the clear presence of communication, socialization, and behavioral deficits. Grant and Nozyce (2013) remarked that in comparison to previous definitions of ASD, the DSM-5’s definition and criteria eliminated some of the DSM-IV’s subcategories of autism (such as Pervasive Developmental Disorder-Not Otherwise Specified and Asperger Disorder). Instead, the DSM-5 now utilizes the broad term Autism Spectrum Disorder to be more inclusive and consistent with the terminology used in the field. This resulted in less specificity regarding symptom descriptions of social and communication struggles that were previously described in more detail by the DSM-IV. Grant and Nozyce (2013) explained that while changes in the DSM-5 aimed to be more inclusive in the definition of ASD, this may have created more opportunities for certain students to be overlooked (especially females who may naturally have higher communication and social functioning). In other words, while the definition of the DSM-5 is seemingly more inclusive at the surface, it has created ambiguity on what exactly needs to be assessed to diagnose ASD across the entire spectrum.

In the school setting, the diagnostic criteria for ASD may be even more ambiguous. The federal definition school professionals use for ASD classification for special education only requires communication and social deficits that adversely affect a child’s educational performance (Safer-Lichtenstein & McIntyre, 2020). School-based evaluation team members are left to decide if the ASD characteristics adversely impact the student’s educational performance to such a degree that specialized instruction is required. Thus, a medical diagnosis of ASD does not automatically imply that a student will qualify for and receive special education services in the school setting. States may also modify their definitions of ASD as long as it still aligns with the federal definition (Safer-Lichtenstein & McIntyre, 2020). This has led to different requirements and procedures for determining if a student with ASD is eligible for special education services or not (Safer-Lichtenstein & McIntyre, 2020). These diagnostic discrepancies are challenging as they can lead to under or over-identification of students with ASD. Furthermore, the educational criteria for classification of ASD (with its heavy focus on academic success) may underemphasize the potential impact on student mental health. Even though a student may be performing well in the classroom, students with ASD are at risk for feeling socially excluded. This can lead to significant mental health consequences if no interventions are present.

In addition to more specific diagnostic and classification criteria, clinical/community-based and school-based mental health professionals are encouraged to provide comprehensive ASD evaluations. For example, Allen et al. (2008) explain that diagnostic difficulties experienced by school psychologists may result in students with ASD being overlooked for special education eligibility. These difficulties experienced by school psychologists are likely due to the subjectivity of the classification process set by federal and state laws. Allen et al. (2008) explained that there are many suggested ways to carry out ASD classification procedures for school psychologists, but how closely these recommendations are followed is unknown. These investigators surveyed 117 school psychologists to examine current ASD assessment practices. Most respondents evaluated ASD from a psychoeducational perspective which often resulted in the sole administration of brief rating scales for diagnosing ASD. While these measures may be helpful in screening students for ASD, relying on them as a primary diagnostic measure is questionable and problematic (Allen et
al., 2008). The authors recommended that school psychologists and other mental health professionals incorporate more comprehensive approaches involving ASD-specific instruments, direct observations, developmental questionnaires, medical professionals’ perspectives, and parent or guardian interviews in the evaluation process.

Recent development of screening instruments and rating scales is promising as more specific characteristics are included that are associated with females with autism. For example, The Questionnaire for Autism Spectrum Conditions (Q-ASC) was developed by Attwood et al. (2011) to identify behaviors and abilities consistent with the female presentation of autism to support positive psychosocial outcomes and prognosis for girls into adulthood. Although this free internet-based scale is not reportedly diagnostic in nature, it can provide very useful qualitative information. In 2018, these researchers piloted the Q-ASC with parents of 238 children with a clinical diagnosis of ASD. The aim of this study was to conduct an exploratory investigation of presenting autism characteristics within a clinical setting, with a focus on refining a preliminary profile for female children and adolescents with autism. Data analysis from the first statistical investigation revealed eight interpretable and reliable components of the Q-ASC using principal components analysis. These components included gendered behavior, sensory sensitivity, compliant behavior, friendships and play, social masking, imagination, imitation, and talents and interests. Practitioners are recommended to be aware of new valid and reliable evaluation materials to help identify ASD in females and guide intervention.

OHIO PSYCHOLOGY & SCHOOL PSYCHOLOGY IMPLICATIONS

Implications are essential for Ohio’s students and school and community-based mental health professionals. Ohio’s school-based definition describes ASD as, “a developmental disability significantly affecting verbal and nonverbal communication and social interaction, generally evident before age three, and that adversely affects a child’s educational performance” (Ohio Department of Education, 2014). Other characteristics often associated with “autism” are engagement in repetitive activities and stereotyped movements, resistance to environmental change or change in daily routines, and unusual responses to sensory experiences. It is noteworthy that ASD is the fourth largest Ohio special education category according to Equity in Education Research Series (2019). It was estimated that 8.6% of Ohio students on an individual education program (IEP) were eligible through the ASD classification (just behind those with specific learning disabilities (39.1%), Other Health Impaired-Minor (17.8%) and speech and language services (11.8%). Interestingly, ASD includes a more significant percentage of Ohio students than disabilities such as cognitive disability (8.0%) and emotional disturbance (6.4%). Furthermore in 2009, 0.5% of all school-age students (ages six through twenty-one) were eligible for special education services through ASD, while in 2018, 1.0% of school-age students were eligible (U.S. Dept. of Education, 2020). Thus, nationally, ASD is one of the fastest-growing categories in special education identification. In practice, we must ensure that females benefit from special education and other school and community-based services provided for those identified with ASD.

IMPLICATIONS FOR PROFESSIONAL PRACTICE & FUTURE DIRECTIONS

This paper aims to promote both systemic and personal changes in identification practices related to females with suspected ASD. As noted throughout this paper, females need to have an accurate and early ASD diagnosis to benefit from the numerous supports and services provided to those in the ASD population. Practitioners need to understand each factor which can contribute to identification errors (both false positives and false negatives) when diagnosing both males and females. Many professionals have not been prompted to question why autism is predominantly a disability seen in males, and they have not been educated on ways it may differently present in females. Educating professionals on these issues, encouraging more holistic as well as specific diagnostic approaches, and encouraging professionals to advocate for reform can result in the systematic changes needed for a more equitable system. In addition to identifying and treating observable symptoms, mental health practitioners are encouraged to fully investigate or “unveil” covert characteristics of autism that females may present (especially in the socialization and social communication areas). This can be done by offering more extensive personal interviews with the student/client, conducting multiple observations in different settings, and utilizing various reliable and valid instruments involving multiple raters. Fostering interprofessional alliances between school and clinical/community-based practitioners is also essential throughout the diagnostic and intervention planning processes for students/clients with suspected ASD characteristics. An understanding of the setting specific diagnostic/classification criteria and treatment options, as well as interprofessional communication and planning, are all essential elements.

When it comes to characteristic differences between males and females with ASD, it is essential to note that there is still a significant need for more research. Having a better understanding of gender differences relative to ASD characteristics will better equip educational professionals in conceptualizing and identifying autism in both males and females with a more holistic view and practice. Future researchers are encouraged to use large, representative samples with sizable female subsamples to better understand these differences in contrast to male-focused foundational autism research (Matheis et al., 2019).

In closing, school and clinical/community-based practitioners are encouraged to use comprehensive and holistic approaches when evaluating all students/clients suspected of ASD. Creating early intervention programs that are more inclusive of females with autism may lessen experiences of adversity later in life. All-inclusive treatment plans can be developed for early intervention through earlier and more accurate diagnoses, especially for females who may be overlooked with more traditional practices. Also, there is a clear argument for more specific and comprehensive diagnostic guidelines and evaluation procedures for ASD in both clinical and school-based settings. This will help to ensure that females are not under-represented in both identification practices and subsequent intervention.


ABIGAIL HOLLOWELL is a second-year graduate student at Youngstown State University studying school psychology. She is also employed as a graduate assistant at YSU. She earned a Bachelor of Science in Education: Intervention Specialist Mild/Moderate from The University of Akron in 2020 and a Masters of Education in Intervention Services from Youngstown State University in 2021. She is passionate about serving students and ensuring they receive the quality and individualized education they deserve. Abigail looks forward to beginning her career as an Ohio school psychologist upon earning her Educational Specialist Degree in School Psychology from YSU.

RICHARD VANVOORHIS, DEd NCSP is an Associate Professor for the Youngstown State University School Psychology Program. He also serves as the Program Director and Internship Coordinator. Prior to his position at YSU, Dr. VanVoorhis was employed as a school psychologist for several years. His research interests include role and function of the school psychologist, job satisfaction of school psychologists, school psychology training/curriculum, parent consultation, and working with families of children diagnosed with low-incidence disabilities.

Author Note: Correspondence concerning this article should be addressed to:
Richard VanVoorhis, D.Ed. NCSP | One University Plaza | Dept. of Psychological Sciences and Counseling | Youngstown State University | Youngstown, Ohio 44555
E-Mail: rwvanvoorhis@ysu.edu
Opioid Abuse in the LGBT+ Population: Contributing Factors and Treatment Recommendations

Anna K. Hayburn, PsyD | Cleveland VA Medical Center

Abstract

A growing body of research has documented a high prevalence of substance use disorders, particularly Opioid Use Disorder, among LGBT+ (lesbian, gay, bisexual, transgender, plus; to include all non-heteronormative and gender diverse) people. There are multiple psychosocial factors that contribute to this disparity, including minority stress, lack of social support, perceptions of substance use as culturally normative, and co-occurring mental/physical health problems. The risk of opioid abuse is magnified when considering the intersection of other identities. Substance abuse treatment is optimal when tailored to the unique needs of the LGBT+ populations, such as promoting an inclusive clinical environment and addressing minority stress within the treatment framework.

EVIDENCE OF DISPARITIES WITHIN THE LGBT+ POPULATION

The 2019 Substance Abuse and Mental Health Services Administration (SAMHSA) National Survey on Drug Use and Health (2020) found that 1.3 million LGB (lesbian, gay, bisexual) adults (9.6% of the LGB population) reported prescription pain reliever misuse, compared to 3.7% of the overall US adult population. Notably, there was also a 9% increase in initiation of prescription pain reliever misuse for LGB people between 2018 to 2019 (SAMHSA, 2019). The survey also found that 11.9% of LGB adults qualified for both a substance use disorder and a mental illness (SAMHSA, 2020). Additional research has found comparable disparities among the LGB population. Schuler, Dick, and Stein (2019) found that rates of lifetime prescription pain reliever misuse were significantly elevated among gay men (19%) and bisexual men (17%) compared to heterosexual men (12%). Bisexual women (25%) and lesbian women (17%) were found to have substantially higher use rates compared to heterosexual women (8.7%) (Schuler et al., 2019). Duncan and colleagues (2019) found that LGB individuals were more likely (20.2%) than their heterosexual counterparts (10.2%) to have used nonmedical prescription opioids. There is a lack of current comprehensive research regarding risk of opioid use for people identifying as transgender, as well as minority categories of sexual orientation beyond LGB. One study by Restar and colleagues (2020) found that 11.8% of a national sample of individuals identifying as young adult transgender females reported nonmedical use of prescription opioids in their lifetime. Benotsch et al. (2013) identified that 23.9% of transgender people within the study’s sample reported use of oral analgesics within their lifetime.

CONTRIBUTING FACTORS

Since research shows that LGBT+ people are generally at higher risk for opioid misuse, it is essential to understand contributing factors in order to have adequate awareness and especially for relevant prevention and treatment considerations. For example, minority stress is considered to be a main contributor for the higher prevalence of substance abuse disorders among the LGBT+ population. The National LGBTQIA+ Health Education Center (NLHEC; 2018) explains the connection; “External stigma can become internalized, leading to identity concealment, self-hate, feelings of worthlessness, and fear of rejection. To escape or mute these challenging emotions, some LGBTQ people turn to opioids and other substances that provide a sense of euphoria or relief” (p. 2).
Navigating minority stress as well as the process of accepting one’s gender identity and/or sexual orientation are unique LGBT+ related stressors that could elevate risk (Felner et al., 2020). Notably, sexual orientation disparities are more pronounced for bisexual adults. Specifically, bisexual women have been found to have the highest rates of prescription opioid misuse (12%) as well as other substance use disorders (Morgan, Feinstein, & Dyar, 2020). Hypothesized contributors include biphobia (even within the LGBT+ community), higher risk of intimate partner violence, and higher rates of poverty (Morgan et al., 2020). Subpopulations within the LGBT+ community may face even greater risk as they experience multiple forms of systemic oppression. As such, intersectional identities (e.g., race/ethnicity, age, disability status, religion) should be taken into consideration for conceptualization and treatment.

Research shows that LGBT+ youth may be at especially high risk of turning to opioids to cope with stigma-related stressors. It is known that one in five such teens report having misused/abused prescription drugs, and sexual minority youth reported initiating opioid misuse at an earlier age compared to sexual majority peers (HRC, 2015; Kecojevic et al., 2012). Risk factors include experiences of childhood abuse, family conflict/rejection, bullying/harassment, and other minority stressors (HRC, 2015; Kecojevic et al., 2012).

One study that interviewed LGBT+ participants in substance abuse treatment programs found that family relationship problems (including lack of emotional support), problematic romantic relationships, experiences of discrimination (heterosexism), internalized homophobia, and history of physical/sexual abuse were commonly reported themes among the population (Sakunpong, 2018). Level of engagement and connectedness with the LGBT+ community could impact overall substance use among adult sexual minority individuals in both negative and positive ways. LGBT+ adults may have easier access to substances if they frequent LGBT+ bars/clubs, which are widely believed to be a safe space for people within the LGBT+ community and therefore a central part of socialization for many within the population. LGBT+ people in a 2018 survey reported perceiving high levels of substance use to be culturally normative (Demant et al., 2018). Additionally, the sense of belongingness derived from engaging in substance use behaviors within the LGBT+ community was viewed to outweigh any negative expectancies or consequences of substance use (Demant et al., 2018).

Notably, COVID-19 restrictions have caused significantly reduced opportunities for connection within the LGBT+ community. This includes not only bars/clubs but also other opportunities for support such as LGBT+ community centers and informal social gatherings. Since many LGBT+ people have limited support and rely on "chosen" families, this could be an added layer to the struggles that accompany the current sense of isolation, leading to increased risk for mental health issues and/or substance abuse (Duncan et al., 2019). It has also been found that opioid use commonly co-occurs with other mental health issues, polysubstance use, and chronic health problems for LGBT+ people (Girouard, Goldhammer, & Keuroghlian, 2019). Depression and suicidal ideation have been found to be mental health concerns that intensify risk of opioid misuse (Morgan et al., 2020). Research is substantially lacking regarding LGBT+ experiences with chronic pain. However, studies such as one conducted by Fredriksen-Goldsen and colleagues (2017) have found that LGBT older adults report higher rates of chronic conditions (including back and neck pain), disability, and mental distress. It can be asserted that minority stress and trauma history could contribute to pain exacerbation secondary to the known relationship between stress and pain; namely, that exposure to stress increases nociceptive system reactivity and is associated with poor outcomes in people with chronic pain (e.g., McHugh et al., 2020).

**NEED FOR TAILORED INTERVENTIONS AND TREATMENTS**

According to a recent study, only 17.6% of substance abuse facilities in the United States have documented LGBT-specific programs, which suggests limited availability despite a well-documented need (Williams & Fish, 2020). This highlights the need for tailored mental health intervention and support within such systems, which could serve as a potential mitigator.

Since the majority of LGB adults reported obtaining prescription pain relievers from family/friends (52.9%) or from a healthcare provider (32.8%), this finding highlights the need for tailored provider education, appropriate pain management practices, and continued state-wide monitoring of opioid prescriptions (SAMHSA, 2020). There are many factors that should be taken into consideration to provide more effective treatment for people within the LGBT+ population. Integrated care models where behavioral health treatment is readily accessible could be one way that could increase accessibility to treatment, improve engagement, and reduce cost.

The standards of opioid use disorder treatment for the general population include a combination of medication-assisted therapy (MAT), counseling, and behavioral health interventions. When prescribing MAT, providers should be aware that MAT can have potentially harmful interactions with certain hormone-modulating medications (NLHEC, 2018). A Provider’s Introduction to Substance Abuse Treatment for LGBT Individuals (2012) published by SAMHSA is recommended as an example of a comprehensive guide for diagnostic and treatment approaches that are tailored to meet the needs of the LGBT+ population as a whole, as well as subpopulations.

To be optimal in their intent, design, and execution, treatment programs should uphold processes that are affirming for the LGBT+ community and provide an environment that promotes inclusivity, such as clarifying pronouns and sexual orientation during the intake process and ensuring that staff/patients know that discriminatory, homophobic, and hostile comments/behaviors will not be tolerated. Consider asking participants about their experiences regarding their...
gender/sexual minority identity to identify both positives and negatives that could be incorporated into treatment. For example, providers could address minority stress (e.g., experiences of discrimination/victimization, identity concealment, isolation), including its impact on risk for relapse (NLHEC, 2018; SAMHSA, 2021). If a program has enough LGBT+ participants, it could provide a voluntary additional group for them which would provide a safe or more cohesive space for discussing minority stress and related issues (SAMHSA, 2012). Of note, LGBT+ individuals may avoid recovery programs such as Alcohol Anonymous due to the valid concern that “many religious institutions denounce or condemn homosexuality” (SAMHSA, 2012, p. 57). However, LGBT+ specific meetings/groups may be available, as well as LGBT+ health centers that could provide treatment/resources, depending on geographic location (SAMHSA, 2012).

From interviews with LGBT+ participants in treatment, Sakunpong (2018) identified main motivators for stopping substance abuse to include social support from family, friends, and treatment staff, as well as the ramifications or often unintended consequences caused by substance abuse (e.g., inability to work). Connectedness with the LGBT+ community in other ways (such as community centers) could serve as a protective factor, since it is known that LGBT+ people often face limited social connectivity as a result of their identity, which could be a risk factor for both substance abuse and relapse (Duncan et al., 2019). There is also evidence that interventions delivered by sexual minority peers, as well as efforts by the program to communicate a positive identification with the LGBT+ community, could improve treatment engagement (Glynn & Van Den Berg, 2017).

Treatment providers should be adequately trained to meet the needs of LGBT+ patients, such as being familiar with common health disparities faced by this population, as well as the many risk factors discussed within this article. To the extent possible, facilities should employ a diverse staff to allow for inclusion of LGBT+ providers and consultants, as well as other minority identities. Applying a trauma-informed approach to care and incorporating minority stress principles within evidence-based interventions are recommended for tailoring treatment to address issues faced by many LGBT+ people (Girouard et al., 2019). Examples of relevant interventions include “facilitating emotional awareness, regulation, and acceptance; empowering assertive communication; restructuring harmful minority stress cognitions; validating the unique strengths of LGBTQ people; and fostering supportive relationships with the LGBTQ community and allies” (NLHEC, 2018, p. 6).

In conclusion, improved awareness of factors that increase risk of opioid abuse among LGBT+ people, combined with a tailored treatment approach and collegial platforms across health professions, can effectively help to address this ongoing disparity and contribute to the overall decline of the current opioid epidemic.

References


References continued


About the Author

**ANNA HAYBURN, PSYD**, is a recent graduate of Wright State University. She is currently completing a postdoctoral residency in pain psychology at the Cleveland VA Medical Center, including the Pain Management Center, Polytrauma/TBI, and the GIVE Clinic which serves transgender veterans. Her psychology training background includes behavioral health in primary care, rehabilitation, and chronic pain settings, with a special interest in sexual and gender minority health disparities and care needs. She is a member of the Psychology Service Diversity Committee and the LGBTQ+ Special Emphasis Program at the Cleveland VA, as well as the Priority One Task Force and LGBT subcommittee through OPA.
Therapeutic Art as Effective Intervention to Provide Trauma Informed Care: An Appeal to the Polyvagal System

Michell Sanchez, LCSW | Kirby Reutter, PhD | Sheresa Wilson-DeVries, MS, MA, PA-C

Abstract

Therapeutic art interventions, as provided with sensitivity, knowledge, and skill, can be utilized to harmonize process and theory from many social and biological sciences. In doing so, these interventions can facilitate healing from trauma in body and mind through a variety of “bottom-up” methodologies. Therapeutic art can offer simple, robust care for almost any age; mitigate internal biological, emotional and mental feedback loops; and address both subconscious and conscious reactions to the social environment. Therapeutic art is an effective tool to promote neuroplasticity and social competency for involuntary populations, low help-seeking clients, and populations with impaired verbal communication. Therapeutic art can also be used as an adjunct to longer term modalities, either as a staple or in brief solution treatment to effectively treat the adverse effects of trauma.

The paradigm of care in health and human services has shifted remarkably due to the Adverse Childhood Events (ACE) study and the awareness of the need to develop and implement trauma-informed care (Felitti et al., 1998; Centers for Disease Control and Prevention [CDC], 2019; Leitch, 2017). The ACE study was a groundbreaking exploration of more than 17,000 individuals which found correlations between childhood experiences (such as abuse, neglect, or household dysfunction) and adult health status, habits, or behaviors. This study, along with vast subsequent research, has demonstrated the profound impact of trauma as a key stressor that shapes the brain, nervous system, and physiology, as well as social / relational interactions (Herzog & Schmahl, 2018). All of these factors lead to impairment in mood, behavior regulation, and comorbid conditions linked with leading causes of death (Felitti et al., 1998; CDC, 2019; Musckett, 2013; Schore, 2003). The evolving development of trauma-informed care has transformed our understanding of how to best address mental, emotional, physical and even spiritual wellness.

Research on trauma-informed care increasingly points to the tremendous importance of understanding how trauma affects manifold aspects of a person, particularly the polyvagal response, comprising affect regulation and social interactions. Healing from trauma starts with empathetically validating painful experiences (Watson, 2016) and facilitating movement through the components / stages of grief, in which the therapist embodies a safe social environment to explore, identify, name, and reframe correlates of trauma and loss (Sprang & McNeil, 1995).

Substantial research in neuroplasticity endorses the reasonable possibility of growth and change after trauma. Yet views on how trauma should be treated and processed have significantly evolved over time. Overemphasis on verbal processing (i.e., recalling details and discussing events repeatedly, recounting the deficits and victimization surrounding traumatic events, or utilizing developmentally inappropriate dialogue) can exacerbate trauma sequelae (D’Andrea et al., 2012; Musckett, 2013; Leitch, 2017). Relatedly, the evolving consensus of data suggests that medication alone as treatment for trauma-related grief and problems is not as effective as therapeutically “working through” trauma and learning skills to develop healthier emotional / cognitive states; this finding especially applies to adolescents and children (Cox et al., 2014).

Polyvagal theory articulates why talk therapy alone is often insufficient. Trauma resides throughout the three layers of the brain and throughout the nervous system (Porges, 2011; Dana, 2018). Since trauma affects the limbic system and other regions / networks of the brain, it cannot be teased out through frontal lobe processing (talk) only. Therefore, effective trauma-informed care holistically ranges from the brain and field of vision (Corrigan & Grand, 2013) to breathing and body movement (van der Kolk, 2015; Porges, 2011; Ogden et al., 2006), including meditation (Tang et al., 2014) and even the spiritual aspects of a person (Levine, 2010).

The creative arts offer a solution to unify the various theories and many methodologies on where trauma lies and how to process it. Creative arts, and more specifically, intentionally guided therapeutic art such as drawing, painting, music, sculpture, etc. offer a promising solution precisely because they integrate various sensory experiences, bilateral brain stimulation (Shapiro, 2014), and even the Brainspotting concept of engaging a visual field that holds the trauma (Grand, 2013). These touch points can be pulled out through the window of the frontal lobe during physical processing via “bottom up” sensory engagement (Grabbe & Miller-Karas, 2017). This entire process is titrated by the therapist, who remains within the client’s window of tolerance, and utilizes as much or as little verbal engagement as needed (Rankin & Taucher, 2011). Therefore, therapeutic art does not in any way need to neglect tried and true components of cognitive behavioral therapy (CBT) or other talk therapies that are effective with a client. In short, therapeutic art can embody a matrix of many effective modalities rolled into one.
The polyvagal theory asserts that humans possess a complex nervous system which responds in sensitive complexity to social interactions based on a hierarchy of nervous system exchanges that scan the social-relational environment and adapt in rank to the perceived risk (Porges, 2011). This powerful yet intricate polyvagal circuit system operates via assorted neuronal paths, depending on the body’s own risk-assessment management system. In a social environment perceived as benign, the ventral vagus signals it is safe to pursue social engagement. If a threat is perceived, flight or flight remains on standby or can be re-activated via the sympathetic nervous system. However, if an individual encounters danger and cannot ascertain the effectiveness of fighting or fleeing, or feels there is no immediate resolution, the freeze response is activated through the dorsal vagus. These many paths (“’poly-vagal’”) are the focus of repair in trauma work. Humans who encounter abuse or neglect are at high risk for erosion of a balanced polyvagal system, resulting in multifaceted dysfunction (Porges, 2011; De Bellis & Zisk, 2014). The traumatized polyvagal system can become hyper- or hyposensitive to danger, become hypervigilant, or begin to default to a freeze response (Porges, 2011).

Activity based (i.e., less verbal) interventions promote engaging and activating problem resolution in novel forms. The traumatized subconscious parts of a person (irrespective of whether the trauma was recent or remote) are linked to the polyvagal response system. As a result, traumatized individuals develop compensatory coping strategies, some effective and some not. For many, the subconscious avoidance of danger may become obsolete and ineffectual; in fact, this avoidance may create even more danger by disrupting healthy social engagement while reinforcing negative perceptions or beliefs, causing a cyclic effect with the nervous system. These feedback loops are both social and chemical, and are often compensated for in less healthy ways by the body or behaviors, pointing back to the ACEs (Porges, 2011).

Therapeutic art interventions have been empirically observed to mitigate pathological polyvagal system responses. Therapeutic arts can deep dive into addressing subconscious beliefs, emotions, biological reactions, and feedback loops embedded in the polyvagal pathways. These interventions employ a new state of safety, dignity and worth by accessing all three layers of the brain via both bottom-up and top-down processes. This methodology can activate the polyvagal nervous system to tease out the strands of trauma laced throughout the body by engaging the visual field, physiological states, limbic system, and bilateral cortical functioning all at once. (Dana, 2018).

Therapeutic art as a treatment modality filled a need for briefer, more solution-focused approaches for highly traumatized populations with lower help-seeking engagement (Jackson, 2015). This approach has also benefited individuals who are largely non-verbal due to age, trauma history, or problems associated with attachment (Malchodi, 2017). These interventions have been implemented in dual diagnosis programs (Steubing et al., 2020); in both prisons (Gussak, 2007) and juvenile justice settings (Ezell & Levy, 2003); for children in protective services (McTavish, 2018); and for migrant populations (Lemzoudi, 2007).

Therapeutic art, delivered in conjunction with empathic, ethical, and culturally/spiritually sensitive care, is positively correlated with self-reported reduction in trauma symptoms and improved mood (Schouten et al., 2014). Recipients further report heightened levels of self-awareness and empathic other-awareness, improved resilience in the face of stress or trauma, enhanced cognitive abilities (Jackson, 2015), and a greater capacity for emotional expression and connection to others (Murray et al., 2010). Pediatric participants of therapeutic art activities (such as writing, drawing, music, dance, film, painting, and sculpture) often gain an alternative means of expressing feelings, vulnerabilities, or insecurities that might have otherwise remained unexpressed or externalized in maladaptive ways (Vise, 2012). For at-risk youth, therapeutic arts can also facilitate cultivation of positive relationships, acquisition of new skills, and participation in prosocial community events (Maschi et al., 2013). Therapists who provided therapeutic art activities in conjunction with other interventions (such as CBT) were able to guide clients using creative means of modeling, problem-solving, stress-reduction, relaxation techniques, imagery, and desensitization (Rosal, 2018). Finally, these interventions can also serve as a framing mechanism which cultivates meaning and empathy, which in turn can become a strength to be shared with others following traumatic events (Greenberg et al., 2018).

Art therapy as a stand-alone modality has mixed reviews of efficacy (Slayton et al., 2010). However, if therapeutic art is provided in conjunction with other evidenced-based models to address the entire polyvagal response, it has significant potential to maximize the best of many treatments in a manner that is simultaneously enjoyable to the client (Dana, 2018). This requires clinical skills partnered with cultural sensitivity, awareness of the complexity of challenges in trauma treatment, and the ability to accommodate the neurodiversity of different clients at various levels of cognitive development. This approach further requires a capacity for reading cues in clients’ affect, breathing, behaviors, and both linguistic and meta-linguistic content (van der Kolk, 2015; Dana, 2018), not to mention their choices in materials and imagery.

The process of guided therapeutic art offers a safe “canvas” to engage the conscious, subconscious and polyvagal hierarchy—but does not insist on dealing only with trauma. On the contrary, this approach allows exploration into past, present and future as equally relevant. Clients can explore emotions, events, ideas, and beliefs through lines and imagery or symbols, regardless of their artistic skill set. These instances of consciousness on paper can be reworked and redefined as many times as needed, with power to redefine them each time. It is the simultaneous literal and virtual context where a person can access their locus of control, a tangible space to address the intangible self, as grounded in real historical events. Here, one has endless opportunity to try, commit to, or discard new ideas, dig for pieces of identity, or assign meaning with the partnership of an committed and engaged therapist.
Therapeutic Art as Effective Intervention to Provide Trauma Informed Care


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**About the Authors**

**MICHELLE SANCHEZ, LCSW** is a licensed clinical social worker with 2 decades of experience working with youth and family-focused agencies, medical clinics, hospice, various academic settings, and the federal government. Michelle provides mental health services for individuals and families of all ages, both locally and internationally. Michelle has provided consultation for faith-based agencies in Texas, New Mexico, and non-governmental organizations in Asia. Michelle is also the author and illustrator of the children’s therapy book, *Aza: The Snail Who lost Her Shell*.

**DR. KIRBY REUTTER, EMDRIA, CDBT, LMHC, MAC** is a bilingual clinical psychologist who contracts with the Department of Homeland Security to provide treatment services for refugees seeking political asylum. Dr. Reutter has presented original research at MIT, provided 4 trainings for the US military, and spoken 4 times at the International Conference on Human Trafficking. In 2018, Dr. Reutter delivered a TED Talk regarding the effects of human trafficking on both brain development and society. Dr. Reutter’s most recent publication is entitled: *DBT Skills Workbook for PTSD: Practical Exercises for Overcoming Trauma and Post-Traumatic Stress Disorder*.

**SHERESA WILSON-DEVRIES, MS, MA, PA-C** has more than a decade of experience in family medicine and completed additional training in addictions medicine in 2017. She has guest lectured Trine University’s physician assistant program, with a particular interest in trauma and addictions. In addition to her adventures in academia and various helping professions, she enjoys adopting goats and children, and experiencing some redemption of her own story in the process.
Abstract

The treatment of schizophrenia has evolved over the past half century in antipsychotic drug development. There has been significant progress in the availability and use of numerous medications. These medications act primarily on dopamine systems. The search for novel and nondopaminergic antipsychotic drugs, to date, has not been successful though numerous development strategies have been pursued which have been guided by various pathophysiological hypotheses. This article examines of the development of antipsychotic medications. It then goes on to review a promising novel therapeutic agent for antipsychotic drug development.

INTRODUCTION

Since the discovery of dopamine as a neurotransmitter in the late 1950s, schizophrenia has been associated with changes in the dopaminergic system. However, the dopamine hypothesis of schizophrenia cannot explain all the symptoms associated with this disorder. Therefore, research has also focused on the role of other neurotransmitter systems in schizophrenia.

Patients with schizophrenia have a poor quality of life and severe functional disability despite treatment with antipsychotic agents (Lieberman & First, 2018). This has been the case since the onset of the use of chlorpromazine; it was first used for the treatment of schizophrenia in 1955 (López-Muñoz, Alamo, et al. 2005). 20 to 33% of schizophrenic patients do not have a response to any antipsychotic drug (Conley & Kelly, 2001). Antipsychotic drugs are associated with side effects which include involuntary motor movements, sedation, weight gain, increases in triglycerides, and diabetes (Huhn, Nikolakopoulou, et al., 2019).

The American Psychiatric Association’s guideline statement for the treatment of schizophrenia recommends that treatment be implemented in the context of a person-centered treatment plan that includes evidence-based nonpharmacological and pharmacological treatments for schizophrenia (Keepers, GA, Fochtman, LJ et al.2020).
Psychologists, particularly those in work in public mental health settings with many schizophrenic clients, tend to have limited backgrounds and understanding of the pharmacological treatment of schizophrenia. This limits the therapeutic alliance between psychiatrists and psychologists in their treatment of schizophrenia. In this paper, an overview of antipsychotic medications for schizophrenia will be reviewed.

**FIRST GENERATION ANTI-PSYCHOTICS**

The original antipsychotic drugs were happened upon largely by chance and then tested for their effectiveness. The first, chlorpromazine, was developed as a surgical anesthetic after an initial report in 1952 (Schatzberg, 2009). It was first used in psychiatric institutions because of its powerful tranquilizing effect.

The use of antipsychotic drugs, beginning in the 1950’s, provided a strategy for the biological treatment of schizophrenia (Seeman, 1987). This led to a search for a primary site for their therapeutic effect. The side effects associated with these anti-psychotic drugs suggested that dopamine blockade was associated with their mechanism of action. Systematic research emerged in the 1970’s with the finding that dopamine pathways were overactive in schizophrenia (Carlsson, 1978). Conventional antipsychotics (termed typical or first-generation antipsychotics [FGAs] (i.e., haloperidol, chlorpromazine), act on the dopaminergic system by blocking the dopamine receptor.

While conventional antipsychotics are efficacious in ameliorating the positive symptoms of schizophrenia (disorganized thought processes, hallucinations, delusions), they have been ineffective in treating negative symptoms and cognitive difficulties such as apathy, lethargy, social withdrawal, anhedonia, impaired attention, memory difficulties, and flat affect.

The search for antipsychotic medications to manage the positive, negative, and cognitive symptoms of schizophrenia led to a new generation of antipsychotic drugs. The atypical antipsychotics (AAP) are also known as second generation antipsychotics (SGAs). A series of SGA compounds, first used in the 1990’s, include clozapine, risperidone, olanzapine, aripiprazole, ziprasidone, and quetiapine (Fleishhacker, 1995).

Although issues regarding medication compliance associated with less adverse side effects was hoped for with SGAs, this has not been the case. As a class, they have a more favorable profile in terms of involuntary motor movements such as tardive dyskinesia, they produce other negative side effects, including hypotension, weight gain, diabetes, an increased risk of stroke, sudden cardiac death, blood clots, and sexual dysfunction (Kane, 2006).

The atypical antipsychotics integrate serotonin, norepinephrine, and dopamine receptors in contrast to typical or first-generation anti-psychotics which bind only to dopamine receptors. Theoretically, this was assumed to impact negative symptoms such as flat affect, and lack of pleasure (anhedonia), along with cognitive memory deficits, but this has not been found clinically (Stahl, 2008).

Neither the first-generation nor second-generation antipsychotics have been the “magic bullet” for the treatment of schizophrenia.

**THE MUSCARINIC HYPOTHESIS OF SCHIZOPHRENIA**

The muscarinic hypothesis of schizophrenia postulates that the muscarinic acetylcholine system plays a crucial role in the pathology of schizophrenia. Several lines of recent evidence suggest an involvement of a cholinergic dysfunction in the psychopathology of schizophrenia (Raedler et al., 2003). Positive and negative symptoms as well as cognitive symptoms are potential targets for cholinergic muscarinic receptors in schizophrenia.

It is interesting that betel nut chewing is a widespread practice in some Asian and Pacific cultures (Sullivan RJ, Andres S, Otto C, et al. 2007). In schizophrenia, betel nut chewing has been associated with fewer positive and negative symptoms. These findings are of special interest in this context, as some psychoactive components of betel nut, arecoline, are muscarinic receptors.

In a treatment study a combination of the muscarinic receptor agonist xanomeline and the anticholinergic agent trospium resulted in significant reductions in the degree of positive, negative, and cognitive symptoms in schizophrenic patients. Additionally, treatment with the combination of xanomeline-trospium was not associated with a high incidence of adverse side effects such as involuntary motor movements or weight gain (Brannan et al., 2021).

Xanomeline is an oral muscarinic cholinergic receptor that has no direct effects on dopamine receptors. Trospium, is an anti-cholinergic drug, that is approved for the treatment of overactive bladder in the United States and in Europe.

To summarize, the cholinergic-muscarinic hypothesis is an addition to existing neurotransmitter theories of schizophrenia and offers a potentially new approach for the psychopharmacological treatment of schizophrenia. A long journey to find an effective treatment for a disorder that is as complex as any in medicine.
References


About the Author

ALAN DUBRO has a PhD in Clinical Psychology and a Master’s degree in Clinical Psychopharmacology. He has been a practicing psychologist for over 30 years. He is a proponent of prescription privileges for psychologists; the main motivation to serve clinical populations in underserved areas. His son, fellow psychologist, and research collaborator, Jared Dubro, began the work with him on this paper in 2015, but did not live to see its completion. In spirit, Jared will always be a collaborator on all future collaborations, and to whom this paper is dedicated.
The Effect of Beliefs about Effort on Empathic Effort

Keegan Early | School of Psychology, Xavier University

Abstract

Empathy plays a key role in healthcare settings. The effect of an effort belief manipulation on empathy (likelihood of volunteering) after a cognitively exhausting task was examined. Participants who were told effort is costly did not report a lower likelihood of volunteering for a cancer campaign compared to participants told effort is valuable. However, the effort is costly group scored higher on a cognitive exhaustion measure than the effort is valuable group. This finding suggests a potential link between effort beliefs and amount of cognitive exhaustion reported after a demanding task. These findings also suggest a distinction between effort beliefs and willingness to volunteer after a cognitively exhausting task. A better understanding of the relationship between effort and empathy may strengthen interprofessional alliances and increase positive patient outcomes.

Mental and physical health issues are on the rise (Bloom et al., 2011; Reinert et al., 2020). As a result, more individuals are seeking support from healthcare professionals such as physicians, nurses, and psychologists, and interprofessional alliances among such individuals can have real consequences for patient outcomes (Denton & Conron, 2016). Empathy from practitioners, regardless of area of expertise, benefits individuals seeking treatment (Hojat et al., 2011; Kim et al., 2004). Research has focused on investigating two competing hypotheses regarding empathy (Batson et al., 1991). The empathic-joy hypothesis states that people show empathy towards others because they gain satisfaction from seeing another’s improvement. The empathy-altruism hypothesis states that people show empathy towards others regardless of the empathizer’s satisfaction.

When given choices about the likelihood that an empathizer would receive personal satisfaction, Batson et al. (1991) found people chose empathy and helping another person regardless of the empathizer’s likelihood of personal satisfaction. However, being empathetic, or not, is a choice that people make. Cameron et al. (2016, 2019) and Ferguson et al. (2020) portray effort as discouraging people from making empathetic choices only if those choices have more emotional and cognitive demands. Inzlicht et al. (2018) posits that although effort is costly, it is commonly associated with reward and thus adds value to effort. However, a greater possible reward may not apply to empathy as research suggests people tend to choose empathy regardless of personal satisfaction (Batson et al., 1991). Effort itself also has value and can still motivate people toward choices demanding more effort (Inzlicht et al., 2018). This finding illuminates an inconsistency in the literature on empathy and effort. Empathy costs emotional and cognitive effort (Cameron et al., 2016, 2019) that can push people away from making empathy choices, but effort itself is also valuable and can motivate people toward more demanding choices (Inzlicht et al., 2018).

Regarding choices people make, the law of least mental effort applies. This law states that people tend to choose tasks that demand low cognitive effort over tasks that demand high cognitive effort. Researchers found that when people make choices, they anticipate the cognitive demands of each task, and the anticipated cognitive demand directly affects decision making (Botvinik et al., 2009; Kool et al., 2010). In a fast-paced practice setting where multiple practitioners are coordinating, the cognitive demands may be high. The same costs investigated in research on choice have also been examined in relation to empathy. Recent studies have found that empathy does in fact have emotional and cognitive costs (Cameron et al., 2016, 2019; Ferguson et al., 2020).
Beliefs about Effort on Empathic Effort

People anticipate both the emotional and cognitive costs of showing empathy and helping others. Thus, people’s choices of whether to show empathy and help others are directly influenced by anticipated emotional and cognitive costs.

The goal of the present study was to investigate how manipulated perceptions of effort as either costly or valuable affected participants’ willingness to volunteer after completing a cognitively exhausting task. Although effort as a variable is difficult to define (Steele, 2020), empathic effort was defined as willingness to volunteer for a cancer campaign. It was hypothesized that participants who were told effort is costly would indicate a significantly lower likelihood of volunteering compared to participants who were told effort is valuable.

METHOD

PARTICIPANTS
Participants were a convenience sample of 72 undergraduate students recruited through a research participant pool, with a final sample of 65 participants due to failed manipulation checks. Participants received 30 min of research participation credit.

MATERIALS
Fictitious Article on Effort Belief. Participants received one of two 1-page fictitious articles written by the researcher to manipulate effort beliefs. One article described effort as costly and to be avoided. The other article stated that effort is valuable and to be pursued.

Cognitive Exhaustion Exercise. The cognitive exhaustion measure consisted of an online Stroop test (“Cognitive tests: Color Reading Interference”) which was a modified version of the original Stroop test (Stroop, 1935). In the online version, words were presented one word at a time on a screen. Participants pressed the key on the keyboard that corresponded to the first letter of the color of the word (e.g., if the word blue were in red, participants would hit the r key for red) as fast and accurately as they could. Each Stroop test lasted 2 min. After the 2 min test, participants received a 30s break and repeated the test. Participants completed a total of five tests. Previous research (Brown & Bray, 2017) has shown this sequence to induce cognitive exhaustion.

MEASURES
Cognitive Exhaustion Measure. This measure consisted of five items that identified whether the cognitive exhaustion exercise successfully induced cognitive exhaustion. This measure was a modified version of the NASA Task Load Index (Hart & Staveland, 1988). Each item (e.g., “This task was mentally demanding”) was rated on a 7-point Likert scale ranging from “Strongly Disagree” to “Strongly Agree.” Cognitive exhaustion scores were calculated by totaling the responses for each participant. Higher scores indicated more cognitive exhaustion.

Empathic Effort Measure. A volunteer flyer described a campus mental health campaign that was modified from Schuman et al. (2014) in which participants read about a cancer campaign. The empathic effort measure consisted of rating three items related to the mental health campaign. The measure identified participants’ willingness to volunteer in general, by working at an information booth and facilitating a support group. Each item (e.g., “How likely would you be to volunteer by running the information table”) was rated on a 7-point Likert scale ranging from “very unlikely” to “very likely.”

PROCEDURE
After participants read an informed consent form, they received the effort belief manipulation. Participants were randomly assigned to read a fictitious article concluding that effort is costly and should be avoided, or a fictitious article concluding that effort is valuable and should be pursued. Next, participants began the Stroop test trials to induce cognitive exhaustion, followed by completing the cognitive exhaustion measure. Participants then read a volunteer flyer and completed the empathic effort measure and demographic form.

RESULTS
For volunteering in general, participants in the effort is costly condition (M = 4.07, SD = 1.68) did not have significantly lower empathic effort scores compared to participants in the effort is valuable condition (M = 3.84, SD = 1.69), t(63) = .55, p = .58. For working the information booth, participants in the effort is costly condition (M = 4.11, SD = 1.89) also did not have significantly lower empathic effort scores compared to participants in the effort is valuable condition (M = 3.67, SD = 1.83), t(63) = .92, p = .35. Finally, for facilitating a support group, participants in the effort is costly condition (M = 3.43, SD = 3.36) did not have significantly lower empathic effort scores compared to participants in the effort is valuable condition (M = 2.84, SD = 4.46), t(63) = 1.16, p = .24.

See FIGURE 1 on page 33

Although there was no a priori hypothesis regarding cognitive exhaustion and the effort manipulation, an exploratory analysis revealed that participants in the effort is costly condition (M = 21.50, SD = 3.36) had significantly higher cognitive exhaustion scores than participants in the effort is valuable condition (M = 19.43, SD = 4.46), t(63) = 2.05, p = .04.
Beliefs about Effort on Empathic Effort

FIGURE 1
Empathetic Effort Scores for Each Empathy Item as a Function of the Effort Manipulation

DISCUSSION

The current research investigated willingness to volunteer after an effort belief manipulation and a cognitively exhausting task. The current research was based on previous findings that suggest empathy requires effort (Cameron et al. 2016, 2019), that effort can be both costly and valuable (Inzlicht et al., 2018), and that a series of Stroop tests is cognitively exhausting (Brown & Bray 2017). Contrary to the hypothesis, the results indicated that believing effort is costly or valuable does not affect willingness to volunteer. Thus, effort beliefs may not play a central role in choosing empathy. However, effort beliefs may play a role in experiencing cognitive exhaustion based on the results of the current study. With respect to interprofessional alliances, a health care professional’s belief about effort may affect their experience of cognitive exhaustion when working in a team. These findings and interpretations should be considered with caution given the homogenous sample and laboratory setting of the present study. The study was conducted with undergraduate students, using a survey about hypothetical situations, thus like many other empathy studies, the results may not be generalizable to everyday life (Depow et al., 2021).

Given the previously mentioned mixed evidence (Cameron et al. 2016, 2019; Inzlicht et al. 2018), more research is needed to investigate how effort beliefs affect empathy and helping others. The inconsistency in the literature about empathy and effort can be seen in everyday life. A person may choose empathy despite its costs in one situation and avoid empathy entirely in another. Further research into effort and empathy can reconcile the inconsistency in the literature as well as further our understanding of why people make empathic choices in certain situations. Empathy is important for patient outcomes (Hoiat et al., 2011; Kim et al., 2004) and creating social connections (Depow et al., 2021), which are essential for interprofessional alliances. A better understanding of the complex relationship between empathy and effort may reveal ways to create and strengthen interprofessional alliances as well as produce better health outcomes for patients.
Beliefs about Effort on Empathic Effort

References


About the Author

KEEGAN EARLY is a senior psychology major at Xavier University in Cincinnati. He is a student affiliate of the APA and a member of The International Honor Society in Psychology (Psi Chi). He plans on attending graduate school for a PhD in clinical or counseling psychology to work with older adults. He is currently working on research investigating the portrayal of older adults in undergraduate introductory psychology textbooks.
**CHRONIC MUSCULOSKELETAL PAIN**

Chronic musculoskeletal pain can cause muscle weakness, functional decline, mobility limitations/difficulties, and a decrease in neuromuscular response (Leveille et al., 2009). Furthermore, special attention is given by healthcare providers to lower limb weakness which can cause slower gait, and decreased mobility and pain (Arnold & Faulkner, 2007). Leveille et al. (2009) found that osteoarthritis was the main disease contributing to joint pain, especially knee pain. A lack of movement or a direct effect of the pain can create a reflex muscle inhibition (Leveille et al., 2009). Unstable balance is commonly caused by gait alterations, adaptations and/or weight shifting (Arnold & Faulkner, 2007; Leveille et al., 2009). Cai et al. (2021) studied the relationship between foot reaction time and chronic musculoskeletal pain determining there is indeed a relationship between pain and falls in older adults. Finally, there is an increase in sedentary behaviors along with decreased cognitive functioning, such as executive functioning and attention (Stubbs et al., 2014a). In sum, the consequences of pain are far reaching, falls being a significant one, making treatment of pain as a pathway to fall prevention an important course of action.

**FALLS**

“Falls rank among the 10 leading causes of death in older adults in the United States” (Leveille et al., 2009, p.2214). Most falls seem to occur during the beginning years of musculoskeletal pain which could be due to an overcompensation to the chronic pain experienced (Leveille et al., 2009). More falls are seen in those with early indications or diagnoses of osteoarthritis in the hips (Arnold & Faulkner, 2007). Falls are positively correlated to age and the risk of death or serious injury (Naseri et al., 2020). In addition, the likelihood of another fall increases once being hospitalized from a fall (Naseri et al., 2020). Stubbs et al. (2014a) found that fear of falling was the largest single factor to an increase in sedentary behaviors. Finally, the risk of falls increases with lower limb arthritis with 80% of falls occurring during ambulation specifically during incline/decline on stairs (Arnold & Faulkner, 2007).

**RECOMMENDATIONS FOR PROVIDERS**

Research suggests, that using a multimodal treatment approach can help maximize patients’ potential for prevention or management of falls (Carrington et al., 2015; Morone & Greco, 2007). This approach can be done through incorporating physical exercise and structured exercise and prioritized as essential non-pharmacological approaches (Stubbs et al., 2014a; Carrington et al., 2015). Keeping in mind that medication may be beneficial, options should also include consultation with a medical team to assure that appropriate attention to evidence of overuse or underuse which can further contribute to falls (Leveille et al., 2009). In addition, when increasing physical activity, it is recommended to consult with a physician if cardiovascular health is a comorbid concern (Stubbs et al., 2014a). Options for exercise can include psychologically driven interventions such as “mind-body interventions [such as] biofeedback, progressive muscle relaxation (PMR), meditation, guided imagery, hypnosis, and complementary alternative medicine (CAM) strategies such as tai chi, qi gong, and yoga” (Edeer & Tuna, 2012, p.104; Morone & Greco, 2007). These interventions have all shown to help decrease pain and increase mobility (Morone & Greco, 2007). Biofeedback has led to reduced chronic low back pain, headaches, and rheumatologic associated pain (Morone & Greco, 2007). PMR has shown to improve headaches and muscle function but does not decrease pain except when paired with meditation, exercise, nutrition, and cognitive approaches (Morone & Greco, 2007). Meditation has shown some improvements in pain as well as mood for those with lower back pain (Morone & Greco, 2007). Guided imagery has shown an increase in mobility and a decrease in pain for women with osteoarthritis when combined with PMR (Morone & Greco, 2007). Hypnosis has shown a reduction in
Chronic Musculoskeletal Pain

pain and was more effective when combined with relaxation techniques (Morone & Greco, 2007). Tai Chi and Qi Gong have provided improvement in joint pain and stiffness, and physical function, but does have a high dropout rate according to Morone & Greco (2007). Yoga has shown improvement in hypertension and psychological well-being with a reduction of pain (Morone & Greco, 2007). Although little research has been done with older adults for all mind-body interventions, the research that has been done demonstrates its feasibility in older adult populations (Morone & Greco, 2007). Many of the above mentioned interventions are skill sets found in psychology and thus can be offered by clinical psychology. And with additional training and/or collaboration with providers of CAM, psychology has an opportunity to work in tandem towards a wholistic and integrated treatment approach.

Research also has found that attention to discharge following a fall related admission critical to fall prevention. Moreover, patient focused discharge interventions at the hospital after a fall, seem to strongly influence the participants mindset around fall prevention behaviors (Naseri et al., 2020). However, Naseri et al. (2020) believe this alone is not enough. This intervention needs to include communication with the patient’s social support system whether it be a partner or family member. Most importantly the patient needs to understand their associated fall risks and liabilities such to make safe choices (Naseri et al., 2020).

RECOMMENDATIONS FOR PATIENTS

Wholistic care of patients needs to be collaborative and therefore, foster active participation and promotion of personal agency around fall preventions. Therefore, research recommends that patients should encouraged to identify and participate in safe exercise and physical activity to help prevent and manage their chronic musculoskeletal pain (Morone & Greco, 2007; Stubbs et al., 2014a; Stubbs et al., 2014b). When conducting daily activities patients are well advised to understand independent living as also learning how and when to seek assistance when needed (Morone & Greco, 2007). Regarding the home, it is suggested that home hazards be identified and modified to ensure a safe moving environment (Naseri et al., 2020). Patients should consider asking about mobile technology options such as apps and remotely accessible healthcare support, as mobile technology can be a key intervention for healthy aging (Parker et al., 2013). Examples of mobile technology include such things as calendars, software applications (apps) and medication reminders, all of which could aid in the ease of pain monitoring (Parker et al., 2013).

Patients and providers should remember that there may be both “barriers and enablers to engagement in fall prevention activities” (Naseri et al., 2020, p.1712). Figure 1 suggests these may include understanding the psychological capability of present memory, attention and decision processes, physical and social opportunities available, and present reflective and automatic motivation (Naseri et al., 2020). This research offers, it is important to remember that knowledge equals capability (physical and psychological), meaning equals motivation, and circumstances equal opportunity (Naseri et al., 2020). Overall, these recommendations provide an integrative approach that illustrates how psychologists are an integral part in psychoeducation and assisting in preventing and managing falls in older adults with chronic musculoskeletal pain.

Figure 1.
Enablers and Barriers.
From “Perspectives of Older Adults Regarding Barriers and Enablers to Engaging in Fall Prevention Activities after Hospital Discharge,” by C. Naseri et al., 2020, Health & Social Care in the Community, 28(1), p. 1715. Copyright 2020 by Health & Social Care in the Community. Reprinted with permission.
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About the Authors

ASHLEY MURPHY is a 3rd year graduate student of the PsyD program at Wright State University School of Professional Psychology with an emphasis on primary care/rehabilitation/health psychology. She received her Bachelor of Science degree in Biopsychology from Ohio Dominican University in 2018. Her current dissertation research involves program development of an app that incorporates chronic pain and trauma. She has a strong passion to help older adults and those struggling with chronic pain.

JULIE L. WILLIAMS, PSYD, ABPP is a Professor of Psychology at Wright State University, School of Professional Psychology in Dayton Ohio, and is Board Certified in Rehabilitation Psychology. When not teaching or providing clinical care, she is writing poetry and engaging in social activism. As a professor of clinical psychology she teaches about the struggle for inclusion, equity, and justice as the source of marginalization and suffering in the disability community and beyond. She strives to speak her truths and teach students passionately how to do the same and locate their work at the source of suffering. She works to teach how to create and sustain clinical spaces that celebrate the mind/body in all its forms and a model of care that is wholistic and liberatory. She is known to challenge herself, her students and colleagues to be brave and willing to change things that need to be changed for the betterment of humanity. She identifies as a survivor of ableism, hard of hearing, a member of the chronic pain community, Dwarf, and queer. She also identifies as privileged as a cisgender woman, White, and economically comfortable individual.


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Article: Interprofessionalism as a Cross-Cutting Skill... (pg.4)
Which of the following is not included as a core competency for Interprofessional Collaborative Practice identified by IPEC (2016)?
   a) Values/Ethics
   b) Roles/Responsibilities
   c) Informational Technology
   d) Interprofessional Communication
   e) Teams and Teamwork

Article: Medical-Legal Partnership... (pg.7)
Medical-legal partnerships have been shown to have a significant impact on which social determinants of health?
   a) Increased access to protective orders against a violent partner
   b) Decreased stress and improved wellbeing
   c) Improved access to primary care for transgender patients
   d) All of the above

Article: Coming Together ... (pg.9)
As public advocates for our profession and those we serve, we can support “Health in All ______ initiatives,” which integrates social determinants of health into policymaking across sectors.
   a) Policies
   b) Laws
   c) Societies
   d) Rules

Article: Ethical Considerations in Supervising... (pg.12)
Whose competence should be considered before undergraduate internships are arranged?
   a) The student's
   b) The professor/faculty supervisor’s
   c) The site supervisor’s
   d) All of the above

Article: Autism Spectrum Disorder in Females... (pg.16)
Mental Health practitioners are encouraged to consider the following when evaluating a female suspected of ASD:
   a) Factors which contribute to identification errors
   b) Identifying and treating observable systems
   c) Identifying and treating covert characteristics
   d) All of the above

Article: Opioid Abuse in the LGBT+ Population... (pg.20)
______ is considered to be a main contributor for the higher prevalence of substance abuse disorders among the LGBT+ population.
   a) Genetics
   b) Minority Stress
   c) Depression
   d) Childhood Abuse

Article: Therapeutic Art as Effective Intervention... (pg.24)
According to the polyvagal theory:
   a) Trauma affects the prefrontal cortex, but not the limbic system
   b) Trauma affects the sympathetic nervous system, but not the parasympathetic branch
   c) Trauma affects all regions of the brain and both branches of the nervous system

Article: Psychopharmacology of Schizophrenia... (pg.28)
On average what percentage of patients do not respond to any antipsychotic medication?
   a) 5 percent
   b) 15 percent
   c) 20 percent
   d) 30 percent

Article: The Effect of Beliefs about Effort... (pg.31)
On which item of the Empathic Effort Measure did the effort is valuable group report a higher empathic effort score?
   a) Volunteer in general
   b) Volunteer at the information booth
   c) Volunteer at the support group
   d) None of the above

Article: Prevention and Management of Falls... (pg.35)
What type of treatment approach is recommended to help maximize patient’s potential for prevention or management of falls?
   a) Physical exercise
   b) Structured exercise
   c) Multimodal
   d) Medication management
   e) Psychologically driven interventions
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