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The theme of this year’s publication is “A New Social Consciousness Informing our Research and Practice.” One definition of social consciousness is to be aware of those around us in society. Increasing our own social consciousness in our personal and work lives can only have positive results. We can find individuals who may require help and offer assistance. We could notice situations in which imparting words of kindness and gratitude to others would be very beneficial. It is also possible to recognize appropriate circumstances to advocate for others who need that support. Just as building social consciousness in our personal and work lives can lead to pleasant results, doing so in the realm of research and practice can be just as useful to ourselves and the field. This year’s published articles illustrate a number of ways in which social consciousness was utilized and incorporated into research and practice.

When it comes to the workplace, Schultz and Dragon provide discussion and suggestions for developing professionalism in Cultural Considerations in the Development and Maintenance of Professionalism in Health Service Psychology. Increasing social justice in school psychology training programs can also increase social consciousness in the field or workplace, which is described by Hollowell et al. in Leaning into Difficult Conversations through a Social Justice Book Club.

Bringing attention to select populations is another way for social consciousness to inform practice. Emick and Catanese discuss how to address the needs of individuals associated with individuals diagnosed with autism in Autism Family Navigation: Promoting Access to Services and Treatment for All. From there, Seccia offers support to siblings of those with chronic health conditions in The Psychological Impact of a Chronic Health Condition on Siblings.

One of the empirical articles in this year’s publication represents the use of social consciousness to inform research. LaRue et al. describe a study examining the impacts of clinician bias when diagnosing personality disorders in Misdiagnosing Borderline Personality Disorder in Correctional Settings: Does Clinician Bias Influence Diagnostic Decision-Making?

This publication concludes with discussions regarding access to resources. VanVoorhis et al. recognize a need to increase access to mental health services in rural areas in Promoting Equal Access to Mental Health Services in Rural Ohio: Perspectives Through a Social Consciousness Lens while Nedelman et al. describe a call to increase access for psychologists to updated professional literature and research in Lost in the Wild: When Psychologists Cannot Access Research.

I hope every reader gains something by reading this publication. There are so many ways to increase social consciousness in any aspect of our lives whether it be personal or social, through the work we do, or in the research we create. Use these articles as motivation to increase the sense of social consciousness in your own lives no matter your current level.

Until next year,
Keelan
The OPA Communication & Technology Committee is calling for manuscripts to review for the 2023 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 following types of articles will not be accepted:

- Brief reports
- Book reviews
- Comments on and replies to previously published articles
- Opinion pieces or commentaries

For more information on what each of the types of articles entails, refer to APA’s Publication Manual (7th Edition).

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 2023 theme, “Hope, Healing and Resilience in Today's World” 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 12, 2023. 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.
Cultural Considerations in the Development and Maintenance of Professionalism in Health Service Psychology

Michelle S. Schultz, PsyD | Wendy R. Dragon, PhD
Wright State University

Abstract

As health service psychologists, it is crucial to consider how professionalism has evolved within health service psychology as well as how socialization into the profession is conducted and how these processes impact the individual. Psychologists must be aware of their own areas of privilege, and mindful of where their own backgrounds are represented in the historical culture of the profession. Failing to do so can potentially serve to marginalize colleagues, trainees, and students from differing backgrounds. In addition, it is important to consider how to support diversity within the profession and serve as allies and advocates in creating an inclusive professional culture and conceptualization of professionalism. This article discusses ways in which to achieve this end.

As health service psychologists, it is crucial to consider how professionalism has evolved within health service psychology reflecting social-class and gender issues that have historically been defined by middle- to upper-class white male norms (Adamson & Johansson, 2016; Hall, 2005). Factors that have been associated with professionalism in our field include the development of a professional identity (e.g., thinking like a psychologist), evidencing behavior and comportment that reflect the values and attitudes of health service psychology, refining interpersonal and self-reflective skills as defined by the profession, and internalizing standards of the profession (e.g., ethics, diversity; American Psychological Association, 2011; Elman, Illfelder-Kaye, & Robiner, 2005). Some of these standards may be seen as more unique to the job of a psychologist (i.e., self-reflective skills), whereas others are more likely to be influenced by the values of those who are already in charge (e.g., some expectations around comportment, interpersonal skills). Still, other standards may be recognized, defined, or ignored depending on the experience of those who are in control (e.g., consider how recently the American Psychological Association released a statement apologizing for their role in “promoting, perpetuating, and failing to challenge racism, [and] racial discrimination”; [American Psychological Association, 2021] despite issues around race being present in the field since the inception of that organization).

More recently, professionalism has been defined as:
(a) accountability (acting with responsibility, commitment, and appropriate comportment), (b) ethical engagement (being honest and trustworthy, acting with integrity, courage, and in accord with ethical and moral standards), (c) self-reflection (demonstrating openness, self-awareness, and thoughtfulness in the self-evaluation process; being committed to self-care and engagement with competence constellation), (d) excellence (doing one’s best and pursuing continued professional development and lifelong learning), (e) humanism (being caring, compassionate, and respectful of others’ dignity and choices), (f) civility (acting in good faith and with respect in interactions with others and seeking mutual understanding and common ground in the face of differences), (g) collaboration (engaging in productive communications and working effectively and collegially with others), (h) cultural humility (maintaining an other-oriented interpersonal stance vis-à-vis aspects of cultural identity significant to others, reflecting on one’s self as a cultural being, aware of one’s limitations in understanding others’ cultural background), (i) psychology’s social contract with society (having a sense of obligation to function competently for the discipline and profession and the publics psychologists serve), and (j) social responsibility (demonstrating altruism and a commitment to service, advocating on behalf of others, and being fair and ethical stewards resources). (Grus et al., 2018, p. 452)

Most of these standards may be consistent with prior conceptualizations of professionalism. However, the inclusion of standards such as cultural humility and social responsibility calls us to rectify some of the problems of our past by asking us to openly recognize our own limitations around the clients that we serve and the students that we train. Currently, graduate education and mentoring of early career psychologists (ECP) typically focuses on both the development of skills related to the profession’s specified work functions and professionalism, as these are overlapping constructs. Students and ECPs are taught not only what to do, but also how to “think and act like” others within health service psychology. Students and ECPs are frequently evaluated not only by their knowledge of health service psychology’s norms but also by how well they ascribe to those norms. Consideration for the individual’s intersectional identities and diversity context (e.g., social class, gender, race, ethnicity, sexual orientation, and ability) and/or previous exposure to...
professionalism (i.e., status as a first-generation student/professional) and the historical context/cultural underpinnings of professionalism is not always taken into consideration when professional development activities or evaluations are undertaken. By not considering the influence of culture and context on the definition and evaluation of professionalism within psychology, certain individuals and/or groups may be excluded from and/or devalued within the field.

As colleagues, educators, supervisors, and mentors, it is crucial to consider how professionalism has evolved within health service psychology as well as how socialization into the profession is conducted and impacts the individual. For example, issuing feedback on “professional dress and style” should take into consideration cultural norms and financial means of the individual along with appropriateness for the practice setting and historically defined appropriate attire. Psychologists need to be mindful of where their own backgrounds are represented in the historical culture of the profession and how that can potentially serve to marginalize individuals from differing backgrounds. In addition, it is important to consider how to support diversity within the profession and serve as allies and advocates in creating an inclusive professional culture and conceptualization of professionalism.

What would redefining inclusivity and professionalism look like?

As a means of creating an inclusive professional culture and conceptualization of professionalism, we encourage health service psychologists to engage in their own self-reflective practice prior to giving feedback to others on their perceived professionalism. At a foundational level, we each need to unpack the messages and feedback we received during our training and early career experiences regarding professionalism. We should pay close attention to areas where this feedback was similar to the messages we received in our homes and communities. If the messages we received in professional spaces resembled messages that we received from our homes and communities, we should be aware that we may be less likely to recognize how privilege influences our views. Through self-reflection, we may gain an understanding of how these messages and feedback impacted our development and shaped our personal beliefs about professional conduct. Further reflection will help us to understand how those beliefs impact the feedback we give to others. It may also require acknowledging how we were hurt in our developmental process and finding ways to heal. Further, we recommend asking ourselves “What does this factor have to do with the individual’s competence?” and/or “How does this factor negatively impact the person from delivering appropriate, effective services?.” If we do not have clear answers to these questions, we need to consider whether we are truly addressing a professionalism issue or perpetuating historically exclusionary practices.
About the Authors

WENDY R. DRAGON, PHD is an associate professor at Wright State University’s School of Professional Psychology (SOPP). She has presented nationally about decreasing the impact of weight stigma in clinical care and about considerations of diversity in supervision. She has supervised doctoral students in delivering standard and dialectical behavior therapy to a diverse clientele. Currently, she supervises doctoral students in assessment through Psychological Assessment Services at Wright State University. She advises doctoral students with dissertations topics on using dialectical behavior therapy with multicultural populations and those with diverse clinical needs. At SOPP, she teaches Psychopathology, Objective Personality Assessment, and Forensic Assessment.

MICHELLE S. SCHULTZ, PSYD is an associate professor in the School of Professional Psychology and has served as program’s associate dean and director of clinical training. She teaches courses in supervision, practice management, trauma, intervention, and assessment. Additionally, she supervises doctoral-level psychology trainees providing psychological services. She completed internship and postdoctoral experiences in treating adolescents and children who experience trauma and/or exhibit disruptive behavior. Areas of interest include child, adolescent and family psychology (therapy and assessment), clinical training, program development, and diversity competence. Specific areas are youth in the juvenile justice system (with special attention to the needs of girls and those with mental health issues), trauma, Non-Suicidal Self Injury (NSSI), emerging adulthood and identity development, women’s issues, clinical supervision, professional development, and diversity competence (specific focus on the intersection of social class, gender, and ethnicity). She engages in private practice consistent with her clinical interests.
Leaning into Difficult Conversations through a Social Justice Book Club

Abigail G. Hollowell, MEd | Carrie R. Jackson, DEd | Marissa Cashbaugh, BSEd

Abstract

In order to be an effective school psychologist and advocate for students and families, it is imperative that practitioners are prepared to work with the diverse population of students attending K-12 schools. This includes the ability to provide equitable services designed to meet the needs of all learners. How can school psychology training programs prepare candidates for social justice work upon entering the field? This nonempirical article provides suggestions for establishing social justice book clubs in order to enhance candidate knowledge of equity and inclusion, as well as to prepare candidates for practicing social justice practice in their work with students and families upon entering the field.

Social justice refers to a society’s need to treat all individuals equitably. In education, this entails providing students with equitable educational experiences by overcoming barriers presented by race, ethnicity, gender/gender identity, sexual orientation, socioeconomic status, disability, immigrant status, and national origin. To achieve this, diversity of students must be acknowledged and celebrated, with educators challenging the inequalities experienced by marginalized groups. The National Association of School Psychologists (NASP) Professional Standards (NASP, 2020) promote the implementation of evidence-based strategies to enhance equitable service provision and social justice work within both general and special education and to ameliorate the impact of systemic barriers present in schools. García-Vázquez et al. (2020) advise school psychologists to recognize stress, acknowledge and confront internalized racism and implicit biases, advocate for marginalized students, and strive toward equity for all students through culturally-responsive practice.

While coursework can provide school psychology candidates didactic instruction around social justice, it is through ongoing dialogue and shared experiences that candidates can meaningfully explore these issues. To better understand and embrace the task of social justice work, educators must understand the historical context, current circumstances, and school policies that have given rise to inequity. Through both course work and experiences with diverse student populations in the field, school psychology candidates recognized the need to advocate for social justice in the schools and communities they serve and inspired them to enhance their knowledge base and skills accordingly. However, multiculturalism is a complex issue that is often not able to be explored in depth due to time constraints imposed by the rigorous curriculum of a specialized course of study, necessitating additional time outside of class be spent on examining the needs of historically underrepresented groups.

SOCIAL JUSTICE BOOK CLUBS

Book clubs offer experiential learning opportunities that may lead to benefits including increased self-awareness, appreciation for differing points of view, cultural awareness, compassion, and communication skills (Kholkhlova & Bhatia, 2021). One fundamental benefit of a book club is that it allows participants to choose topics of interest and importance to its members. Book clubs allow participants to enrich their knowledge through discussing learned topics in a more connected manner and encourages generalization of concepts into real-life contexts (Kholkhlova & Bhatia, 2021). This solution-oriented focus on preparedness is a large part of what allows a book club to help develop cultural competence in a way that may be applied in a professional setting. Rodriguez et al. (2022) found that such professional development activities helped to promote affirmation, awareness, resource sharing, knowledge, and transformative action.

ESTABLISHING BOOK CLUBS

The first iteration of the Social Justice Book Club at Youngstown State University (YSU) was founded by candidates who found inspiration following a conference illustrating the importance of social justice. The goal of the book club was to provide candidates an opportunity to explore new ideas and perspectives, enhance cultural competence in serving a diverse student population, and promote empathy and understanding in interacting with students, families, and colleagues.

An email invitation was sent to interested candidates describing the goals of book club, the estimated time investment, and potential readings. To maximize participation, candidates were surveyed on which dates and times would work best for meetings. Opportunities to select and vote on books of interest were also provided to ensure the selections were relevant to the goal of book
club discussions. Sylvan (2018) indicated that book clubs allow students to feel empowered by selecting books and to be inspired by the relationship between class content and professional experiences.

A Google document was shared by the facilitator to provide discussion questions for meetings, offering an efficient way for participants to prepare for and contribute to the upcoming discussion. One candidate commented that throughout her time in the book club, participants leaned often on the question “what can we do about this?” as a tool to guide discussion and devise solutions amid conversations which were often emotionally charged.

BUILDING SOCIAL JUSTICE COMPETENCIES IN EARLY CAREER SCHOOL PSYCHOLOGISTS

Participants described the book club as impactful to their learning and growth as professionals. One candidate remarked that “as a future school psychologist, I want to understand other people’s life experiences to better serve them... it is important to seek out this information in order to grow and do better.” Another candidate emphasized that one of the largest takeaways from book club participation has been the opportunity to have “deep, meaningful conversations” with peers, which allowed her to “learn of their experiences and points of view which helps strengthen my own... you can’t leave a meeting without learning something new and reflecting on your own experience. You leave feeling recharged to go do the best good.” These sentiments align with the central goal of the book club, which is to empower people to have difficult conversations that spur empathy, reflection, and growth.

One candidate noted that individuals must work to eradicate inequity when it is revealed, emphasizing that “many people are simply not aware of the struggles that occur specifically for Black Americans on an everyday basis due to a lack of exposure, and misconceptions and prejudices can be formed simply through this lack of exposure and media portrayals.” This opportunity for immersive experiences is multifaceted in a book club. On one hand, readers naturally become immersed in the experiences of others by consuming narratives which portray what it feels like to be present for an event. Secondarily, immersion occurs through conversation about the text itself and with other individuals who may have experienced similar events. In this way, a book club becomes an extremely effective modality for engaging with ideas outside the scope of one’s experience and, as a result, discussing the best ways to support all members of the community. Rich (2021) contends that book club participation facilitates the development of compassionate professionals with a focus on social justice, as well as strengthening their ability to advocate for the equitable treatment of others. Beyond serving as a forum for discussion and a safe place for learning, one candidate explained that the book club allowed participants to “brainstorm ways we can be more effective” within a cultural framework.

IMPACT ON PROFESSIONAL PRACTICE

School psychology programs have been called upon to expand social justice training in order to improve outcomes for all learners. Grapin (2017) suggests that school psychology programs should provide candidates the skills and knowledge to better understand how cultural variables influence the implementation and success of interventions, to increase culturally competent service delivery, to recognize both implicit biases and systemic racism, and to promote one's ability to engage in systems-level change. School psychologists may apply these skills to culturally-responsive assessment and intervention, advocacy, volunteerism, providing professional development opportunities, and disseminating educational materials to the community. Miranda et al. (2014) confirmed that including social justice training in school psychology programs results in a commitment to advocacy as well as knowledge in how to tailor assessment and intervention to individual student needs.

Faculty members can support candidates in becoming more mindful of systemic barriers, recognizing inequity in education, identifying individual needs of students, and facilitating the development of multiculturally-competent practice relating to these issues. Khokhlkova and Bhatia (2021) purport that book clubs may also improve candidate-faculty relationships, which has been associated with increased motivation and satisfaction for candidates regarding educational and career goals. Accordingly, school psychology faculty participated in

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<td>The New Jim Crow: Mass Incarceration in the Age of Colorblindness</td>
<td>Michelle Alexander</td>
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<td>White Fragility: Why It’s So Hard for White People to Talk About Racism</td>
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<td>They Called Us Enemy</td>
<td>George Takei</td>
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<td>The Savvy Ally: A Guide for Becoming a Skilled LGBTQ+ Advocate</td>
<td>Jeannie Gainsburg</td>
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each book club meeting, providing insight into how readings related to professional responsibilities and the ethical implementation of school psychology practice (such as culturally-fair test selection and administration, insight into the overidentification of marginalized groups, and best practices in collaborating with diverse students and families).

**SUMMARY**
Candidates expressed that self-awareness was improved through participation in the book club, a key competency when collaborating with others as school psychologists. The reported knowledge, professional, and personal growth benefits experienced by YSU book club participants align with those discussed by Kholkhlova and Bhatia (2021), Grapin (2017), and Miranda et al. (2014). Alongside worthwhile dialogue, the book club allowed candidates to develop personal relationships, creating allies who may be relied on both personally and professionally in the development of social justice- and empathy- informed perspectives and practices. This is especially important entering a field that can be isolating at times, as these relationships may endure well beyond program completion.

**References**


Autism Family Navigation: Promoting Access to Services and Treatment for All

Jessica Emick, PhD | Kerry Catanese, PhD

Abstract
Early identification of autism spectrum disorder (ASD) is associated with improved cognitive and behavioral outcomes. Unfortunately, families engaging in the autism diagnostic process and treatment post diagnosis often experience delays in accessing diagnostic evaluations and treatment post diagnosis. These delays are worse for racially and ethnically diverse children with ASD and children with ASD from lower income families. One promising intervention to address these unmet needs is an Autism Family Navigation Program (AFN). In our developed model, Autism Navigators provide expertise in neurodevelopmental disorders, navigation of family and community systems, and special education and related services. An AFN program can help guide families through next appropriate steps and bridge gaps in treatment and service delivery and reduce health disparities. This paper outlines the lessons learned from developing an AFN model that uses clinical and school psychologists as navigators and considers next steps.

OVERVIEW
Families of children with ASD often experience a higher risk of unmet specialty or therapy care needs along with barriers to accessing appropriate care (Aylward et al., 2021; Chiri & Warfield, 2012). Research has consistently supported the idea that children with ASD who are racially and ethnically diverse or from lower socio-economic environments experience health disparities when compared to children with ASD who are White or more affluent. Specifically, racially and ethnically diverse children with ASD experience delays in access to diagnostic evaluations and early intervention services for ASD (Mandell et al., 2009; Bishop-Fitzpatrick & Kind, 2017). Black children are diagnosed with ASD at least 1.5 years later than their White counterparts (Ennis-Cole, Durodoye, & Harris, 2013), and they are three times more likely than White children to receive another diagnosis before receiving an ASD diagnosis (Mandell et al., 2007; Bishop-Fitzpatrick & Kind, 2017). Additionally, Black and Latino children experience greater lag time between diagnosis and treatment, and they receive fewer ASD treatment services compared to their White peers (Ennis-Cole et al., 2013; Bishop-Fitzpatrick & Kind, 2017). Children from lower socioeconomic status households, regardless of race or ethnicity, with ASD experience delays in timely ASD diagnosis (Durkin et al., 2010) as well as fewer hours of ASD treatment services as compared to more affluent peers (Nguyen et al., 2016).

These findings highlight the need for new clinical interventions and supports to address health disparities and promote access to timely and evidence-based diagnostic processes and treatments for all children and families with ASD. Family navigation services, which are adapted from patient navigation models originally used to support oncology patients, show promise as an effective way to guide families most at risk through the diagnostic process and bridge gaps in treatment and service delivery (Godoy et al., 2019; Broder-Fingert et al., 2019). The present article will provide guidance on how to apply effective Autism Family Navigation Services in everyday practice to support diverse children and families. It will also discuss future implications regarding how to support diverse families who are waitlisted for autism-related services and how to apply a navigation model with disorders other than Autism.

HISTORY OF PATIENT NAVIGATION SERVICES
Patient navigators were first developed to reduce health disparities in cancer care. There is strong evidence of oncology patient navigation programs effectively reducing barriers to quality medical care by improving patients’ timely access to medical services and related supports (Riley & Riley, 2016). A focus of early patient navigation programs was to coordinate oncology care by connecting patients to hospital and community resources and ensuring patients adhered to treatment recommendations like follow-up appointments and medication (Schockney, 2010). More recent models of navigation services within health care settings have expanded in focus to include family involvement, resources beyond the medical care system, and chronic care issues and disorders such as ASD.

Family Navigation within the field of Autism has a relatively brief history of around 10 years, and early models of Autism Family Navigation (AFN) focused on navigation for at-risk children and navigating the diagnostic process (Feinberg et al., 2016). Later models focused on providing navigation services after a child received an ASD diagnosis (Gordon-Lipkin, Foster, & Peacock, 2016; Roth et al., 2016). Research suggests AFN can help to reduce barriers to accessing health care services related to ASD diagnosis and treatment. Children who received family navigation services were more likely to...
complete an ASD diagnostic assessment than children who received routine clinic care (Feinberg et al., 2016). Additionally, caregivers of young children with Medicaid and a recent ASD diagnosis were more successful with scheduling and completing appointments and found AFN services useful as compared to caregivers of young children with insurance other than Medicaid (Roth et al., 2016). In a recent study, family navigation services were found to decrease the time to diagnosis and increase likelihood of diagnostic ascertainment for children from racial/ethnic minority, low-income families who are identified as being at-risk for ASD. Ethnicity appeared to moderate the strength of these findings (Feinberg et al., 2021). Navigation services also increased the number of at-risk toddlers who were evaluated for ASD and from an urban, low-income population as well as the quality of ASD screening in primary care clinics (DiGuiseppi et al., 2020). Implementation of AFN services is complex, however an understanding of the complexity of family navigation services for ASD is crucial for implementation (Broder-Fingert et al., 2019). As a result, careful planning is essential to the implementation of an Autism family navigation program.

DEVELOPING AN EFFECTIVE MODEL OF AUTISM FAMILY NAVIGATION SERVICES IN AN OUTPATIENT CLINIC

Based on the above research and our own experiences as psychologists in a large multidisciplinary clinical practice that serves a racially and economically diverse population of children and families, we created an Autism Family Navigation Program within our clinic to better support clients and their families in accessing services and receiving recommended follow-up care and to reduce health disparities in outcomes for minority and low-income families. While setting up a model for navigation services, we discovered a few challenges related to researching other models of navigation. Specifically, we found inconsistent language and titles as well as unclear assigned navigator roles. In some models, Autism Navigators are called keyworker, case manager, coach, or service coordinator (Ogourtsova et al., 2019). Additionally, there is notable variance in the education and training of Autism Navigators. In some models, Autism Navigators are peers (e.g., parents who have a child with a diagnosis of ASD) while in other models Autism Navigators are licensed mental health professionals. In one model, created by the Autism Institute at the Florida State University College of Medicine Autism Navigation training is based on self-paced training that is open to all professionals (Autism Navigator, 2022). These differences in training and focus on navigation makes it difficult to develop and compare efficacy of models.

Within our model, Autism Navigators are psychologists who have expertise in neurodevelopmental disorders, navigation of family and community systems, and special education and related services. They work with families whose children are both newly and previously diagnosed by our own and other local providers to create a safe place for families to process emotions associated with an ASD diagnosis, provide psychoeducation about ASD, teach parent coping and advocacy skills, teach basic behavioral parenting strategies, and provide information and connections to ASD services. Being an effective navigator requires a unique set of interpersonal and content knowledge skills, in addition to being comfortable doing work that may be out of the traditional clinical psychologist role. In our clinic, we have found that psychologists with direct knowledge about special education processes and experience working on teams are most comfortable in AFN roles. To ensure our Autism Navigators have knowledge about evidence based behavioral procedures, our navigators receive training in manualized parent-training programs such as the ECHO RUBI program (Sohl et al., 2022). While we do not adhere to a manualized program, it ensures our Autism Navigators have a consistent background in evidence-based procedures known to reduce disruptive behavior and improve adaptive behavior in children with developmental disabilities. Our Autism Navigators also collaborate with local Autism agencies to share autism-related resources that may benefit clients and their families. Our AFN program has created an internal resource manual that is regularly updated to document and share all identified resources necessary to stay current on any supports that are available.

Our navigation services are typically billed through the child’s insurance as family therapy. Services begin by developing individualized treatment goals with a child’s primary caregiver(s) and then meeting with the child’s primary caregiver(s) for biweekly, hour-long sessions. Sessions can be held either in-person or via telehealth depending on the client’s insurance coverage and preference. In general, caregivers have reported preferring telehealth AFN services as this service modality reduces travel time and promotes accessibility for more family members to participate. The frequency of sessions can be reduced when the client and their family demonstrate progress on their treatment goals.

NEXT STEPS

Looking forward, we plan to expand to include children and families who are currently waitlisted for an ASD evaluation. Given the extraordinary wait time for ASD diagnostic evaluations in our local area, we are expanding our AFN services to include children who are at a high risk for ASD (e.g., have failed an M-CHAT) to provide support throughout the diagnostic process. Previous research about the effectiveness of a pre-diagnostic navigation model is emerging but suggests it may be useful to decrease time to diagnosis and encourage earlier engagement with related services. Additional future implications involve the possibility of providing navigation services to other disorders other than ASD using a model like that developed for Autism.
Possible Topics and Resources Needed for Autism Family Navigation

| Basic Psychoeducation and Parent Guides to ASD | Sleep Training Resources |
| Resources for Explaining ASD to Siblings | Toilet Training Resources |
| Behavior Management Tools for Caregivers | Parent Stress Resources |
| Recreational and Support Resources for Individuals with ASD | Autism-Related Phone Applications |
| Recreational and Support Resources for Caregivers | Formal Parent Trainings |
| Respite Resources | Parent-Focused ABA resources |
| School Resources | Grant and Funding Resources for ASD Services |

Key Navigation Resources

- Basic Psychoeducation for Autism - Autism Speaks’ Newly Diagnosed Kit for Families https://www.autismspeaks.org/newly-diagnosed
- Educational Resources - Ohio Department of Education Parent Mentor Program and Autism Scholarship Information https://parentmentor.osu.edu/ and https://education.ohio.gov/Topics/Other-Resources/Scholarships/Autism-Scholarship-Program
- Local Resources for Clients and Caregivers - Milestones https://www.milestones.org/ and your local County Board of Developmental Disabilities
- Respite Resources - Autism Speaks’ Respite Care Guide https://www.autismspeaks.org/respite-care-0
- Provider and Parent Autism Trainings - Nationwide Children Hospital’s Project ECHO Series https://www.nationwidechildrens.org/for-medical-professionals/education-and-training/echo/series#FAMILY

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.

About the Authors

JESSICA EMICK, PHD is a licensed Pediatric Psychologist. She received her Master of Arts degree in Neuropsychology from the University of Northern Colorado and her PhD in School Psychology from the University of Maryland, College Park. She frequently presents nationally on topics related to assessment, Autism Spectrum Disorders, and early childhood development. She teaches in a graduate psychology program and provides Autism assessment and consultation at Total Education Solutions in Fairlawn, Ohio and where she serves as Director of Psychological Services.

KERRY CATANESE, PHD is an early career psychologist and school psychologist who recently completed her postdoctoral fellowship with Total Education Solutions (TES). Throughout her postdoctoral training, Kerry provided family navigation services to caregivers of children and adolescents diagnosed with autism spectrum disorder. She also provided psychological assessment services to clients of the TES Fairlawn Clinic and psychoeducational assessment services to students enrolled in Cleveland area schools during her postdoctoral fellowship. Kerry presently primarily provides teletherapy services to children and caregivers to treat anxiety, trauma, parenting stressors, and family conflict. She is also a current member of the Ohio Psychological Association’s Early Career Psychologist and Public Sector Issues Committees.


The Psychological Impact of a Chronic Health Condition on Siblings

Maria Angela Seccia, PsyD

Abstract

A childhood chronic health condition may have psychological implications for the whole family. In the past, studies have focused only on ill children and their parents; recently, researchers have increased attention to its impact on siblings. This review aims to gain an understanding of the current literature about the impact of a childhood chronic illness or disability on siblings, the factors associated to their mental health and the intervention programs. Different databases were systematically searched. Included studies were systematic reviews, meta-analyses and experimental studies published in the last ten years with siblings 0-18 as participants. Findings can be summarized into three categories: positive effects, negative effects, and impaired mental health symptoms. The most common interventions adopt a family-centered-care model, and they mainly consist of group interventions and empowerment experiences. This overview highlights the need to extend the research for this issue: it may be useful to ensure more tailored interventions.

INTRODUCTION

Recent progress in pediatric medicine has resulted in an increase in the number of children living with chronic illness or disability, leading to a growing awareness of its psychological impact on their family. Previous studies in this area of research have focused only on ill children and their parents, ignoring the implications for siblings. Recently, their role has been taken more into consideration using the term siblings to refer to healthy brothers and sisters of children with a chronic illness or disability. This attention to siblings is due to the idea that the relationship between brothers and sisters cannot be categorized as a common relationship: it influences the psychic development, the identity organization, and the social skills during the childhood; it represents the first chance to live a peer-to-peer relationship and to share experiences and emotions incorporating both conflict and companionship.

THE IMPACT ON FAMILY

Williams (1997) defined a chronic illness as a “medically diagnosed ailment with a duration of 6 months or longer, which shows little change or slow progression”. Childhood chronic illness has long been thought to have a negative impact on the psychological functioning and behavior of the ill child, but all family members could be affected. Grootenhuis and Last (1997) show that a frequent hospitalization undermines parents’ psychological health more than the diagnosis or the treatment. These difficulties result intensified when a father or a mother tries to assume the role of the therapist of their own ill child. However, it is possible to find various protective factors for the mental health of parents, such as correct and usual information about the evolution of the illness and the perception of a social support, especially for mothers. These factors can help parents to be more resilient: in a study of Krantz et al. (2022), several parents refer that «they learned to value small moments of joy and create deep connections through involvement in family routines and rituals».

THE PSYCHOLOGICAL REACTION OF SIBLINGS

The psychological adaptation to the new family reality depends on different variables associated to the sibling relationship, the illness, and the parental experience.

The birth order plays a key role: if the ill child is the oldest, siblings can easily accept the illness or disability because it has always been since they were not born. However, youngest healthy siblings may have difficulties restoring a personal identity beyond that of being brother and sister of a chronic patient or a disabled child. On the other hand, it may be difficult for a healthy firstborn accepting not only another child in the family, but also the arrival of a worrying chronic health condition. Regarding to gender, Breslau and co. (1981) show that especially the firstborn females often have a stronger sense of responsibility in caring for their ill brother or sister.

Variables linked to the childhood illness or disability are the most influential on the psychological reaction of siblings (Lobato, 1983). For example, in case of a genetic pathology, questions about its hereditariness and the risk of having the same disease one day may come to light. Furthermore, siblings may wonder if they are worthy of being healthy and if they will be able to meet the expectations of their parents. About the neurodevelopmental disorders, Knott and co. (1995) have demonstrated that siblings of autistic children spend less time together than siblings of children with Down’s syndrome. Indeed, siblings of autistic children often do not tolerate their behavioral rituals, feel sad because of their relational rejection, and, at the same time, they feel embarrassed about some
unusual behaviors. Finally, although severity did not seem to have any effect on psychosocial functioning of siblings, it has been shown that illnesses that affect day-to-day functioning (e.g., bowel disease, cancer) are associated with negative effects compared with illnesses that do not (Barlow and Ellard, 2006).

**Positive effects**

Chronic diseases of childhood may have implications for the psychosocial wellbeing of children and their families; however, the sibling relationship may be resilient and perhaps even enhanced in the context of an illness and a disability. In terms of positive effects, siblings have been found to be more caring, mature, supportive, responsible, and independent than their peer. At the same time, ill children can benefit from these traits of siblings to improve their social skills and quality of life.

**Negative effects**

Sometimes there can be reactions that come from the desire to receive more attention and to get a better position in the relationship with the ill or disabled child. Some consider these reactions normal, others pathological, based on how much space they occupy in the life of the siblings.

A caretaker role involves siblings as a parent, participating in such activities as feeding and dressing their brother or sister. There is evidence that the caretaking role is more common when there is a disability, and internalizing behaviors may be a response to these inflated caretaking demands (Sharpe & Rossiter, 2002).

The burden of care for children with chronic disease generally falls upon parents, who must balance the child’s healthcare needs with those of other family members. In addition, parents themselves may have difficulties accepting a child’s diagnosis and prognosis and can experience anxiety about the child’s future health. Siblings may perceive that they receive less time and attention from parents, and there is low parental awareness of this condition (Fredriksen et al., 2021).

Siblings often feel shame having an ill or disabled brother, especially when the family tries to hide the disease and the disability from strangers. Thus, they may feel forced to lie or to avoid inviting friends at home. At the same time, siblings can feel tormented by a sense of guilt for these feelings.

**Impaired mental health**

In certain cases, the childhood illness or disability makes all family members unable to face the situation, to use their internal resources and to accept external ones. Even siblings’ mental health appears compromised in different ways.

The rivalry with their ill or disabled brother may induce siblings to catch parents’ attention through behavioral disorder or psychosomatic symptoms: for example, they exaggerate tolerable symptoms or fake symptoms to receive the same privileges of the ill child.

The stigma towards the disease, especially the psychiatric disease, is widespread in our society and it feeds the sense of shame and the social isolation in siblings (Bowman et al., 2014) affecting their social relations. Siblings sometimes have no time for hobbies or entertainment activities because their brother’s illness upsets daily routine cause of the excessive time needed to manage a chronic health condition.

Psychological reactions of siblings can be classified into two categories: internalization and externalization. Among the most common internalizing symptoms, distress about brother’s illness and unsatisfied needs causes anxiety and depression (Barlow & Ellard, 2006; Incledon et al., 2015). Furthermore, siblings internalize their somatic symptoms that emerge like with headache, stomach, tiredness, pains
Siblings

and frequent nightmares.

On the externalization side, siblings may develop an elevated level of hyperactivity and inattention or have difficulties adapting to the new reality preferring negation as the best coping strategy. At times, siblings’ normal development can be compromised by a cognitive and social disability. Finally, the scarce presence of parents for healthy children may induce siblings to have a low self-esteem and inadequate social skills.

INTERVENTIONS

In front of these different psychological reactions, it is necessary to involve siblings in a psychological support intervention including all family members by using a Family-centered-care (FCC) model: this approach is based on the idea that the family is the ill child’s primary source of strength and support, and patients and family are integral part of the health care team. Indeed, siblings-reported relationship with parents has been found to be a significant predictor of siblings’ mental health (Fredriksen et al., 2021). For this reason, in the last years, several types of intervention have spread both in hospital and out-of-hospital settings.

A group experience is considered one of the best practices with children and teenagers, so it can be applied also to siblings as mutual aid groups, therapeutic groups, and psychoeducational groups.

Finally, Sibshops practice, pioneered by Donald Meyer in Seattle in the nineties, consists of workshops during which siblings can get more information about their brother’s illness through recreational activities. They may be also part of programs adopted during Siblings camps involving siblings, parents, and health care team. Lot of organizations have developed to adopt interventions on siblings. For example, The Ohio State University Nisonger Center in Columbus has offered support groups, such as Ohio SIBS: it is an organization of siblings of people with disabilities that came together in 2000 to support siblings throughout the lifespan by connecting them with resources and creating a community (https://ohiosibs.org/).

CONCLUSION

For a long time, siblings’ mental health has been left out of psychological interventions, probably because of their apparent perfection and adaptation to the illness and disability of their brother or sister as a protective strategy for their parents. In the last years, instead, several studies have shown that paying attention to their needs is extremely important to safeguard the wellbeing of the ill or disabled child and of the family. However, it is needed to underline that most studies tend to focus on psychopathology and lack of adjustment giving little space to the investigation of protective factors and opportunities for growth. In addition, at present, several questions remain unanswered in some countries, such as Italy. Thus, there is abundant space for further studies in analyzing the psychological impact of a chronic health condition on siblings to adopt adequate prevention and intervention programs and to get a new social consciousness about this issue.

About the Author

MARIA ANGELA SECCIA, PSYD is a Clinical Psychology graduate and a Pediatric Psychology expert with a Second Level Master’s Degree at LUMSA University in Rome. She recently completed an advanced training course in Neuropsychology. She did her post graduate internship at a Child Neuropsychiatry ward and a Mental Health Center gaining experience in the fields of neurodevelopmental disorders and psychiatric diseases with children and adults. She is completing the iter to become a licensed psychologist and she would like to start the psychotherapy school next year.

Author Note: Correspondence concerning this article should be directed to:
M. A. Seccia, Barletta, Italy; mariaangela.seccia@gmail.com
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Krantz, M., Malm, E., Darin, N., Sofou, K., Savvidou, A., Reilly, C., & Boström, P. (2022). Parental experiences of having a child with CLN3 disease (juvenile Batten disease) and how these experiences relate to family resilience. *Child: Care, Health and Development*.


Inaccurate diagnoses in correctional settings due to clinicians’ biases may lead to inappropriate mental health treatment, poorer prognosis for improving clients’ outcomes, and recidivism. The current study examined whether clinician setting bias affects the diagnosis of Borderline Personality Disorder (BPD) versus Antisocial Personality Disorder (ASPD) amongst clients in correctional and inpatient clinical settings. A sample of 124 mental health professionals responded to a vignette designed to display prototypical BPD symptoms to determine whether manipulating setting bias impacted mental health professionals’ abilities to accurately diagnose BPD. Results indicated that the setting in which the client was being diagnosed significantly impacted the diagnosis participants assigned. Participants were over three times more likely to diagnose ASPD for fictional clients in a correctional setting. Recommendations were made to increase access and consumption of setting bias training for mental health professionals to address the impact setting bias may have on diagnosing and treating clients.
Of the sample, 19% of participants identified as male and 81% of participants identified as female. The majority of them held a master’s degree, with the majority of participants (65%) holding degrees in either clinical or counseling psychology. Sixty-two percent of participants were in the process of completing an additional degree, most commonly in either clinical or counseling psychology. Sixty-two percent of participants reported having more than two years of clinical experience.

**Procedure**

Mental health professionals were given one of four vignettes describing a client who should be diagnosed with BPD. The client in the vignette was developed to express clear traits of BPD that we believe clinicians have mistaken for ASPD traits. The only differences in the vignettes were the gender of the client (male or female) and the treatment setting (inpatient-correctional setting or inpatient-psychiatric setting). These vignettes were composed by the first author and reviewed by the other authors for accuracy of diagnosis for BPD and not ASPD. After reviewing the vignette, the mental health professionals were asked several questions regarding the client and were asked to diagnose the client with either BPD or ASPD.

The questions asked of participants included what diagnosis they would give and perceived competence in treating the client, amount of diversity training the clinician had received, and whether the clinician thought that setting influenced their decision. As this was an exploratory analysis, no effort was made to determine whether these items were overlapping or could be used as a scale.

**Design and Analysis**

The current study was a quasi-experimental, 2 (inpatient-correctional setting or inpatient-psychiatric setting) x 2 (male, female) between-subjects design. A statistician at the Wright State University Statistical Consulting Center provided professional consultation and assistance determining what would be appropriate analyses for this data set (due to sample size and manner of collection of data) as well as with the analyses of these results. SAS version 9.4 (SAS Institute Inc., Cary, NC) was used for all analyses and a level of significance of \( \alpha = 0.05 \) was used throughout.

**RESULTS**

**Treatment Setting and Diagnosis**

See Table 1 (page 20) for frequencies for the diagnosis of ASPD and BPD in residential and correctional settings. There was strong evidence to suggest there was a significant relationship between Treatment Setting and Diagnosis \((X^2(1, N=99) = 4.01, \ p = 0.045)\). The estimated odds ratio was 3.23, suggesting that the odds of participants diagnosing the client in a correctional setting vignette with ASPD was 3.23 times the odds of a client in a residential setting (note that if we were modeling the probability of a BPD diagnosis all p-values would be identical, with the only difference being the odds ratio would then be less than one). A 95% confidence interval for the true odds ratio in the population of all such clients was \((1.03, 10.21)\). This means the true odds ratio could feasibly be as little as 1.03 times higher or as much as 10.21 times higher for a correctional setting compared to a residential setting. This confidence interval does not encompass 1.0, lending further support to conclusion that these groups were statistically significantly different in the way that they were diagnosed.

There was not sufficient evidence to suggest there was a significant mean difference in perceived competence between clinicians diagnosing clients in a correctional setting and clinicians diagnosing clients in a residential setting \((F(1, 99) = 0.00, \ p = 0.95)\).

**DISCUSSION**

Setting bias appeared to impact the diagnosis clinicians assigned. The results of the study highlight the possibility that BPD may be underdiagnosed in correctional settings, perhaps because clinicians weighing the criminal involvement criteria of ASPD more heavily than other criteria. It also may be the case that correctional settings inherently generate biases for clinicians, especially when it comes to diagnosing ASPD and BPD. Catching these biases while clinicians are in training would help in reducing the impact clinician setting bias has on diagnosing and treating BPD.

Focusing on implementing coursework in forensic training programs would be an excellent place to start in reducing clinicians setting bias in correctional settings. Specifically, coursework that focuses on skills and attitudes related to setting bias would provide the foundation for clinicians building competency with providing mental health treatment in correctional settings. For example, giving clinicians in training an opportunity to engage in self-reflection regarding what biases they may have when it comes to correctional settings. Setting bias training could take place through process-oriented coursework in which clinicians in training have a safe space in which they are able to discuss potential biases they may hold. Questions trainees may be asked could include the following: “What diagnoses immediately come to mind when you think of clients being treated in correctional settings?”; “How is my conceptualization of clients impacted if they are being treated in correctional settings?” Through discussion and processing, clinicians can brainstorm customized methods they can use to ensure biases do not impact their ability to diagnose and provide treatment in correctional settings.

**LIMITATION OF THE STUDY AND FUTURE DIRECTIONS**

One limitation of the study is the standardization of the vignette used in the study. Symptoms of ASPD and BPD can look different for male and female clients (Sansone & Sansone, 2011). Due to the varying ways in which ASPD and BPD are expressed across genders, one challenge of this study was developing a vignette of a fictional client in which the symptoms the client was expressing is typical of how men and
women express BPD. As a result, the vignette was designed by the authors to depict a client who clearly meets criteria for BPD based on the DSM-5 criteria for BPD. Using the same symptom presentation of BPD for both the male and female vignettes, (simply changing one word —female to male) may not have been salient enough to activate gendered schemas for therapists in the same way as having a client present. To control for this limitation, it may be helpful to use an audio or video example of a fictional client for in future research. Each audio/video example would have either a male or female client express first-hand their mental health concerns. Similar to the written vignettes, these files would depict a fictional client who meets criteria for BPD.

Due to not receiving enough responses to generate statistical significance of the data, another limitation of the study is that certain statistical analyses were underpowered. Specifically, analyses for whether treatment setting impacted participant’s perceived competence were found insignificant. However, the p value of their perceived competence was .95, suggesting that even with 50 more participants, individuals assigned to the correctional setting condition would not have reported being significantly less competent to treat the client, despite being three times more likely to provide the wrong diagnosis.

A future direction for research might be to determine whether diagnostic category has an impact on inmates' treatment gains. For example, an inmate with a diagnosis of ASPD versus BPD would have considerably different treatment plans.

CONCLUSION
Setting bias training may be beneficial to increasing clinicians’ awareness of the biases they hold through self-reflection. More work needs to be done by training programs to adequately prepare clinicians to work in diverse settings. Trainings that involve self-reflection of implicit and explicit biases clinicians have around criminal involvement could help clinicians decrease the impact setting bias has on decision-making or the treatment they are facilitating.

<table>
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<th>TABLE 1</th>
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<td>Frequency of Diagnosis by Treatment Setting</td>
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<td>Residential</td>
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<td>Correctional</td>
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<td>Total</td>
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Note: Frequency of participants who did not provide a diagnosis = 25.

References


GILLIAN LARUE, PSYD, MS earned her doctorate in Clinical Psychology at Wright State University. She completed her predoctoral internship at Central Regional Hospital in Butner, NC and her postdoctoral fellowship at the Durham VA. Currently, she is a staff psychologist at the Veterans Recovery Center (PRRC) at VA—Tennessee Valley Healthcare System (TVHS) where she works with veterans with chronic and severe mental illness. Her areas of clinical interest include serious mental illness, multicultural and diversity issues in clinical psychology, and social justice advocacy.

Author Note: Gillian LaRue is now at VA Tennessee Valley Healthcare System, Department of Veterans Affairs. Correspondence concerning this article should be addressed to Gillian LaRue. Email: larue.7@wright.edu.

WENDY R. DRAGON, PHD is an associate professor at Wright State University’s School of Professional Psychology (SOPP). She has presented nationally about personality assessment and the impact of diversity variables on forensic decision making and clinical care. She has supervised doctoral students in delivering standard and dialectical behavior therapy to a diverse clientele. Currently, she supervises doctoral students in assessment through Psychological Assessment Services at Wright State University. She advises doctoral students with dissertations topics on using dialectical behavior therapy with multicultural populations and those with diverse clinical needs and forensic dissertations on how to assess diverse populations and how to provide appropriate clinical care. At SOPP, she teaches Psychopathology, Objective Personality Assessment, and Forensic Assessment.

MICHELLE S. SCHULTZ, PSYD is an associate professor in the School of Professional Psychology and has served as program’s associate dean and director of clinical training. She teaches courses in supervision, practice management, trauma, intervention, and assessment. Additionally, she supervises doctoral-level psychology trainees providing psychological services. She completed internship and postdoctoral experiences in treating adolescents and children who experience trauma and/or exhibit disruptive behavior. Areas of interest include child, adolescent and family psychology (therapy and assessment), clinical training, program development, and diversity competence. Specific areas are youth in the juvenile justice system (with special attention to the needs of girls and those with mental health issues), trauma, Non-Suicidal Self Injury (NSSI), emerging adulthood and identity development, women’s issues, clinical supervision, professional development, and diversity competence (specific focus on the intersection of social class, gender, and ethnicity). She engages in private practice consistent with her clinical interests.

LATRELLE D. JACKSON, PHD, CCFC, ABPP - Dr. Jackson is a professor, clinically certified forensic counselor, board certified clinical psychologist, and the interim dean at Wright State University’s School of Professional Psychology (SOPP) in the College of Health, Education, and Human Services. She earned the distinction of diplomate in clinical psychology in 2018. In 2017, Dr. Jackson served as the WSU interim associate vice president for student affairs while maintaining her faculty role in the SOPP. Prior to joining the faculty at WSU, she worked at Regent University where she was an associate professor, the director of clinical training, the director of the Psychological Services Center, the special assistant to the vice president for student services and the executive vice president for academic affairs.

She earned a Bachelor of Arts in Psychology, Master of Arts in Rehabilitation Counseling, and a doctorate in Counseling Psychology from The University of Georgia. Her American Psychological Association (APA) accredited internship was completed at Michigan State University. Dr. Jackson’s professional appointments include working at Penn State University and the University of Florida. She has held academic appointments with the Department of Rehabilitation Counseling, African American Studies, Counselor Education, and Counseling Psychology at these institutions. Committed to integrated wellness, community empowerment, and moral leadership, Dr. Jackson has engaged in a variety of regional academic, business, and civic endeavors in addition to national service in the Division 35 (Society for the Psychology of Women) and Division 36 (Society for the Psychology of Religion and Spirituality) of the American Psychological Association.
Promoting Equal Access to Mental Health Services in Rural Ohio: Perspectives Through a Social Consciousness Lens

Richard W. VanVoorhis, DEd | Kenneth L. Miller, PhD
Department Psychological Sciences and Counseling, Youngstown State University
Susan M. Miller, PhD - Educational Research and Design, North Lima, Ohio

Abstract
Authors present data on access to mental health services in rural U.S. areas and the state of Ohio and describe factors that perpetuate disparities in access to service delivery. We present comparative prevalence data on mental health problems in rural, suburban, and urban areas and highlight areas of greatest service need. Authors present unique characteristics of rural and Appalachian regions of Ohio, as well as social, cultural, and financial dynamics that may influence mental health providers’ decisions to live and work in these communities. We conclude by offering potential solutions to current limitations in professional practice, mental health training, and interdisciplinary collaboration designed to increase access to and improve mental health service delivery in rural and underserved areas.

STATEMENT OF THE PROBLEM
Almost one-fifth of Americans experience mental and behavioral health problems (Andrilla et al., 2018; Reinert et al., 2021). Regarding recent data provided by Mental Health America, Ohioans ranked 25th (out of 51 states and the District of Columbia) in their overall mental health ranking. This represented a worsening of Ohio’s 11th place overall mental health ranking in 2021 (Reinert, 2021). Americans also have unequal access to mental health services based on geographical regions. Using data from nine geographic census divisions, Andrilla et al. (2018) ranked access to psychiatrists and psychologists across the United States. As part of the East North-Central division, Ohio ranked in the midrange for access to psychiatrists and psychologists. However, this particular division ranked lowest for the number of psychiatric nurse practitioners at 1.2 per 100,000 patients.

A second geographic measure influencing the prevalence of mental distress and access to mental health care is residence in a rural setting. Hendryx (2008) found that seventy percent of Appalachian counties (across 13 Appalachian states) had a shortage of mental health professionals. He concluded these shortages could be attributed to confounding social variables such as lower education. Other researchers (Probst et al., 2006) attributed higher rates of depression to conditions associated with rural life, such as poverty and lack of access to care. Stigma is also identified by rural drug and alcohol users as a factor that prevents them from seeking mental health or substance use treatment (Cucciare et al., 2019).

CHARACTERISTICS OF RURAL AND APPALACHIAN CULTURES
These facts raise numerous questions about the limited access to mental health services in rural areas with significant needs. Although common characteristics of rural areas in the United States (e.g., limited access to social and cultural resources, professional isolation) may help to explain a shortage of mental health professionals opting to live in these areas, we report characteristics of rural areas in Ohio to further explain disparities in access to mental health services.

Ohio is a largely rural state. There are four urban centers in the state: northwest (Toledo), southwest (Cincinnati/Dayton), central (Columbus), and northeast (Cleveland/Akron/Youngstown) regions (Ohio.gov, 2022). Except for Youngstown (population 60,068 in 2020), no large cities are in Ohio’s 32 Appalachian and rural counties. Appalachian counties in Ohio extend across the entire eastern and southern borders of the state, while there are several other rural Ohio counties in different locations throughout the state.

Characteristics of Appalachian culture can include religious fundamentalism and a deep connection to the land as opposed to valuing education and social contact with outsiders.
Appalachian culture may be characterized as centering on isolationism, familism, and homogeneity, which likely developed from the initial geographic isolation of many communities (Elam, 2002). Values held by people living in Appalachia may include freedom, independence, and self-reliance (McGuire & Warner, 1979). However, poverty is the most constant companion in Appalachian communities (Elam). These same characteristics have also been descriptive of rural life in general (Lichter & Brown, 2011). Appalachia struggles with problems typical of rural poverty, including social stratification, unemployment, inadequate social services, poor education, and poorly developed infrastructure.

CHALLENGES FOR MENTAL HEALTH PRACTICE IN RURAL COMMUNITIES

As highly educated professionals, mental health service providers are likely transformed intellectually, emotionally, socially, and financially by their educational and professional accomplishments. Their accomplishments are laudable, and the outcomes of this transformational process are understandable. Given these outcomes, the reinforcement needs of many mental health professionals may simply be at odds with the realities of life and practice in rural/Appalachian areas.

For example, two challenges unique to a rural mental health practice are (a) professional visibility and (b) exposure/lack of anonymity (Brownlee, 1994; Hasting & Cohn, 2013). Mental health practitioners are trained to maintain a professional persona. Achieving this goal becomes difficult as participation in a small community guarantees the likelihood of social contact with clients who could be neighbors, other school parents, and providers of other professional services. There may also be sharp ideological and values differences that make creating social support systems and friendships difficult for mental health professionals who live in rural settings (especially if the mental health professional is perceived as an outsider).

Furthermore, recent evidence reveals that mental health professionals may be reluctant to travel a significant distance to relocate to a different (and unfamiliar) geographic region. This may often be the case for migrating from a particular university training program location to find employment in an Appalachian region. In a recent study examining vocational preferences of ninety Ohio school psychology interns, VanVoorhis et al. (2022) found that interns rated social service, or the opportunity to help others, as a top work value. However, it is noteworthy that many interns were reluctant to travel a substantial distance within the state to accept their first school psychology position. Furthermore, most interns were unwilling to relocate to a different geographic region (i.e., southeastern Ohio and other more remote rural areas) to find their first position in school psychology.

Findings collected through the Ohio School Psychology Association (OSPA)/Inter-University Council Task Force to Address School Psychologist Shortages (OSPA, 2016) also indicated that a common barrier to providing school psychology services in rural regions was the reluctance of interns and first-year practitioners to relocate to more rural areas. Furthermore, the task force shared that university training programs have difficulties placing school psychology interns in these more remote regions due to supervision and in-person class attendance requirements.

A SOCIAL CONSCIOUSNESS LENS

Collins (n.d.) described social consciousness as the state of being aware of the problems that affect many people in society and wanting to do something to help those people. From a social consciousness perspective, the problem of staffing underserved areas may create a unique personal dilemma or sense of dissonance. Mental health professionals may be called to the profession and driven by the opportunity to help others. However, they often may have other professional and personal values (or reinforcement needs) that may constrain their willingness or ability to explore job possibilities in underserved geographic regions, especially rural settings.

Although these interpretations are speculative and made with caution, they may be revealing. Interns and early career psychologists may believe (accurately or inaccurately) that living and working in rural communities will not afford them opportunities to achieve their professional goals (e.g., higher salary, advancement opportunities, professional connectedness) or to live in a manner consistent with personal values (e.g., proximity to family and friends, regular access to familiar cultural events, and relationships with “like-minded” others). Consequently, there are likely unintentional and negative systemic consequences of mental health professionals pursuing professional goals and dreams in geographic areas that closely align with personal and professional needs. These decisions may perpetuate the chronic problem of limited access to mental health services and continued social inequities in Appalachia and other rural areas of Ohio and across the nation.

A SOLUTION-FOCUSED APPROACH

To fulfill our professional obligations as change agents, as well as the American Psychological Association’s ethical principles (APA 2017), mental health professionals must be aware of service shortage needs and actively work within and across various systems to solve these problems. Professionals may find ways to be actively involved in statewide association committees to address shortages of service providers in rural regions, such as the Ohio School Psychology Taskforce. Meeting service needs in rural and Appalachia areas may also be accomplished through volunteer work or telehealth practices. Mental Health America (n.d.) reminds us that telehealth practices can make mental health care more accessible for many people (including those in rural and underserved areas). Through telehealth practices, some mental health professionals may elect to take on additional duties serving rural regions while continuing to live and work in their more preferred geographic region.

University faculty in mental health training programs are encouraged to regularly hold discussions related to service disparities, examine their causes, and promote strategies designed to remediate them. Such discussions should also help candidates understand the meaningful and rewarding
work that can be accomplished in rural and underserved regions. Furthermore, establishing field experience training and hiring partnerships with rural and underserved areas can allow candidates to gain confidence and experience in these new environments. They also may find other personal and professional reinforcements through active service in these areas. This ‘foot in the door’ strategy may foster a willingness of program graduates to establish professional roots in underserved regions.

Indeed, these discussion points also lend strong support for direct student recruitment in underserved and rural areas as well as what has been coined as grow your own mental health training programs in underserved and rural regions (i.e., psychology, school psychology, psychiatric nursing, psychiatry, counseling, etc.). Trainers and employed mental health professionals are encouraged to play an active and prominent role in supporting the development of new or expanded training programs designed to help staff underserved regions.

Furthermore, as the use of technology has rapidly grown (especially during the pandemic), specific online and virtual classroom experiences may assist in reducing or eliminating problems associated with access to traditional face-to-face training programs.

**CONCLUSION**
There is a saying in Appalachia, “As the twig is bent, so shall the tree grow.” We must continue to work together to shape equal access to support mental health services for people in all geographic regions, including the Appalachia and rural regions of Ohio. The short and long-term future depends on this critical collaboration and effort. We must continue to bridge the gap between mental health service delivery and various geographic regions through inter-disciplinary partnerships, recruitment and training enhancements, increased technological innovations, and other solution-focused approaches. We must continue to bend the twig together in the right direction.

**About the Authors**

**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.

Richard W. VanVoorhis  https://orcid.org/0000-0003-0266-3521

**Author Note:** The authors report there are no competing interests to declare.

Correspondence concerning this article should be addressed to Richard W. VanVoorhis, Department of Psychological Sciences and Counseling, Youngstown State University, Youngstown, OH 44555. Email: rwvanvoorhis@ysu.edu

**KENNETH L. MILLER, PHD** is a professor in the Department of Psychological Sciences and Counseling at Youngstown State University. He is a Licensed Professional Clinical Counselor- Supervisor (Ohio), a National Certified Counselor, and a Board Certified Medical Psychotherapist and Psychodiagnostician. His research interests include resilience development, measurement of cultural bias and discrimination, educational equity, and professional dispositional competencies. In addition to teaching and research responsibilities, Dr. Miller provides clinical consulting services to community clients.

Kenneth L. Miller  https://orcid.org/0000-0002-3418-662X

**SUSAN M. MILLER, PHD** is an educational psychologist who, in addition to her scholarship activities, provides educational, research, and evaluation services. A former university faculty, Dr. Miller has taught undergraduate and graduate students, primarily those in education or who are preparing for the teaching profession. She was awarded research grants totaling over a million and a half dollars and has numerous presentations and publications. Her research interests in educational equity includes the assessment of bias and discrimination and the synergetic partnership of education and community. Currently she is involved in research on the nature of resilience.

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Lost in the Wild: When Psychologists Cannot Access Research
Anthony J. Nedelman, PhD | Keelan Quinn, PhD | Laura Burns, PhD

Abstract
Accessing current literature is extremely important for psychologists. Staying up to date is required for using evidence-based practice, getting licensed, acquiring board certification, and to maintain and/or expand clinical competencies. Psychologists also have an ethical responsibility to be well-educated and informed in their areas of practice. However, psychologists who are not employed with a university, hospital, or federal workplace seldom have database access. This paper outlines the systemic problem, offers some limited solutions, and promotes the ongoing advocacy for access to research databases more widely.

THE ROLE OF RESEARCH AND LITERATURE IN THE FIELD OF PSYCHOLOGY
Access to updated research and literature is extremely important for the field of psychology. Not only is it recommended by the American Psychological Association (APA), the scientific and professional organization that represents psychologists in the United States, but it is also fundamental across all activities for licensed psychologists as well as those in training. Being able to access recent research and literature is embedded within the science and practice of psychology, including research, licensure processes, board certification, and continuing education requirements. Unfortunately, access to research databases is often cut off post-graduation and not available to individual practitioners who are not affiliated with universities, hospitals, or federal workplaces.

National Organization’s Recommendation
The APA advises practicing psychologists to utilize evidence-based practices in psychology (EBPP). This is defined as “the integration of best available research with clinical expertise in the context of patient characteristics, culture, and preferences” (American Psychological Association, 2016). Using EBPP is important because it applies empirically supported principles into the practice of psychology. EBPP also has a number of well-research benefits and challenges, which are outside the scope of this paper (review Cook, Schwartz, & Kaslow, 2017). The APA promotes psychological science through research in psychology, the improvement of research methods, and the application of research findings. The APA Science Directorate’s broad mission is to communicate, facilitate, promote, and represent psychological science and scientists.

Licensure
The access to and knowledge of current and reliable research, such as EBPP, is foundational in the licensing process in the United States and Canada. All psychologists are required to take and pass the Examination of Professional Practice in Psychology (EPPP), which is developed by the Association of State and Provincial Psychology Board (ASPPB) and covers areas that span most, if not all, activities psychologists engage in. Of note, failing to be knowledgeable of current research trends in the topics covered (e.g., assessment, intervention, etc.) will make passing the exam extraordinarily difficult.

Board Certification
Board certification through the American Board of Professional Psychology (ABPP) is a process that many licensed psychologists pursue. A successful candidate will demonstrate the skills and knowledge in each of the ABPP foundational competencies. These include professionalism, reflective practice/self-assessment/self-care, scientific knowledge and methods, relationships, individual and cultural diversity, ethical legal standards and policy, interdisciplinary systems, and evidence-based practice, which is defined as “the capacity to integrate current research literature into clinical practice, research/evaluation, and other functional competency domains where applicable (American Board of Professional Psychology, n.d.).” Failing to be knowledgeable on current literature and EBPP can make board certification out of reach.

Continuing Education
Once licensed, all psychologists in the United States are required by state licensing boards to continue the development of clinical skills throughout their career by receiving continuing education (CE). APA defines this as “an ongoing process consisting of formal learning activities that (1) are relevant to psychological practice, education, and science, (2) enable psychologists to keep pace with emerging issues, including equality, diversity, inclusivity, and technologies, and (3) allow psychologists to maintain, develop, and increase competencies in order to improve services to the public and enhance contributions to the profession” (cited in Neimeyer, Taylor, & Wear, 2009). Some examples of formal CEs may include attending workshops,
organizations want to access current literature or conduct their own research? After graduation, most universities do not permit graduates to utilize their online databases. For those that do, access may only be provided on campus or during certain hours when the public is allowed admission on campus. This is very inconvenient and often impossible for psychologists working full-time and individuals who are no longer geographically close to their university.

Seeking research services through local libraries could be helpful, although they often do not have full access to updated and relevant literature. Psychologists attempting to access literature through their local libraries typically only have access to abstracts or summaries as opposed to full articles. Local public libraries also seldom have access to the more important journals in the field, particularly psychology. Finally, psychologists do have the option to purchase access to academic journals, but at a high cost. Unfortunately, there are so many journals to choose from it is often difficult to decide which journal to prioritize and for how long a psychologist should purchase them. Most psychologists already have limited financial resources, which they may choose to instead purchase clinical tools and supplies to utilize with clients. Adding the cost of academic journals may not be feasible or possible for some, particularly those in independent practice.

Balancing the need for access to current research and the systemic obstacles to acquiring it can be challenging for many psychologists.

**WHAT TO DO:**

**A MEASLY WORKAROUND FOR A SYSTEMIC PROBLEM**

As discussed, access to research is essential to the field. There is a growing body of evidence to suggest that psychologists’ clinical performance improves when they are engaged in research (Smith & Thew, 2017). However, the modal number of research publications (i.e., zero) for psychologists has hardly increased in over twenty years (Barrom, Shadish, & Montgomery, 1988; Norcross, Karpiak, & Santoro, 2005). Some have argued that the primary barriers to clinical psychologists conducting research include prioritizing clinical hours, not having time dedicated to research, and not having sufficient funding (McHugh & Byrne, 2011).

Larger organizations such as hospital systems and universities provide access to databases as part of their employee benefits, and some even include research hours into their weekly expectations and responsibilities; but what happens when psychologists who are not affiliated with these organizations want to access current literature or conduct their own research? After graduation, most universities do not permit graduates to utilize their online databases. For those that do, access may only be provided on campus or during certain hours when the public is allowed admission on campus. This is very inconvenient and often impossible for psychologists working full-time and individuals who are no longer geographically close to their university.

Seeking research services through local libraries could be helpful, although they often do not have full access to updated and relevant literature. Psychologists attempting to access literature through their local libraries typically only have access to abstracts or summaries as opposed to full articles. Local public libraries also seldom have access to the more important journals in the field, particularly psychology. Finally, psychologists do have the option to purchase access to academic journals, but at a high cost. Unfortunately, there are so many journals to choose from it is often difficult to decide which journal to prioritize and for how long a psychologist should purchase them. Most psychologists already have limited financial resources, which they may choose to instead purchase clinical tools and supplies to utilize with clients. Adding the cost of academic journals may not be feasible or possible for some, particularly those in independent practice.

Balancing the need for access to current research and the systemic obstacles to acquiring it can be challenging for many psychologists.

**THE PROBLEM: WHEN THE ESSENTIAL BECOMES INACCESSIBLE**

As discussed, access to research is essential to the field. There is a growing body of evidence to suggest that psychologists’ clinical performance improves when they are engaged in research (Smith & Thew, 2017). However, the modal number of research publications (i.e., zero) for psychologists has hardly increased in over twenty years (Barrom, Shadish, & Montgomery, 1988; Norcross, Karpiak, & Santoro, 2005). Some have argued that the primary barriers to clinical psychologists conducting research include prioritizing clinical hours, not having time dedicated to research, and not having sufficient funding (McHugh & Byrne, 2011).

Larger organizations such as hospital systems and universities provide access to databases as part of their employee benefits, and some even include research hours into their weekly expectations and responsibilities; but what happens when psychologists who are not affiliated with these
Google Scholar can be a very helpful resource for accessing research articles. This is a search category through Google that utilizes a database consisting only of academic journal articles that are produced by scholarly societies or commercial publishers. Mumper (2016) outlines some helpful tips to utilize Google Scholar to access research literature. Even though the interface is fairly user friendly, there are some helpful recommendations for finding available data. Some university libraries are searchable through Google Scholar by selecting “Library Links” in the settings section. If the provided results are too vast, the user can filter or refine them on the left side of the screen. Google Scholar conveniently shows how often each article is cited by others along with a correct APA-citation of the article. Downloading full versions of articles on Google Scholar creates an obstacle for many researchers as full access to most articles is unavailable. In the few instances in which the article is readily available for a free download, a link either to its current location or to a university library is shown. Even when available links are not provided, Mumper (2016) recommends clicking the citation anyway as some researchers may provide alternative ways to access the publication. Conducting a general Google search of the article name may also provide a way to access the article in the event it is not accessible in the Google Scholar database.

Searching open access databases is another option to find updated research articles. SAGE Open is “is a peer-reviewed... open access journal from SAGE that publishes original research and review articles in an interactive, open access format. Articles may span the full spectrum of the social and behavioral sciences and the humanities” (SAGE Journals, n.d.). This is a great option not only to find research conducted by colleagues in the social science realm, but to also get one’s own work published.

What else can psychologists do? Searching local libraries may be a potential option for some to access hard copies of relevant journals, but it is rare. It is not uncommon for psychologists to connect with colleagues who already have access to journals and/or databases to retrieve information not available to them. This is not recommended, however, as it violates United States Copyright Law and potential ethical concerns of acting accordingly.

The primary goal of this paper is to promote awareness of the ongoing obstacles many psychologists without university, hospital, and/or federal affiliations face in accessing updated research and literature in the field. This primarily involves psychologists working in the private sector or working for agencies. Another goal is to advocate for solutions, which are currently few and far between. Because accessing this literature is so important in all areas of psychological training and practice, access to such resources should be more open and readily available. Further, state psychological associations are poised to best assess their membership and address their psychologists’ need for access to current research.

References


Most Gender AFFIRMING Care is NOT a medical intervention.
The vast majority of gender affirming care takes a mental health based approach to a person’s social transition. This can look like: Confiding in a mental health care provider about your gender or sexuality. Asking educators and clinicians to refer to you by your chosen name and pronouns. Having the space to explore gender expression or how you look and choose to express your gender identity publicly.

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Article: Cultural Considerations in the Development... (pg.4) Recent definitions of professionalism in health service psychology include:
  a) Collaboration  b) Self-Reflection  c) Social Responsibility  d) All of the Above

Article: Leaning into Difficult Conversations... (pg.7) Miranda et al. (2014) confirmed that including social justice training in school psychology programs results in which two of the following?
  a) Increased knowledge of systemic racism  b) Commitment to advocacy
  c) Facility to tailor assessment and intervention to individual student needs  d) Better understanding of barriers to social justice

Professional development focused on cultural competence helps by increasing all but which of the following?
  a) Resource sharing  b) Knowledge  c) Implicit Bias  d) Transformative action

Article: Autism Family Navigation ... (pg.10) Children from lower socioeconomic status households with ASD experience:
  a) Delay in timely ASD diagnosis but no differences in the number of hours of ASD treatment
  b) Delay in timely ASD diagnosis and fewer hours of ASD treatment services
  c) Timely ASD diagnosis but fewer hours of ASD treatment services
  d) Timely ASD diagnosis but no differences in the number of hours of ASD treatment

Autism Navigation Services have been shown to:
  a) Increase likelihood of diagnostic ascertainment for children from racial/ethnic minority, low-income families who are identified as being at-risk for ASD
  b) Increase rates of scheduling and completing appointments for newly diagnosed children with Medicaid
  c) Decrease the time to diagnosis for children from racial/ethnic minority, low-income families
  d) All of the above

Article: The Psychological Impact of a Chronic... (pg.14) What is the best model used for interventions on siblings?
  a) Family psychoterapy  b) Family-Centered Cared  c) Sibshops model  d) Cognitive-Behavioral approach

Article: Misdiagnosing Borderline Personality... (pg.18) What type of bias do the authors believe impacted the results of their study?
  a) Gender bias  b) Racial bias  c) Setting bias  d) All of the above

The results of the study highlight the possibility that Borderline Personality Disorder may be _________ in correctional settings.
  a) Over diagnosed  b) Appropriately diagnosed  c) Under diagnosed

Article: Promoting Equal Access to Mental Health... (pg.22) According to the article, recent evidence reveals that mental health professionals may be _________ to travel a significant distance to relocate to a different (and unfamiliar) geographic region.
  a) Excited  b) Reluctant  c) Neither A nor B

University faculty in mental health training programs are encouraged to:
  a) regularly hold discussions related to mental health service disparities
  b) Examine causes of mental health disparities
  c) Promote strategies designed to remediate mental health service disparities
  d) All of the Above

Article: Lost in the Wild... (pg.26) Which of the following is not a reason the authors advocate for more widely accessible research access?
  a) Necessary for licensure and board certification
  b) Required by law
  c) Continuing education and ethical responsibility
  d) Important for licensure
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Leslie Kern PhD
Jill Klingler PhD
Brandon Kozar PsyD
Elizabeth Kryszak PhD
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Carroll Lahniars PhD
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John Lodge PsyD
Mae MacIntire PhD
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Carolyn McCabe PhD
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Sharie McNamme PhD
Jessica Meyer PhD
Robert Moore MA
Margaret Mosher PhD
Mary Ann Mulcahey PhD
Margaret Oeschger PhD
Indira Palekar PhD
Stana Paulauskas PhD
Jacob Raak PhD
Carrie Robinson PhD
Helen Rodebaugh PhD
Beth Rosen PhD
Richard Rynearson PhD
Matthew Sacco PhD
Daniel Sanders PhD

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Marc Schrimm PsyD
Donald Scott PhD
Richard Sexton PhD
Arnold Shenfeld PhD
David Shuller PhD
Sherry Simon PsyD
Carole Smith PhD
Brittany Sommers PhD
Catherine Staskavich PhD
Susan Steinberg PhD
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Timothy Sullivan PhD
Elizabeth Svenson PhD
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Kimberly Tate PsyD
Karen Taylor PhD
Mary Ann Tettelbaum PhD
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Susan Urmetz PsyD
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OHIO PSYCHOLOGICAL ASSOCIATION
395 East Broad Street, Suite 310
Columbus, OH 43215
(614) 224-0034 | (800) 783-1983
www.ohpsych.org

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