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Table of Contents

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Letter from the CEO

Psychology: An Inclusive Community of Growth and Care

Michael O. Ranney, MPA
Chief Executive Officer
Ohio Psychological Association

It is our tradition to make the Annual Convention theme the focus of *The Ohio Psychologist*, our annual peer reviewed journal. Thus, our theme this year is ***"Psychology: An Inclusive Community of Growth and Care."*** We saw at the convention how this theme took us to the confluence of science/research, social justice, education and the clinical realm highlighting the many ways the psychology community touches and improves people's lives. It is exciting to see that translated into the excellent articles that have been accepted to be published in the 2018 issue of our journal.

Dr. Steven Kniffley with LaTrelle Jackson, PhD, Danielle Graddick, MA, Ernest Brown, MA, Max Tokarsky, MA explores African centered teaching models and the practical implementation of African centered teaching approaches. ***(Translating an Afrocentric teaching philosophy utilizing an applied practice model)*** Use of this model for professional development, understanding diversity and student centered learning is explored. Dr. Kniffley's article concludes with best practice recommendations for implementation of an African centered teaching model in graduate training programs.

In ***Ethical Issues in Dealing with Questionable Disclosures*** Elizabeth V. Swenson, PhD, JD explores ethical issues arising from some unusual client disclosures. Vignettes illustrate each relevant ethical standard and mistakes that might easily be made.

We are all well aware of the terrible opioid epidemic and its impact on people in Ohio. This will be an area in which OPA will be doing significant work in the months ahead. Dr. Ashley Braun-Gabelman, PhD, has written a timely and important article entitled ***Opioid use disorders: The female experience.*** In this epidemic the gender gap is narrowing and women are suffering from opioid use disorder (OUD) in increasing numbers. This article outlines the changing demographics of OUD and reviews specific concerns regarding the female experience of OUD including disease trajectory, co-occurring conditions, treatment planning, retention and barriers, motherhood and pregnancy.

I think we've all seen the numerous posts on the OPA list serv about emotional support animals. More and more this area has been fraught with controversy, confusion and risks for mental health providers who are often asked to provide letters of support. In ***Exploring Current Perspectives of Mental Health Providers on Emotional Support Animals*** Cynthia Van Keuren, PsyD, Kevin Young, PhD, Catherine Gaw, PsyD provide a review of the understanding of emotional support animals from the perspective of mental health providers.

Finally, using the metaphor of Grand Central Station (***A Ticket to Ride: A Metaphor for Definition in an Inclusive Community***), Amel Sweis-Haddad, PsyD takes us on a journey that investigates ways to create a safe environment with freedom to grow.

Another Important tradition is to publish the work of poster winners from convention, recognizing the excellent work of Ohio psychology students. In this journal you will find articles of two student poster presenters who were recognized at convention:

- We are provided with an analysis of assessment options for transgender and gender non-binary (TGNB) individuals for whom there are few viable assessment measures. ***(Implications of Psychological Assessment Norms for Transgender and Gender Non-Binary Populations: A Literature Review)*** Assessment

is complicated because of the many factors that can skew the interpretations. The article by poster winners Peyton Jones, Leanna Pittsenbarger, Devon E. Douglas, Michelle D. Vaughan (Wright State University, School of Professional Psychology) discusses future directions and alternatives to evaluating TGNB individuals.

- Allison Koneczny, a psychology student from Denison University, writes about her work with undergraduate participants were asked to complete a writing activity about a negative life event. ***(Self-Distancing and Emotional Reactivity: How Gender Moderates Effects of Coping)*** She reviews factors that may induce self-distancing and gender differences.

So, all aboard for psychology trip through our inclusive community of growth and care.

OPA is unique among state psychological associations in publishing a peer reviewed journal. We hope you find it useful and we would appreciate your feedback. As a bonus, you can receive CE credit for reading the journal by completing the quiz and submitting it to OPA-MCE (see instructions on page 35).

Next year's journal theme will be Working Together to Build a Culture of Understanding. Please be thinking of an article to write that relates to that this theme for next year and watch for the call for articles.

In the meantime, thank you to all of our authors and contributors to the 2018 *Ohio Psychologist*.

Normally, this introduction would be written by the Editor of our Journal. We are currently searching for an editor so if you are interested or know of people who would be a good fit for that role please call me at the OPA office at 614.224.0034.

Translating an Afrocentric Teaching Philosophy Using an Applied Practice Model

Steven D Kniffley Jr., PsyD, MPA, ABPP | LaTrelle Jackson, PhD
Danielle Graddick, MA | Ernest Brown, MA | Max Tokarsky, MA
Wright State University School of Professional Psychology

Abstract

Given the dearth of Black students in psychology training programs, it is important for instructors to tailor their teaching approach to meet the specific learning needs of this population (Chandler, 2011). An African centered teaching model is one such model that can positively facilitate these students learning. Expanding on previous literature, this article focuses on five main themes from the African centered teaching literature (relationship, experiential learning, authenticity, context, and collectivism). A case study based on the author's work as law enforcement diversity consultants is presented highlighting the practical implementation of an African centered teaching approach. Students narratives are included emphasizing the impact of African centered teaching in the areas of professional development, understanding diversity, and student centered learning. Best practices and recommendations for the implementation of an African centered teaching model in graduate training programs are also noted.

By the year 2043, persons of color will represent the majority of the population in the US (US Census Bureau, 2016). This shift will increase the number of persons of color who will need mental health services. However, several studies have demonstrated that the number of mental health professionals of color will significantly lag behind this population growth and subsequent increased need for mental health services (Chandler, 2011; Piper-Mandy & Rowe, 2010). A significant contributor to this discrepancy is the limited number of Black students in psychology graduate programs. For example, Chandler (2011) found that the rates of Black psychology graduate students has been declining over the last 15 years. Given the dearth of Black graduate psychology students, it will be important for graduate faculty and graduate programs to tailor their teaching approach to meet the specific learning needs of this population.

Expanding on research by Black scholars such Dr. Na'im Akbar and Dr. Molefi Asante, this article focuses on five main themes from the African centered teaching literature (relationship, experiential learning, authenticity, context, and collectivism) (Goggins, 2011). Using the author's current work as diversity consultants, a case study is presented that highlights the practical implementation of these five themes. In addition, student narratives are included to demonstrate the impact an African centered teaching model can have in the areas of professional development, understanding diversity, and engaging in student centered learning. Lastly, this article offers recommendations for the implementation of an African-centered teaching model in a psychology graduate program. While other teaching models exist that are less specific to certain identity variables, the authors chose to explore an African centered teaching model because it provides a tangible example of the intersectionality between professional psychology and an Afrocentric ideology within an apprentice model (which is a foundational aspect of clinical training)

AFRICAN-CENTERED TEACHING

According to Goggins (2011), African-centered education prepares students to assume membership and active participation in their communities. This process is facilitated through a curriculum that increases the student's knowledge and application of the history, science, and philosophy of African people. Asante (1987) indicated that the three goals of African-centered teaching are: (1) develop moral social leadership skills, (2) create tangible solutions for the challenges facing the Black community, and (3) foster relational development between the student, their families, and their communities of origin. Underlying these goals are five principles that direct the experience between instructor and student: (1) building relationships, (2) engaging students in experiential learning, (3) facilitating authentic learning, (4) understanding contextual dynamics, and (5) promoting collectivism.

The relationship between instructor and student should be circular where learning is facilitated by both parties and is non-hierarchical in nature. In addition, an African-centered teaching approach emphasizes that learning should be "hands-on" and synthesizes past experiences with present day problems and concerns. Furthermore, learning should be authentic and facilitate a meaningful connection between the instructors learning objectives and the personal goals/aspirations of the student. Lastly, an African centered teaching approach is adaptable to the education styles and experiences of the student and facilitates community problem solving.

CONSULTATION MODEL OVERVIEW

Psychologists in higher education are challenged to develop creative venues for training the next generation of practitioners, consultants, and educators in light of current complexities in the field. In addition to the need for assessing student learning styles, incorporating current research and evidence-based practices in didactic training, and facilitating engaged learning environments, professors need to contextualize material from an integrated, diversity-sensitive perspective for maximum educational potential. Furthermore, by advancing this framework to also use an applied practice model, the learning process is enhanced for broader mastery and professional development.

One arena that synthesizes diversity competency factors and the application of core psychology principles is consultation. In particular, mental health consultation is an ideal professional practice in that students have structured learning experiences with guided mentorship as they cultivate tangible skill sets. In many respects, mental health consultation embodies key Afrocentric tenets, such as relationship valuing, respect for expertise/authority, and a collectivistic conceptualization; thus, it serves as an excellent training tool for operationalizing lessons taught in the classroom.

Mental health consultation, by definition, serves the explicit purpose of helping consultees help themselves (Wallace & Hall, 1996). The objective is to assess consultee/client needs, determine the optimal strategy to meet identified objectives, provide an intervention and/or deliverable, and conclude with recommendations or after care plans. This method of consultation has been valued for its ability to meet current needs, but also anticipated future needs of the organization. In addition, goal clarity and diversity factor assessments are addressed with similar importance as when professionals develop treatment plans in psychotherapeutic settings (Sears, Rudisill, & Mason-Sears, 2006). Given the nature of the problem, organizational needs, and setting considerations, this study used a program-centered administrative consultation approach to conduct a tiered diversity training process with a mid-size police department.

As the authors considered translating an Afrocentric teaching philosophy utilizing an applied practice model, this form of consultation was an excellent training medium that easily encompassed the three goals of African-centered teaching – develop moral/social leadership skills, create tangible solutions for the challenges that face the Black community, and foster relational development between the student, their families, and their communities of origin.

CASE SUMMARY

A university professor was asked to develop a training program designed to enhance the cultural awareness and diversity competencies of a regional police department. In light of recent national, state, and local events involving police relations with members of the Black community, it was deemed beneficial to address the knowledge, attitudes, and skills of police officers. The objective was to assess diversity awareness and competency factors, then make recommendations for program enhancements.

The university professor contracted with the police chief and assembled a team of clinical psychology doctoral students. After assessing program needs, gathering qualitative and quantitative data reflecting officer attitudes/awareness levels, and developing a training intervention based on the developmental status of the police department staff, the consultation team mapped out a tiered intervention plan – Phase 1 and 2. The first year, considered Phase 1, targeted raising awareness and sensitivity to unconscious beliefs, and attitudes of bias and prejudice. The second year, Phase 2, addressed organizational transformation by advancing beyond awareness to address factors that limit human potential and effectiveness.

This applied practice model cultivated the consultation team's examination of moral, social, psychological, and developmental factors. Thus, they were better equipped to facilitate the evaluation process from an empathic, culturally-contextualized perspective (i.e., "I am because We are"). Next, there is a direct impact on the Black

community if the police who serve that community conduct their job with sensitivity to language, situational, and cultural variables. Tangible solutions for the challenges within the community can be generated from a foundation of relationship building (i.e., "collectivistic framework" – each party has a role and responsibility for desired outcomes). Lastly, this relational teaching style allowed the professor to navigate a reflective process while supporting the trainees' impactful community work.

STUDENT NARRATIVES

Professional development. During our training with the officers, I was given the platform to develop skills related to professional development. There are two specific Afrocentric training principles that had the most influential impact on my experience. First, the relationship that was maintained with my professor was egalitarian in nature. Our professor allowed us to acquire all of the research necessary to implement the police training. After solidifying the curriculum, our instructor asked what role we would like to maintain during the training. I felt that I was given the freedom to choose how hands-on I wanted my experience to be. Lastly, our professor gave us the opportunity to participate in the feedback session after the conclusion of the training. Overall, our relationship allowed me to feel comfortable enough to play a major role in the implementation of the police training.

Diversity training. From an African centered perspective, the building, or establishment, of relationships that are circular and non-hierarchical in nature is essential to learning and growth. The embodiment of this African centered principle by our professor throughout the research and development process helped me to better conceptualize what would be most effective in delivering the diversity training protocol to the police officers. I learned that we were likely to get more engagement, responsiveness and feedback from the officers if the diversity training was delivered in a manner where both parties were co-participants in the process; that we could learn something from them just as they could learn something from us.

Student centered teaching. I feel that an Afrocentric education model has helped me to find growth specific to my needs. Academically, I gained new experience in research, program development, consultation, presentation, and publication. Personally, I was provided an opportunity to collaborate with local community as well as peers that nourished my passions for connection and social justice. Within the non-hierarchal nature of our team's working relationship, I was supported in the application of developing skills in a way that was accepting, non-corrective, and confidence building. Such a project has nurtured growth in my holistic and authentic self beyond the typical scope of my graduate training by undertaking my diverse needs via an experiential and affirming approach to education.

CONCLUSION

Considering the application of an African centered teaching model in the current case example and themes noted from the student narratives the following recommendations are suggested for instructors and programs seeking to adapt this model for the teaching experience of their students:

1. Allude to the emic approach by empowering emerging minority professionals to draw from their own reflective experience as a mechanism for engaging with majority culture organizations in an expert role.
2. Engage students in leadership oriented learning where they are co-owners in facilitating their learning experience as well as translating that learning into practical application to address community based issues.
3. Foster a familiarity with an African centered teaching model with the students via a discussion of the principles presented in this article and their real world application to graduate training.

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Ethical Issues in Dealing with Questionable Disclosures

Elizabeth V. Swenson, PhD, JD

John Carroll University

Abstract

This article explores some questionable disclosures that do not precisely fit the commonly recognized mandatory and permissible disclosures that are outlined in the American Psychological Association Ethical Principles of Psychologists and Code of Conduct (APA, 2017). This article covers a client's admission to a felony and a psychologist's hunches that elders may be being emotionally abused. The Principles of Psychologists and Code of Conduct are cited to show important ethical issues. Vignettes illustrate each relevant standard, covering ethical dilemmas and mistakes that might easily be made.

Most everyone is familiar with the standard list of mandatory and/or acceptable disclosures of confidential information from therapy sessions. These are detailed in the American Psychological Association Ethical Principles of Psychologists and Code of Conduct (APA, 2017).

Consider standard 4.05 (b) Disclosures

> Psychologists disclose confidential information without the consent of the individual only as mandated by law, or where permitted by law for a valid purpose such as to (1) provide needed professional services; (2) obtain appropriate professional consultations; (3) protect the client/patient, psychologist, or others from harm; or (4) obtain payment for services from a client/patient, in which instance disclosure is limited to the minimum that is necessary to achieve the purpose.

REPORTING A FELONY

In the following vignette a psychologist wonders how to decide if a disclosure without client permission is ethical.

> *Howard Fast, PsyD is told by his despondent patient, Emily Sorrow, that she has felt guilty ever since she fed an overdose of opioids to her husband of 35 years who was suffering from severe pain and dementia. Ms. Sorrow could no longer cope with his dementia, could not afford long-term care, and just knew that Earl would not have wanted to live like this anyway. Dr. Fast greatly disliked being in the position of helping a patient justify a murder.*

Is this a crime that needs to be reported? Standard 4.05(b) is of no help here. Consulting the General Principles, which should be done when no standard is on point, helps us think through the ethical dilemma without leading to an answer.

Principle A: Beneficence and Nonmaleficence tells us to work to do good and not to harm people with whom we work.

Principle B: Fidelity and Responsibility, in pertinent part, tells us to be trustworthy and to be responsible to our community.

The Ohio Revised Code § 2921.22 has a general reporting statute which states, "no person, knowing that a felony has been or is being committed, shall knowingly fail to report such information to law enforcement authorities." If a person fails to disclose information to law enforcement, they are guilty of failure to report a crime and may be charged with a misdemeanor. But further, under Ohio Revised Code § 2921.22 (G)(1), there is an exemption for the psychologist-patient privilege. In summary, this confession does not need to be reported in Ohio. Other states may differ.

REPORTING THE SUSPICION OF ABUSE

Consider the following vignette:

> *Kaja Goldman, PhD is treating Mary Jones for the effects of emotional abuse by her boyfriend, Herman Fiend. Despite realizing that his treatment of her has been a major problem for her in socializing with others, and in doing her best work as a writer, she cannot break up with him. She feels increasingly as if he has a spell on her. Herman works as a transporter in a large nursing/assisted living facility. Kaja thinks that this is not the best employment setting for Herman as it is just too easy to emotionally abuse the patients there. Although there is no evidence that he abuses*

anyone but his beloved girlfriend, Kaja thinks this might need to be reported.

First, let us remember what Standard 4.01 (Maintaining Confidentiality) of the Ethics Code requires:

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

This is the basis for considering any disclosures. Dr. Goldman has the primary obligation to keep the information learned in therapy confidential. But what about Standard 4.05(b)(3), permitting disclosure to protect another from harm? Also take in to account that under Ohio Revised Code 5101.61 mandatory reporting extends to elder abuse. The problem here is that Kaja does not know that any elder is being abused. It is only a hunch. At this point she should consult an attorney. She should not go ahead and report her hunch which would breach confidentiality.

Here is a similar case:

> *Ingrid Foster, M.A. offers aftercare therapy to a variety of conflicted young adults, many of whom have been actively addicted for several years of their lives. John Andra is a client of hers. In the course of discussing his addiction history, he mentions that he purchased heroin from a group of attorneys joined in a complicated business association. Ingrid decides that she must report this organization to the Ohio Bar Association or the Ohio Supreme Court. Can she do this?*

Possibly, with her client's permission. Or better yet, she might persuade him to do so. But this relationship is just conjecture on the part of her client, so he does not want to take it further. Thinking of all the young lives at risk due to overdose, Ingrid reasons that this falls within the purview of Standard 4.05(b)(3). She calls the Ohio Psychological Association Ethics "hot line" and explains her dilemma to an Ethics Committee member. The psychologist she consults reminds her of Standard 4.01 and Standard 4.04(b): "Psychologists discuss confidential information obtained in their work only for appropriate scientific or professional purposes and only with persons clearly concerned with such matters." He asks her if she has included any words to support this decision in her informed consent form. Upon reflection, she decides that she cannot breach confidentiality without knowing with certainty that this is a criminal enterprise imposing great harm.

CLIENT RELEASES

The most clear disclosure of confidential information is when a client signs a release of the information. This is codified in Standard 4.05(a) Disclosures: "Psychologists may disclose confidential information with the appropriate consent of the organizational client, the individual client/patient, or another legally authorized person on behalf of the client/patient unless prohibited by law."

Consider the following vignette:

> *Robert Pershing, PsyD's records for Helen Prince have been subpoenaed by Prince's husband's attorney in a divorce action. Robert is not sure how to respond and hopes to make the subpoena go away. He consults his attorney asking that the subpoena be quashed. In the meantime, Helen decided that she doesn't care what her psychologist discloses about her treatment. She voluntarily consents in writing to the release of her information.*

In Standard 4.05, disclosures are divided into two parts: those that are mandated by law and those that are permitted by law. The most prominent mandated disclosures are the reporting of child or elder abuse or neglect and the duty to warn or protect, which is found in Ohio Revised Code § 2151.421. A court order for information also is a mandated disclosure, although there are ways to circumvent it. Another aspect of Standard 4.05(b) is permitted disclosure. These are divided in to four possible "valid purposes." The first of these is to obtain needed services, such as to hospitalize a patient. The second is to obtain consultation. This is frequently needed to provide the best possible service to the patient. The third is to protect the client, psychologist or another person from harm. The duty to protect is often considered mandatory, if it is a credible threat against another person. Typically this requires good judgment and an ability to identify the third party. This is codified in Ohio Revised Code § 5122-3-12. This statute also applies to a credible threat of suicide. The fourth permissible disclosure of personally identifiable information is to obtain payment for services. Under the fourth permissible disclosure are the words that the disclosure is "limited to the minimum that is necessary to achieve the purpose."

Consider the following vignette:

> *Robert Boyce, PhD is upset with his former client Madison Martin for failing to pay his bill properly. Although Robert willingly accepts credit card payment, he has been notified that Madison has withdrawn payment on her credit card and reported that services were not received. In anger he writes to the credit card company that Madison not only has received treatment for her depression but that she also has a border line diagnosis and is erratic in her behavior. He predicts that this will convince the company to reinstate the payment. Clearly this is more information than the company needs.*

Because Standard 4.05(b) includes the words "such as," other disclosures may be appropriate. They require the use of clinical judgment and sensitivity to the confidential nature of the information. In addition, no more personally identifiable information may be disclosed than absolutely necessary. And importantly, the possibility of this disclosure needs to be included in the informed consent document following Standard 4.02, Discussing the Limits of Confidentiality:

> (a) Psychologists discuss with persons (including, to the extent feasible, persons who are legally incapable of giving informed consent and their legal representatives) and organizations with whom they establish a scientific or professional relationship (1) the relevant limits of confidentiality and (2) the foreseeable uses of the information generated through their psychological activities.
>
> (b) Unless it is not feasible or is contraindicated, the discussion of confidentiality occurs at the outset of the relationship and thereafter as new circumstances may warrant.

CONCLUSION

To make the choices in disclosure easier to resolve, Behnke (2004, 2014) proposed a conceptual room with three doors. The first door he labeled client consent; the second, legal mandate, and the third, legal permission. These "doors" can be used as a framework for the vignettes on disclosure discussed in this article.

To read more about difficult ethical issues, take a look at the books by Fisher (2017) and Campbell, Vasquez, Behnke, and Kinschereff (2010), that are written to be helpful to psychologists.

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Opioid Use Disorders: The Female Experience

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Abstract

In Ohio and across the nation, we are in the midst of the ongoing opioid epidemic. Although historically, men have been affected by addiction in greater numbers, the gender gap is now narrowing. Women are increasingly suffering from opioid use disorder (OUD) and are one of the largest growing groups of people afflicted by this condition. Biological and psychosocial distinctions differentiate between men and women who have the same disease of OUD. These delineations have important implications for prevention, treatment and progression of the disease. The present paper outlines the changing demographics of OUD and reviews specific concerns regarding the female experience of OUD including disease trajectory, treatment planning, retention and barriers, and pregnancy.

CHANGING DEMOGRAPHIC LANDSCAPE

Over the past several decades, we have seen significant changes in the demographics of those who use and misuse opioids. Compared to the 1960's, when the majority of opioid users were men who used heroin, presently we see both men and women using heroin and prescription opioids in increasing numbers. Heroin use has increased dramatically among women, those with private insurance, and those with higher incomes (CDC; 2016). As of 2010, women of childbearing age comprised about one third of those with opioid dependence (Unger et al. 2010).

After the rise in prescription opioid use that was observed in the early 2000s, as of 2014, prescription opioid misuse has been decreasing overall (Marsh, Park, Lin, & Bersamira, 2018). Findings are equivocal regarding gender differences in prescription opioid misuse. Several large scale studies have indicated that compared to men, women are more likely to use and misuse prescription opioid medication (CDC, 2016; Green et al., 2009, Rosenblum et al., 2007; Simoni-Wastila et al., 2000,2004, c.f. Back et al., 2011). However, the 2013 and 2014 reports of the National Survey on Drug Use and Health found that men continue to display higher rates of prescription opioid misuse. According to the CDC, overdose deaths involving opioids among women rose 400% from 1999 to 2010 (CDC, 2013). Among women who died due to unintentional overdose, more than heroin, alcohol or other drugs, prescription opioids were found to be the most common cause of death (Shah et al., 2007).

Recent findings suggest that women of all ages are at greater risk of developing OUD compared to men (Koons, Greenberg, Cannon, & Beauchamp, 2018). One explanation for this finding is that women tend to be prescribed opioids more often than men (Anthony, 2008; Gu, 2010; Isacson and Bingefors, 2002; McCabe et al., 2005; Parsells, 2008; Roe, 2003; Simoni-Wastila, 2004; Zhong 2013). This may be owed to greater frequency of chronic pain conditions among women, compared to men. Additionally, women are more likely to report their pain. (Berkley, 1997; Dixon et al., 2004; Koons et al., 2018; Wiesenfeld-Hallin, 2005). Combined, these factors lead to increased vulnerability for opioid use among women.

As with prescription opioid use and misuse, heroin use among women is increasing rapidly. From 2002 to 2013, heroin use among women rose 100% (NSDUH 2002; 2013). Rates of injection heroin use between men and women are comparable (NSDUH, 2013). For women, injection drug use appears to be closely linked to her partner's use of drugs such that women who inject heroin often have a partner who injects as well. Women are most likely to be introduced to injection drug use by a male partner, compared to men who are most likely to start injecting with a friend (Powis et al., 1996). Women are more likely than men to share needles, likely related to the tendency to use with a partner, leading to a higher risk of infection and infectious disease (Maher et al., 2006).

Pregnancy

Although a full review of pregnancy and OUD is outside the scope of the present paper, this population deserves special mention. In 2012-2013, 5.4% pregnant women age 15 – 44 used illicit drugs, 0.1% used heroin and 1% reported use of nonmedical opioids. Maternal opioid use during pregnancy and Neonatal Abstinence Syndrome (NAS) have both been increasing in recent years (Patrick et al., 2012).

According to a joint statement by the American College of Obstetricians and Gynecologists and the American Society for Addiction Medicine (2012), Medication Assisted Treatment (MAT) is recommended in opioid dependent pregnant women. The gold standard treatment for OUD during pregnancy continues to be methadone. However, a large-scale study titled the MOTHER (Maternal Opioid Treatment: Human Experimental Research) project, found that in fact, compared to methadone, those treated with buprenorphine had similar maternal effects and less severe NAS (Jones et al, 2012). Because methadone clinics tend to be less widely available, especially in rural areas, and may be inaccessible to some, the authors recommend that women who are naive to MAT be treated with buprenorphine. In addition, it is worth noting that breast-feeding should be encouraged among mothers using MAT, with benefits outweighing potential risks (ACOG, 2013).

Finally, shame and stigma are of particular relevance among pregnant women with OUD. Common emotions and concerns among pregnant women receiving MAT include denial, guilt, shame, embarrassment, concerns about parenting, and an overall feeling of lack of support from healthcare professionals (Varty & Alwyn, 2011). Additionally, many states continue to charge pregnant women who use drugs with civil and criminal charges. Not only does this decrease the likelihood of getting help and treatment for OUD, it leaves women less likely to get necessary prenatal care as well (ACOG, 2011).

Disease Trajectory

A concept known as telescoping indicates a faster time course of substance use disorder, from first use to substance related problems and negative outcomes. In other words, telescoping is a more rapid disease progression, including more drug related problems in a shorter time frame. Telescoping has been shown to be an accurate fit and description for women who have an alcohol use disorder (AUD), compared to men with AUD. For women with OUD, several studies indicate a shorter duration of illness as well as greater incidence and severity of psychiatric, health and family problems (Greenfield et al., 2007; Hernandez-Avila et al., 2004; Unger et al. 2010; c.f. Holscher et al. 2010). Women are more likely to have co-occurring psychiatric disorders including mood and anxiety, eating disorders, and post-traumatic stress disorder (Back, 2011; Green et al., 2009; Grella et al., 2009; Peles et al., 2014; Ross et al., 2005). The combination of the telescoping effect and greater likelihood of comorbid illness often leads to a more complicated presentation of OUD.

TREATMENT

Despite a more rapid disease progression and increase in associated problems, women are unfortunately, less likely to go substance use treatment, compared to men. The most common referral sources to treatment for women with OUD include community agencies, welfare, and other healthcare providers (Greenfield et al., 2010). Fortunately, for women who do make it to treatment, gender is not predictive of either length of stay or outcome (Greenfield et al., 2007).

Why is there a gender gap when it comes to treatment for OUD? The greatest barriers to treatment for women are those having to do with childcare. Women continue to be more likely than men to be primary or sole caregivers (Bawor et al., 2015), which raises practical obstacles such as finding appropriate childcare so the mother can attend treatment, whether inpatient or outpatient. Many women, especially those who are primary caretakers, may leave treatment early or not go at all due to childcare constraints (Castillo & Waldorf, 2008). Additionally, many women worry that disclosing that they have OUD will jeopardize child custody (Greenfield et al., 2010).

Women, particularly mothers, tend to face even greater stigma than other people with a substance use disorder. Research shows that mothers who abuse substances are

judged more harshly by the public and even by healthcare providers (Castillo & Waldorf, 2008). Higher levels of shame are also associated with relapse among women (Wiechelt & Sales, 2001). These factors all decrease the comfort and likelihood of asking for help.

On the other hand, there is evidence that children can be a great motivator for women to seek treatment for OUD. Some research indicates that women who live with their children are more likely to go treatment. Further, when it is possible for mothers to have their children with them and/or to maintain custody, this leads to greater treatment retention (Greenfield et al., 2010). Socioeconomic factors, including the financial means to secure childcare, may at least partially explain how motherhood, childcare and treatment engagement interact.

In addition to often being caregivers of children, women commonly take on care-taking roles professionally. Women are also increasingly in leadership roles both at home and in the workplace. Thus, it can be a difficult role-shift for women to be in the position to ask for help, rather than being the helper and caregiver.

As we've seen, when compared to men, women are less likely to receive treatment for OUD. However, when women with OUD are compared to women with other substance use disorders, such as alcohol, sedatives, or stimulants, women with OUD may be more likely to enter treatment. A large-scale study looking at the health data of all women ages 15-49 in the state of Massachusetts from 2002-2008, found this to be the case. (Bernstein et al., 2015). Unfortunately though, rather than ongoing treatment, most of these women entered inpatient detoxification for 5 days or less. Only 15% of women completed treatment. This initial entry into treatment makes sense, given the withdrawal profile of opioids. Not surprisingly, women with OUD who only completed detoxification were more likely to relapse compared to those who completed ongoing treatment. It is imperative that following detoxification, appropriate follow up care be arranged. Without continued treatment, increased problems and risks present themselves including a now decreased tolerance, higher risk of relapse and overdose, and a lack of skills to arrest the relapse process.

When women do go to treatment, there is no clear evidence that gender specific treatment is more beneficial than mixed-gender (Zweben, 2003). However, programs that address the particular psychosocial needs of women such as childcare, pregnancy, and mental health, have been shown to be beneficial (Grella et al., 1999; Greenfield et al., 2007; Volpicelli et al., 2000). Additionally, some women report a preference for female only groups. Indeed, there are certain sensitive topics including trauma, especially of a sexual nature, and intimate partner violence which may warrant gender specific groups. Other issues that may tip the scales in favor of a female-specific treatment include increased stigma against women and mothers and balancing the many responsibilities of treatment, work, and home.

CONCLUSION

Certain limitations of the present paper should be noted. In particular, this paper represents a broad overview of gender-specific issues in OUD rather than a comprehensive review. More specific concerns relating to women of color, trans-women, lesbian and bisexual women certainly merit additional attention.

Women continue to suffer from OUD in increasing numbers. Biological, psychosocial and societal factors are such that women's experience of OUD is often quite different from their male counterparts. Despite often having a faster time course of the disease, women are less likely to go to treatment compared to men. Oftentimes, barriers to treatment lie in issues related to care-giving and childcare. Women, especially mothers and pregnant women, continue to face increased stigma from the public, from those in their lives, and even from their healthcare providers. It is imperative that we recognize these important differences in order to effectively understand and treat women with OUD.

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Exploring Current Perspectives of Mental Health Providers on Emotional Support Animals

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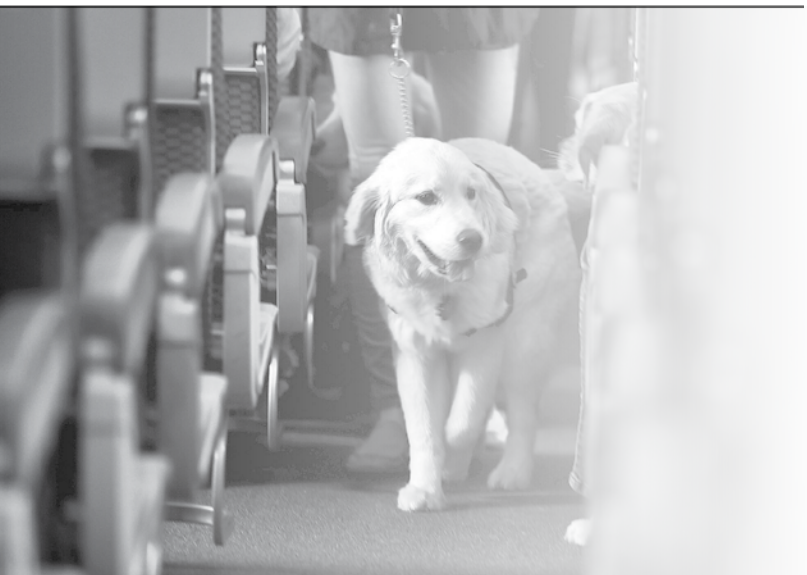
Abstract

The prevalence of Emotional Support Animals (ESA) is growing as is the related controversy surrounding the use of these animals. The increasing social media attention to ESAs often provides touching stories of animals who have helped improve the emotional quality of life of their handlers. But the ever-growing presence of ESAs is causing confusion for the public in distinguishing between ESAs and service animals. Meanwhile, mental health providers are being asked to write letters of support for ESAs in the absence of clear guidelines as to whether this falls within a generalist's scope of practice or is consistent with effective therapy models. This article looks to elucidate the current understanding of ESAs from the perspective of mental health providers. Based on this survey of mental health professionals, there are no particular criteria to qualify a mental health professional to write letters of support for ESAs. It would be important for advocacy groups and professional organizations to discuss the role of ESAs in treatment planning and guidelines for writing letters of recommendation.

There has been growing interest in the use of Emotional Support Animals, or ESAs. These animals can now be frequently found in spaces we would not have previously seen them, such as on airplanes, in college dormitories, and in medical centers. Psychologists and other mental health providers are often asked to write letters of support for those seeking an ESA but may not fully appreciate variables for consideration (Boness, Younggren, & Frumkin, 2017). In order to best understand the factors to consider when writing letters of support for ESAs, it is important to understand the distinctions between service animals and ESAs. Service animals are the only group of animals afforded protection by the Americans with Disability Act (US Department of Justice). These animals undergo extensive training and assist the handler with a specific, identified disability. Within this category are psychiatric service dogs who are trained to perform a specific task related to a person's emotional disability (Schoenfeld-Tacher, R, Hellyer, P., Cheung, L., & Kogan. L., 2017).



The relatively newer category of assistance animal is the Emotional Support Animal. These animals are determined by a health care provider to be necessary in assisting the handler with a disability-related need. ESAs are not required to undergo any specific training or perform specific tasks related to the handler's disability. ESAs are afforded no protection under the Americans with Disabilities Act. Unfortunately, there are concerns of fraudulent use of ESAs as allowing pets, rather than service animals, to gain access to public places (Schoenfeld-Tacher, R. M. & Kogan, L. M., 2017).

CONSIDERATIONS FOR THE MENTAL HEALTH PROVIDER:

ESAs have garnered considerable attention as of late regarding air travel and housing. According to the Air Carrier Access Act, passengers wishing to travel with ESA must have a letter on the letterhead of a licensed mental health provider indicating that the passenger has a mental health disability, that having the animal accompany the passenger is necessary to the passengers mental health or treatment, that the individual providing the assessment is a licensed mental health profession and the passenger is under his/her care, and includes the date and type of the professionals licensed and the state in which it was issued. Notably, a quick Google search will show you that there are providers available online who will certify ESAs online in the absence of having met the animal or diagnosed the patient; subsequently, this process is vulnerable to misrepresentation and fraud.

It is important to realize that as a mental health provider writing a letter of support for an ESA, the mental health provider is declaring the patient to be disabled by their mental health symptoms and that the animal's presence improves the disabling symptoms (Boness & Younngren,

unpublished manuscript). Documenting this information and providing the endorsement for an ESA could fall outside of the provider's scope of practice, depending on the mental health professional's training and scope of practice.

There is also very limited empirical literature on the effectiveness of ESAs, calling into question the rationale for integrating ESAs into mental health treatment planning. Endorsement of ESAs has the potential to create conflicts within the therapeutic relationship as the need for the animal in the management of mental health symptoms may change over time. For example, if the mental health provider endorses the ESA as part of a patient's plan of care for depression management, what is to become of the ESA should the depressive symptoms resolve? In addition, there should be some consideration as to the provider's responsibility in monitoring the welfare of the animal that has been recommended as part of the patient's plan of care. For example, can a mental health provider reasonably provide a recommendation for a dog to someone who is undergoing treatment for impulse control disorder or anger management problems?

The purpose of this study was to assess the understanding of mental health professionals of the roles of ESAs, professionals' comfort with providing letters of support for ESAs, and the process of integrating ESAs into treatment planning. The information was gathered through an online survey.

Participants:
The survey developed for this study was distributed to the email list for licensed psychologists in Ohio and to mental health professionals working at the Cleveland VAMC. The survey was posted from April 3, 2017 through May 18, 2017. Because the survey was available through social media, it is not known whether the survey may have been forwarded to other mental health professionals not included in the original sample. A total of 152 mental health professionals responded to the survey. Respondents ranged in age from 26 to 80 years old, with 41 males and 109 females responding. The mental health professionals who responded ranged in terms of years practicing from 1 to 55, with a mean of 16 years (SD 12).

Method:
An online survey was designed by the primary author with input from those involved in researching ESAs. The survey was available from April 3, 2017 through May 18, 2017. One hundred fifty-two individuals who identified themselves as mental health providers completed this survey. The second author categorized the free text responses according to thematic representation. For the majority of the questions, this allowed for responses to be categorized as yes, no, or other.

For the purpose of this particular article, the following dependent variables were prioritized for the survey of the mental health providers:

1. Do you believe that you are qualified to determine a client's need for an ESA?
2. Have you made a recommendation for an ESA?
3. Do you use any standardized measures in determining the need for ESA?
4. Are you familiar with the literature on the effectiveness of ESAs?
5. Do you collaborate with the trainers who are working with your clients and their ESA?
6. Do you determine which tasks are in the best interest of the client's emotional support needs?
7. Do you believe that mental health providers who have recommended an ESA are responsible for monitoring the health and welfare of the ESA?

Procedure:
All participation was voluntary and anonymous.

RESULTS

In total, results from the survey failed to show a significant pattern of relationship between any of the measured therapist variables and the dependent variables described above. In total, of the 28 potential relationships between these variables (4 therapist variables by 7 dependent variables), only one (education level by belief in qualification to determine ESA) was statistically significant, and it should be noted that even this finding is tempered by both a small observed effect size, and a relatively circumscribed response pattern difference within the sample. As can be seen in Table 1 on page 18, individuals with a doctorate other than a Ph.D. or a Psy.D. were more likely to view themselves as qualified to determine a client's need for an ESA than were individuals with other degree types. Overall, this was representative of a larger pattern in responding among individuals. Exploratory EFA (principle components analysis) showed relatively little

TABLE 1: Response totals for qualification question by degree type

Educational Identifier		Do you believe that you are qualified to determine a client's need for an ESA?			
		No	Yes	Maybe	Total
	PhD	39	17	11	67
	PsyD	15	6	3	24
	Other Doctorate	2	7	2	11
	MSW	8	4	0	12
	Other Masters	18	7	1	26
	Other Social Work	1	1	1	3
	Other	5	3	1	9
Total		88	45	19	152

concordance among the responders, but what agreement there was (26% of variance accounted for) was explained by a factor which appears to represent responder confidence.

DISCUSSION

The results of this survey indicate that mental health professionals are not like minded in their understanding of or support for ESAs. This study demonstrates the needs for clear guidelines for mental health professionals as the demand for letters of support continues to grow. As the data from this survey indicates, there is no consensus among mental health providers as to the process of endorsing, the effectiveness on symptoms, or the responsibility for monitoring ESAs in the treatment of mental health conditions. The survey results show that there is no particular demographic or subgroup of mental health providers who view themselves as being more qualified than any other group when it comes to writing letters of support for ESAs.

As pressure grows for mental health professionals to write letters of support for ESAs, it would be helpful for professionals to have access to definitions and guidelines when making decisions about writing such letters. But again, if no one among those surveyed consider themselves to have the relevant expertise, it will be difficult to identify a work group of professionals to create these guidelines. Perhaps it would be helpful to approach this professional dilemma by identifying the roles, if any, that we see ESAs playing in our plan of care and then developing research that would speak to the effectiveness of ESAs in our care.

It would be important for advocacy groups and professional organizations to discuss the role of ESAs in treatment planning and guidelines for writing letters of recommendation.

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A Ticket to Ride:
A Metaphor for Definition in an Inclusive Community

Amel Sweis-Haddad, PsyD

Abstract

In order for a community of diverse individuals to create a caring and safe environment where they can exercise their freedom to move and grow, communication between individuals needs to be improved so they can achieve goals and resolve conflicts. A metaphor utilizing Grand Central Station illustrates the importance of clear definitions and synchronicity. NYC commuters generally understand that railroad and subway lines are defined by their terminal stops and travel based on the understanding that a line is bi-directional, with sequential stops along the way on a linear continuum. The destination that is pursued determines the route that is taken. The metaphor addresses how the communication problems and conflict that arise between individuals (or groups) can be mitigated through the use of consensual definitions, as well as reliable translations of those definitions, so that individuals (or groups) can arrive at a particular solution or endpoint and avoid unnecessary confusion.

One of the most basic problems encountered in a diverse community is that of communication. When there are problems with language usage, difficulties arise with decision making about how to achieve goals or navigate toward a particular destination. As a Behavioral Psychologist who works with children and their families, I understand that the success of my work is dependent upon family members and teachers using clear definitions of behavior so a child understands what is expected and can navigate toward desirable ends.

It is understood that Behavioral Intervention Plans work best when there are clear definitions of appropriate and inappropriate behaviors. Parents and teachers generally identify behaviors that are phrased in a diametrically opposed manner (for example: behaviors are labeled as Inattentive or Attentive, Oppositional or Compliant, Disorganized or Organized, Anti-social or Social, etc…). The use of antonyms helps identify behaviors that are polar opposites, like the two endpoints on a line. The use of opposite words or terms help anchor behavioral concepts, much like the terminal points on a line containing many sequential points (stops). It is this line, or continuum, where we conceptualize that behaviors are expressed and where behaviors are shaped in therapy.

It is also understood that individuals comprise a community, and that groups of individuals have different definitions based on cultural, religious and political beliefs. This paper utilizes a metaphor to address how the communication problems and conflict that arise between individuals (or groups) can be mitigated through the use of agreed upon definitions, as well as reliable translations of those definitions, so that individuals (or groups) arrive at a particular solution or endpoint and avoid unnecessary confusion.

I was in New York City for Spring Break with my daughter. We were at Grand Central Station, lost as could be, trying to find our way to the United Nations. Which subway line? Which track? What time should we leave? Should we take a Local or Express line? So many questions… so little time!

Ah, an information booth in the middle of the main concourse with a knowledgeable person ready to answer our many questions! Standing in line, we finally had our turn to speak with the woman behind the glass window, an African American woman with long braided hair. I asked her several questions, one at a time. She, in turn, unflinchingly answered each question, one at a time. Her experience had taught her well. We told her our desired destination and she gave us the route. She explained there were several other routes but the one she recommended was the one with the least amount of stops and was the most direct. She told us the track and the next departure time. This woman essentially mapped out for us the most efficient way to travel. All she needed to know was our desired destination and when we wanted to leave. We were set!

Day two in New York City: We wanted to visit The Statue of Liberty. Same problem. We were not sure which line to take and went to the information booth. Same questions. Same helpful lady. Once again, she gave us our route, departure time, and noted the express and local lines so we could choose which one we desired.

Third day: In our effort to visit beacons of hope, freedom, and peace, we encountered the same story with the information booth lady. By then I had come to the realization that I was very jealous of this woman. She was experienced, smart, and efficient in her advice. I wanted to be just like her. Really! I was jealous! She was

the wise Oracle, possessing knowledge and know how. She possessed a working knowledge of Manhattan that was enviable. She could virtually tell anyone how to get to any destination and even had maps that she willingly shared. She was a Metro North employee and I was a Psychologist; and what we shared in common at that moment was a sincere desire to help people obtain their goals.

I thanked her again for her help the last day of our stay and exclaimed that it must give her a great sense of satisfaction to be able to help people the way she does, assisting them to get from one place to another. I told her I wished I could do it as well as she did. It was at that moment that I saw a powerful metaphor that could be used to help decipher and remediate the challenges parents face today. I needed a ticket that day, but I needed the ***right*** *ticket and there were some important things I needed to know before I bought one.*

In 2016 and 2017, I wrote two papers for the *Ohio Psychologist* called "Using metaphors to Address the Maladaptive Behaviors of Children" and "The Rhetoric of Psychologists Who Lead, Connect and Heal Families." It thus seemed quite appropriate for me to expand on the ideas contained in those papers by addressing how psychologists can promote an inclusive community of growth and care using the Grand Central Station metaphor.

New York City is one of those fashionable and erudite international cities filled with ethnic, cultural, and economic diversity. Its famous railroad station is the largest in the world with 44 platforms, encompassing almost 48 acres. It is big! It is one of the world's most popular tourist attractions. People from all over the world come to New York to live, work, and vacation. It is truly diverse. And for those 750,000 passengers who choose to travel through the station daily during the week, there is a recognition that although they are autonomous, free spirited individuals endowed with the freedom to choose, there is an inherent structure to their mode of getting from point A to point B.

The architects of the railway system specified and identified particular points along defined pathways as stops and terminal points. Indeed, the correct name for this magnificent place is Grand Central Terminal. *Terminal* being the word used because it is the final stop on a particular line. However, it is also a stop on other intersecting subway lines. Commuters generally understand that railroad and subway lines are defined by their terminal stops and take the appropriate mode of transportation based on the understanding that a particular line is bi-directional. Commuters must know which direction they want to travel on a particular track.

Spatial positions, such as stops along a particular railway or subway line are *sequential* stops on a linear continuum. Commuters of diverse backgrounds and intentions move in *space-time* by identifying WHERE they desire to go and WHEN they desire to go. They can then volitionally take a step in the direction of their desired destination. Their understanding of the railway and subway system layout (map) and the timetables (schedule) is the necessary first step for them to make a rational free choice in obtaining their goal to get to a desired location. It is this "foreknowledge" that allows them to move purposefully, at a given time, from a point in space-time toward some other point, much like a Euclidean vector.

The consultative behavioral work I do with families is client driven. Parents come to my office and identify specific problems that their children are encountering. I help parents identify solutions for these problems and then help them to motivate their children to make desirable choices. This is accomplished by teaching parents how to simplify communications so they are positive and goal oriented. For example, if a child wants to play outside but has not done homework, the parent is encouraged to tell the child, "Yes, you can go outside AFTER you finish your homework." Parents help their children reach goals or "destinations" by mapping *pathways* to help their children reach goals. Since purposeful behavior is goal oriented, individuals need to first know where they are going in order to map out an efficient route to get there. Generally, people choose the fastest, shortest and most efficient routes to obtain their goals. Elementary school math teaches: the shortest distance

between two points is a straight line. Thus, I emphasize: *Destination determines route.*

The child is thus conceptualized as traveling along a linear continuum to get from point A to point B. At any given point, the child is either *closer* or *further* away from the desired destination. This pathway has two clearly defined terminal points. The points are dichotomous: going outside OR not going outside. One choice is "acceptable" and valuable to the child while the other is described as "unacceptable" and problematic by the child (staying inside). The child understands that to get outside homework must be done first. Although the route is linear, the terminal points are dichotomous. The "*Terminal Markers*" must be understood to be at opposite ends of the linear spectrum in order for the child to *choose* which direction to travel.

What arises from this paradigm is a *value based system* where parents and children identify certain destinations as either desirable or undesirable. Members of a diverse community, like the one in New York, have their own individualistic norms and pathways but they must understand the same language (or provide translations) for the defined pathway names and terminal stops. It seemed inherently logical for the architects of Grand Central Terminal to draw a map with clear definitions of stops along the line and create a schedule in order for the diverse community to avoid chaos. Commuters need to know which direction to travel and when to catch their train. Terminals cannot have the same name and one cannot just ride a train whenever desired. There is a time and place for action. Commuters must synchronize their watches with the four face round Vanderbilt clock atop the information booth. Grand Central Terminal does NOT work with arbitrary definitions and times that are individually determined. The stops along the tracks are clearly defined (and scheduled) in order to help commuters assess whether they are closer or further to their desired destination.

In 1884 thousands of watches and clocks had to be synchronized in order for the renovated train station to properly function so trains could run on time and not collide. A daily synchronization was set up since the commuter network would be a busy place with people of diverse backgrounds and intentions, traveling in different directions. People were free to travel in the newly renovated railroad but there was a schedule with clearly identified terminal stops. Sure, there were stops in between the terminal points, but for ease of travel, direction was to be determined by the terminal stop. In order for New York's diverse community to thrive and grow, its architects had to ensure the safety and care of the commuters. *Synchronization* was necessary to avoid chaos along the commuter pathways.

Logically, we understand that freedom requires individuals to *discern* distinct differences so a course of action can be chosen. We do not just look at similarities. Behavioral psychologists help clients develop better discernment by utilizing clear definitions. We work with clients to develop intervention plans whereby certain behaviors are understood to be positive while others are understood to be negative, or simply desirable and valuable or undesirable and problematic. Value judgments are inevitable.

One of the greatest challenges and/or opportunities behavioral psychology faces today is how it improves communication and reduces conflict between individuals and groups. Psychologists are encouraged to embrace the metaphor that clients are trying to buy a "ticket to ride" on a line with dichotomous terminal points. *The railway and subway lines are inclusive; anyone can ride. But the names of the lines and stops are exclusive.* The terminal points are dichotomous. We champion freedom. However, the truth remains that in order for a community to be a caring and safe environment where people exercise their freedom to move and grow, we must speak clearly, securing the signposts and terminal points, teaching our children how to obtain goals and reach their desired destinations. They must know the outcomes of the pathways they choose. There must not be confusion. We have a responsibility to care for our children.

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Implications of Psychological Assessment Norms for Transgender and Gender Non-Binary Populations: A Literature Review

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Abstract

Psychologists utilize hundreds of different assessment measures that are statistically normed for a variety of populations, including cisgender men and women. However, there are few assessment measures with norms for transgender and gender non-binary (TGNB) individuals. The available literature identifies complex issues related to using popular assessments with TGNB individuals. For example, clinicians sometimes must determine whether existing, binary male or female norms best fit for a TGNB client, which can impact scoring and skew interpretations. Additionally, minority stress and changes that occur during medical transitions can add complexity to interpreting assessment results. Elevations on personality/psychopathology instruments may be due to effects of gender minority stress or medical transitions rather than be indicative of actual psychopathology. Changes in cognitive functioning can result from engaging in hormone therapy, which could affect the results of cognitive and neuropsychological measures. Interpreting assessments without consideration of these variables could result in misdiagnosing or overpathologizing an already marginalized population. Future directions and alternatives to evaluating TGNB individuals are discussed.

INTRODUCTION

Statistical norms allow clinicians to interpret scores on psychological assessments by relating one's individual test score to those of a similar population having, for example, the same gender, age, or education level. A multitude of the psychological and neuropsychological assessments used by psychologists and other professionals are statistically normed for cisgender women and men but not for transgender and gender non-binary (TGNB) individuals. TGNB is commonly used as an umbrella term to describe a wide variety of individuals who have a gender identity that does not fully match the sex they were assigned at birth. For the purpose of this paper, the term *transgender* is used to describe a person whose sex assigned at birth was male or female and they identify as the opposite gender of their assigned sex (i.e. man or woman). The term *gender non-binary* is used to describe people whose gender identities do not fall within a binary model of gender (i.e. does not identify fully as either a man or a woman). However, not all TGNB people self-identify as transgender or gender non-binary (American Psychological Association, 2015).

The lack of statistical norms for this population often leads examiners to choose between categorizing transgender examinees by their gender identity or their sex assigned at birth for scoring and interpretation purposes. This categorization can often lead to an inappropriate or inaccurate interpretation of test data, which could cause clinicians to misdiagnose these examinees. This raises the question of how statistical gender norms are applied to individuals who identify as transgender or outside of the male-female gender binary, face discrimination and stigma related to their gender identity, or may potentially be undergoing gender-affirming medical transitions.

EFFECTS OF GENDER MINORITY STRESS ON ASSESSMENT

The minority stress model describes how the prejudice, discrimination, and stigma faced by socially marginalized groups can cause increased stress and poor health outcomes in these populations (Meyer, 1995; 2003). TGNB individuals experience alarmingly high rates of discrimination, violence, and rejection based on their gender identity or expression. This population reports high rates of physical and sexual violence, unemployment, homelessness, healthcare disparities, and overall harassment related to their TGNB identities (McCarthy, Fisher, Irwin, Coleman, & Pelster, 2014). These stressors result in a variety of negative mental health outcomes including, but not limited to, increased rates of depression, anxiety, low self-esteem, paranoia, substance use, suicidal ideation, suicide attempts, and completed suicide (Hendricks & Testa, 2012; McCarthy et al., 2014).

Minority stress and other cultural experiences unique to the TGNB population are thought to impact scores on psychological tests, especially personality and psychopathology assessment instruments (Keo-Meier &

Fitzgerald, 2017). The Minnesota Multiphasic Personality Inventory – 2nd edition (MMPI-2) is one of the most commonly used personality instrument (Butcher et al., 2001) and has been researched with the TGNB populations more than any other test of personality (Keo-Meier & Fitzgerald, 2017; Miach, Berah, Butcher, & Rouse 2000). Experiences of gender dysphoria, which refers to one's discontent with their assigned sex (American Psychiatric Association, 2013), and/or gender minority stress can cause elevations on the Depression and Anxiety scales. Additionally, gender dysphoria related to body image concerns can influence elevations on the Hypochondria and Hysteria scales. Interpersonal problems related to the lack of acceptance of TGNB individuals in society can potentially elevate the Psychopathic Deviance scale (de Vries, Doreleijers, Steensma, & Cohen-Kettenis, 2011). Duckworth and Anderson (1995; as cited in Keo-Meier & Fitzgerald, 2017, p. 57) found that high rates of discrimination and family rejection along with feelings of being misunderstood, lonely, resentful toward unaccepting family members, suspicious and guarded, and afraid of physical attacks can affect elevations on the Paranoia scale (See also: Hendricks & Testa, 2012). Lastly, elevations on the schizophrenia scale may be associated with strained family relationships, social alienation, and questioning self-worth and identity (Butcher et al., 2001). Affirming clinicians should understand how cultural experiences unique to TGNB individuals are likely to influence assessment results to avoid overpathologizing this marginalized population.

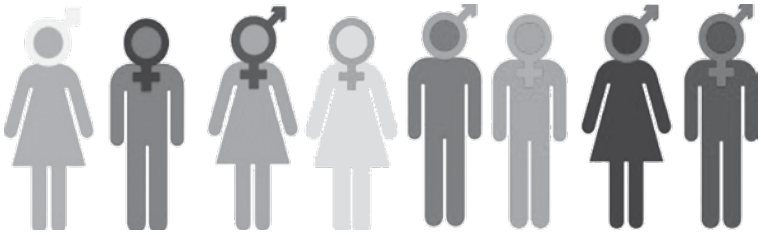
EFFECTS OF GENDER-AFFIRMING TREATMENTS ON ASSESSMENT

The neurophysiology, cognitive functioning, and mood levels have been shown to change in TGNB individuals who choose to undergo gender-affirming hormone therapy or surgery (Meier, Fitzgerald, Pardo, & Babcock, 2011; Davis & Meier, 2014; Hulshoff Pol et al., 2006; Keo-Meier et al., 2015). These changes can affect how TGNB individuals score on a variety of assessments normed for cisgender identities, including cognitive, neuropsychological, and personality instruments. Hormone therapy for transgender women that pairs the suppression of testosterone with the addition of estrogen can reduce anger and aggression proneness, sexual arousal, sexual desire, and spatial ability while increasing verbal fluency. Conversely, testosterone addition in transgender men can increase aggression proneness, sexual arousal, and spatial ability while reducing verbal fluency (Hulshoff Pol et al., 2006). Hormone therapy was found to be associated with an increased quality of life and decreased levels of anxiety, depression, stress, and paranoia (Meier et al., 2011; Keo-Meier et al., 2015). Lastly, gender-affirming surgical procedures are associated with lower levels of body dissatisfaction and gender dysphoria (Davis & Meier, 2014). The effects of these varied treatments on different cognitive and psychological factors can lead to fluctuations in assessment scores which could present an inaccurate clinical picture of the individual's broad functioning depending on their transition (Keo-Meier & Fitzgerald, 2017).

Therefore, clinicians must take one's stage of transition, if any, into consideration when interpreting assessment findings to provide the most affirming care.

RECOMMENDATIONS FOR SCORING AND INTERPRETATION

There is no standardized method for scoring assessments that use cisgender scoring templates when used with TGNB clients. Therefore, Keo-Meier and Fitzgerald (2017) encourage clinicians to use extensive data gathered from in-depth clinical interviews, requested records, and symptom inventories to answer assessment questions if possible. If gender-normed assessments must be used (i.e. due to agency policies, availability issues, monetary restrictions, or program eligibility requirements), clinicians should consider scoring the measure(s) with both male and female templates before interpreting the findings in the context of other collected data to determine which template most aligns with the rest of the assessment information. However, clinicians who administer and score assessments with a computer may face financial barriers to score measures multiple times. In such instances, clinicians should select the scoring template that is most congruent with the client's gender identity if possible. Additionally, clinicians can administer the Gender Minority Stress and Resilience Scale (Testa, Habarth, Peta, Balsam, & Bockting, 2015), which measures one's experience of gender minority stress and protective factors for psychological well-being, to inform a more accurate case conceptualization when interpreting assessment results.



CONCLUSION

Overall, the current literature discusses the implications of the current lack of cognitive, neuropsychological, or personality assessment measures that have been normed or validated for use with the TGNB population (Keo-Meier & Fitzgerald, 2017). To provide the most accurate, affirming assessment services to TGNB individuals, clinicians must consider their clients' experiences of minority stress and transition, if any, when interpreting assessment results. By expanding on previous literature, additional research must be conducted to obtain TGNB-normed data for psychological assessments to provide the best care to this population.

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Self-Distancing and Emotional Reactivity: How Gender Moderates Effects of Coping

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Abstract

Previous research has shown that self-distancing from negative life events is associated with lower emotional reactivity, with gender being a possible modifier. In this study, undergraduate participants were randomly assigned to the manipulation or control condition and asked to complete a writing activity about a negative life event. The manipulation group was instructed to use second or third person pronouns to induce self-distancing, while the control group was given no pronoun-change instruction. There was a significant condition x time interaction on emotional reactivity (partial eta2 = .07). However, the manipulation failed to produce a self-distanced perspective, with no significant gender differences.

When people cope with experiences, they attempt to use cognition to mitigate negative emotional responses. Cognitive coping is conceptualized as the cognitive efforts to manage the intake of emotionally arousing stimuli (Compas et al., 2001). Rumination is an example of a maladaptive coping strategy. It is the focused attention on the symptoms of one's distress, and on its possible causes and consequences, as opposed to its solutions (Nolen-Hoeksema et al., 2008), and can lead to feelings of depression and loneliness. Women tend to ruminate more than men and are twice as likely to have depression (Johnson & Whisman, 2013).

Self-distancing is an adaptive coping strategy that is relatively new to the world of research. It is the ability to take a step back from the current situation, taking an outsider's perspective to a personal issue. The ability to self-distance can allow people to work through negative experiences in ways that promote meaning-making rather than rumination (Kross & Ayduk, 2011). This is something that can be done daily and lead to greater abilities of emotion regulation, self-reflection, and greater overall wellbeing (Pennebaker, 1997; Kross & Ayduk, 2011).

SELF-DISTANCING THROUGH PRONOUN USE

Using second or third person pronouns instead of first person pronouns is a way to self-distance oneself from an event (Orvell et al., 2017). One way to do this is by referring to oneself in the "generic-you" form. This form is used when a person refers to themselves as "you" instead of "I" or "me." One study found that producing the generic-you perspective while reflecting on negative experiences allows people to "normalize" their experience by extending it beyond the self (Kross et al., 2014).

GENDER DIFFERENCES IN PRONOUN USE

The use of singular first-person pronouns is associated with lower social standing (Kacewicz et al., 2017), as well as greater levels of depression (Edwards & Holtzman, 2017). Women's communication contains more first-person pronouns (Newman et al., 2008) and aims to clarify internal perspectives more than men's communication (Newman et al., 2008). Because of this difference in pronoun use, women are less likely to have spontaneously self-distanced than men.

THE PRESENT STUDY

This study investigates the relationships among gender, self-distancing, and emotional reactivity. It is expected that (a) participants in the self-distancing condition will report less emotional reactivity to their negative event and greater levels of self-distancing from the event and (b) that women in the self-distancing condition will report a greater decrease in emotional reactivity to their negative event than men in the self-distancing condition.

METHOD

Participants

Participants consisted of undergraduate students at Denison University in Granville, Ohio. They ranged in age from 18-24, with the mean being 19.7 years. They were recruited via the SONA system as well as via flyer and were compensated with either 3 SONA credits for their Introductory Psychology course or a $10 Amazon gift card.

TABLE 1: Participant Demographic Information

	Control Condition		Treatment Condition		Total	
	Number	%	Number	%	Number	%
Gender						
Female	24	72	20	64.5	44	68.8
Male	9	27	11	35.5	20	31.3
Age						
18	6	18.2	4	12.9	10	15.6
19	13	39.4	10	32.3	23	35.9
20	5	15.2	9	29	14	21.9
21	5	15.2	4	9.7	9	14.1
22	3	9	3	9.7	6	9.4
23	0	0	1	3	1	1.6
24	1	3	0	0	1	1.6
Race						
African American	0	0	4	12.9	4	6.3
Asian	6	18.1	2	6.5	8	12.5
Indian	0	0	1	3	1	1.6
Latin(x)	3	9	1	3	4	6.3
Multiracial	2	6.1	3	9.7	5	7.8
Other	1	3	0	0	1	1.6
White	20	60.6	19	61.3	39	62.5
Total	33		31		64	

The intended sample size was 80 participants, with 20 participants in each condition. However, there ended up being 64 participants in total, with 24 women in the control condition, 20 women in the treatment condition, 9 males in the control condition, and 11 males in the treatment condition.

MEASURES

Demographics

Participants were asked to report their age, gender, ethnicity, and race.

Scales

This study utilized the Patient Health Questionnaire (PHQ-9) (Kroenke et al., 2001), the Rumination Reflection Questionnaire (Trampnell & Campbell, 1999), and the Self-Compassion Scale (SCS) (Neff, 2003), to assess levels of depression, rumination, and self-compassion within participants.

Participants reported levels of self-distancing pre and post manipulation. The measure for self-distancing was adapted from a different research study exploring pronoun use in relation to self-distancing (Kross et al., 2014).

Participants reported levels of emotional reactivity pre and post manipulation. The measure for emotional reactivity was also adapted from the Kross et al., 2014 study. The pre-manipulation responses were controlled for as a covariate in the analyses in order to more precisely compare the differences in post emotional reactivity between participants in different conditions.

Design

This study utilized a 2 (gender) x 2 (condition) x 2 (time) mixed design with four conditions, female/manipulation, female/control, male/manipulation, and male/control. Participants were first randomly assigned to either the manipulation or control group.

The manipulation began with a series of questionnaires including demographic information, the PHQ-9, the Self-Compassion Scale, and the Rumination Reflection Scale. Participants then reached a point in the survey that they were prompted to recall a negative event in their life. After this, participants reported how self-distanced and emotionally reactive they felt towards the event.

Participants were then instructed to complete a writing activity about their negative event. Those in the treatment condition were directed to change their pronoun use while writing, while those in the control condition received no direction on pronoun use.

Participants were able to move on to the final questions of the survey after the timed 10-minute writing period ended. They were asked to re-imagine their negative event once more, and to complete the post-manipulation self-distancing and emotional reactivity questionnaires. Once finished, participants received a debriefing form and mental health resources.

RESULTS

Sample

Analyses of pretest data revealed that participants in the intervention and control groups were comparable on measured demographics such as age, $t(62) = .558$, $p = .46$, gender, $t(62) = .753$, $p = .39$ and covariate variables (such as baseline emotional reactivity), $t(62) = .001$, $p = .98$.

Manipulation Check

To ensure there was no significant baseline difference between the control and manipulation group, self-distancing baseline scores were compared, $t(62) = 2.41$, $p = .846$. Because there was no difference at baseline, it can be inferred that the difference between the control group and treatment groups' reported levels of self-distancing post manipulation can be attributed to the effects of the manipulation itself.

There was no significant interaction between time and condition on mean reported levels of self-distancing, $F(1, 62) = .004$, $p = .95$, no main effect of time, $F(1, 62) = .004$, $p = .95$, and no main effect of condition, $F(1, 62) = .033$, $p = .87$. Because of this, it appears that the manipulation had no influence on levels of self-distancing experienced by the participants. (See Table 2 on page 31).

Emotional Reactivity

There was no significant difference between the control and manipulation groups' reported emotional reactivity at baseline, $t(62) = .001$, $p = .98$.

There was a significant interaction effect between time and condition on mean reported levels of emotional reactivity, $F(1, 62) = 4.54$, $p = .04$, partial eta2 = .07. Participants within the control group reported decreased emotional reactivity post-manipulation, while participants in the treatment condition reported increased emotional reactivity. (See Table 2).

There was also a significant main effect of time on mean reported levels of emotional reactivity, $F(1, 62) = 5.47$, $p = .02$, partial eta2 = .08. The overall mean score of emotional reactivity at baseline was 14.02 (SD = 4.72), while the overall mean score post-manipulation was 13.75 (SD = 5.31).

There was no significant main effect of condition on reported levels of emotional reactivity, $F(1, 62) = .72$, $p = .40$.

Gender x Condition Interaction

When controlling for baseline emotional reactivity and PHQ-9 score, there was still no significant interaction effect of condition x gender on reported levels of emotional reactivity post manipulation, $F(1, 62) = 2.192$, $p = .14$, nor a main effect of gender on reported levels of emotional reactivity, $F(1, 62) = 5.19$, $p = .47$. However, there was a significant main effect of condition on reported levels of emotional reactivity post manipulation when controlling for baseline emotional reactivity and PHQ-9 score, $F(1, 62) = 6.40$, $p = .01$, partial eta2 = .09. After the manipulation, participants in the treatment condition felt significantly more emotional about their event compared to participants in the control condition. (See Table 2 on page 31).

DISCUSSION

It was expected that participants in the self-distancing condition would (a) report less emotional reactivity to their negative event and greater levels of self-distancing from the event and (b) that women in the self-distancing condition would report a greater decrease in emotional reactivity to their negative event than men in the self-distancing condition. Neither of these hypotheses were fully supported based on analyses of the data. Unexpectedly, participants in the self-distancing condition reported significantly greater emotional reactivity towards their negative event than those in the control condition.

There was no significant difference in levels of self-distancing experienced between the treatment and control groups. The manipulation's inability to induce a self-distanced perspective could possibly be due to a "dosage" error. Typically, studies investigating self-distancing have a manipulation of about 15 to 20 minutes, as opposed to 10, and the manipulation is repeated over three consecutive days (Park et al., 2016; Gortner et al., 2006).

As for gender differences, there was no significant condition x gender interaction effect on reported levels of emotional reactivity, and no main effect of gender on emotional reactivity. These results could be due to the small sample size of the study.

In the future, It would be beneficial to conduct a study with a longer data collection period in order to increase the sample size to examine trends based on gender. A future manipulation should also include a writing period of at least 15 minutes each day for three consecutive days to ensure participants take on a self-distanced perspective. Measurements of self-distancing and emotional reactivity should occur immediately after each manipulation and include both a 1-month and 6-month follow up. This would allow for a better understanding of what both the short-term and long-term effects of self-distancing are on emotional reactivity, and how they may differ by gender.

TABLE 2: Mean Differences by Condition and Gender

	Control		Manipulation	
	Pre	**Post**	**Pre**	**Post**
	M (SD)	*M (SD)*	*M (SD)*	*M (SD)*
Self-distancing	7.12 (3.52)	7.06 (2.93)	6.97 (2.69)	6.97 (3.85)
Emotional		12.94		14.61
Reactivity	14.12 (4.87)	(5.60)	13.90 (4.64)	(4.92)
Rumination	39.65 (8.61)	NA	43.79 (7.90)	NA
PHQ9	14.00 (5.13)	NA	13.96 (4.02)	NA
Self-compassion	80.62 (17.05)	NA	73.43 (17.73)	NA

	Males		Females	
	Pre	**Post**	**Pre**	**Post**
	M (SD)	*M (SD)*	*M (SD)*	*M (SD)*
Self-distancing	7.17 (3.19)	6.30 (2.80)	6.98 (3.13)	7.41 (3.63)
Emotional		13.00		14.17
Reactivity	12.52 (5.05)	(5.69)	14.85 (4.37)	(5.10)
Rumination	40.68 (8.09)	NA	42.05 (8.09)	NA
PHQ9	12.84 (8.09)	NA	14.53 (4.54)	NA
Self-compassion	80.42 (18.70)	NA	75.68 (17.08)	NA

Condition	**Gender**	**Mean**	**Std. Error**
Control	**Female**	13.12	0.84
	Male	12.33	1.19
Treatment	**Female**	13.99	0.91
	Male	15.83	1.15

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Article: Translating an Afrocentric Teaching Philosophy... (pg. 4)

1. The relationship between instructor and student should be circular where learning is facilitated by both parties and is non-hierarchical in nature.
   a) True b) False

2. Which of the following is NOT one of the three goals of African-centered teaching?
   a) Develop moral/social leadership skills
   b) Increase the number of Black students in psychology graduate programs
   c) Create tangible solutions for the challenges that face the Black community
   d) Foster relational development between the student, their families, and their communities of origin

Article: Ethical Issues in Dealing with Questionable Disclosures (pg. 8)

3. The Ohio Revised Code § 2921.22 has a general reporting statute which states, "no person, knowing that a felony has been or is being committed, shall knowingly fail to report such information to law enforcement authorities." Does Ohio's Revised Code include a psychologist-patient privilege exemption?
   a) Yes b) No

4. Standard 4.05(b) divides permitted disclosure into four possible "valid purposes." Which of the following is NOT a "valid purpose" under Standard 4.05(b)?
   a) to obtain needed services, such as to hospitalize a patient
   b) to obtain consultation
   c) to protect the client, psychologist or another person from harm.
   d) to comply with requests by a third party payer
   e) to obtain payment for services.

Article: Opioid use disorders: The female experience (pg. 11)

5. The combination of the telescoping effect and greater likelihood of comorbid illness often leads to a more complicated presentation of OUD in women?
   a) True b) False

6. Which of the factors below contribute to the gender gap women face when seeking out treatment?
   a) Finding appropriate childcare
   b) Jeopardizing child custody
   c) Being judged more harshly by the public
   d) Relapsing and the shame associated with it
   e) All of the above

Article: Current Perspectives on Emotional Support Animals (pg.16)

7. The Air Carrier Access Act requires passengers wishing to travel with ESA to have a letter on the letterhead indicating…
   a) the passenger has a mental health disability
   b) the ESA is certified to serve in this capacity
   c) the ESA accompany the passenger is necessary to the passengers mental health or treatment
   d) the individual providing the assessment is a licensed mental health profession and the passenger is a patient
   e) A, C and D
   f) A, B and D
   g) All of the above

8. There is consensus among mental health providers as to the process of endorsing, the effectiveness on symptoms, or the responsibility for monitoring ESAs in the treatment of mental health conditions.
   a) True b) False

Article: A Ticket to Ride… (pg. 20)

9. Definition and valuation of a child's behavior for the purpose of behavioral intervention is essential for the remediation of a child's inappropriate behaviors.
   a) True b) False

10. Children need to know which direction they are "traveling" in order to ascertain whether they are closer or further from their goal or destination.
    a) True b) False

Article: Implications of Psychological Assessment Norms for Transgender and Gender Non-Binary Populations… (pg. 24)

11. What three factors, as described by the Minority Stress Model, can cause increased stress and poor health outcomes in the TGNB population?
    a) Socioeconomic status
    b) Prejudice
    c) Discrimination
    d) Stigma faced by socially marginalized groups
    e) A, B and D
    f) B, C and D
    g) All of the above

Article: Self-Distancing and Emotional Reactivity… (pg. 28)

12. Participants in the self-distancing condition reported significantly less emotional reactivity towards their negative event than those in the control condition.
    a) True
    b) False

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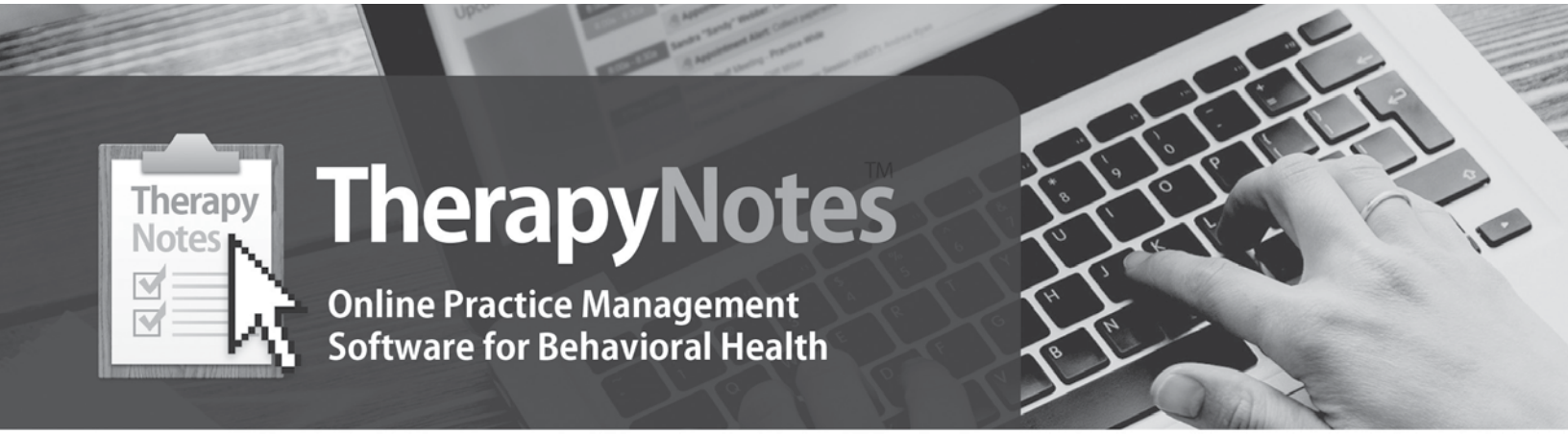

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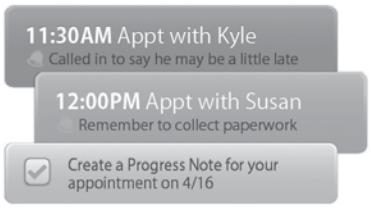

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