CONGRATULATIONS!

DCRE’s own Nancy Dessources Adegoke has just published her dissertation!

Black women are often viewed as being less susceptible to disordered eating behaviors and negative body image due to the different beauty standards within the culture. Beauty ideals are considered more flexible and challenge the standards set by mainstream or westernized society and thus it is assumed that Black women are less susceptible to eating disorders. However, these beliefs no longer hold true in various segments of Black society. Current research shows that Black women also fall prey to eating disorders and body dissatisfaction and that a cultural shift on this issue seems to be taking place. The intention of this book is to explore factors such as acculturation and skin color dissatisfaction in the development of disordered eating behaviors among Black women. This research will highlight the complex relationship between cultural identity and eating disorders among Black women. It also challenges prevailing assumptions regarding Black women and eating disorders and illustrates the need to further examine the etiology of eating disorders among Black women.
Secondary Infertility: Understanding the Psychological Impact on Women & Implications for Counseling

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Abstract

The purpose of this article is to define secondary infertility and enhance awareness of the unique emotional stressors associated with it. A brief review of the literature is provided and specific implications for counseling are addressed. The author concludes with support for the need for this to continue as an increasing niche specialization amongst mental health practitioners.

Keywords: secondary infertility, mental health, stress, counseling, women’s reproductive health
What is Secondary Infertility?

Infertility, whether primary or secondary, is defined as an inability to achieve a pregnancy after 1 year of regular sexual intercourse without contraception or, for women over the age of 35, after 6 months of regular, unprotected intercourse (Centers for Disease Control and Prevention, 2013). Secondary Infertility, in particular, is a term that refers to the inability to conceive after the birth of one or more previous children (RESOLVE, 2013). Where with primary infertility women are involuntarily childless, with secondary, women are not. The differences of already having had success at conception and currently parenting an existing child/children adds to the unique distress that women experiencing secondary infertility undergo.

Review of the Infertility Literature

Numerous researchers (Berghuis & Stanton, 2002; Cousineau & Domar, 2007; Griel, 1997; Jaffe & Diamond, 2011; & Ponjaert-Kristofferson & Baetens, 1999) have documented the negative emotional impact of infertility. The psychological factors experienced by infertile women may include stress, diminished self-confidence, multiple losses, shame, depression, anxiety, anger, and grief. The literature (Abbey, Andrews, & Hallman, 1991; Morrow, Thoreson & Penney, 1995; Schmidt, 2006) also reveals that women generally report higher levels of infertility related distress than men. Domar, Zuttermeister, & Friedman (as cited in Cousineau & Domar, 2007) note that, with the exception of experiencing chronic pain, depression and anxiety scores of infertile women were indistinguishable from the depression and anxiety experienced by women with cancer, myocardial infection, HIV-positive status, and other illnesses. Freeman, Boxer, & Rickels (as cited in Cousineau & Domar, 2007) note that many women who face infertility report it as the most upsetting experience of their lives.

Though there is an abundance of data demonstrating the distress of infertility in general, the literature on the psychological adjustment of those experiencing secondary infertility is limited (Fishman-Simmons, 1995; La Joie, 2003; Schneider, 2009). This is a group of individuals that have been pooled together with those experiencing primary infertility in regard to sampling, or, have not been part of samples at all (La Joie, 2003). This is problematic considering that Fishman-Simmons (1999) notes that secondary infertility is much more common than primary infertility. Jaffe & Diamond (2011) further note that in the United States, the proportion of women with secondary infertility is 70% compared to 30% of those with primary. Secondary infertility, states Fishman-Simmons (1995), “seems to be in the same place where infertility was two decades ago…in the closet and unaddressed” (p.1). Though sparse, it is important to note, however, that there is some research available that distinguishes between primary and secondary infertility (Bradow, 2012; Lieblum & Greenfeld, 1997; & Logan, 1988) and moreover, in recent years, some research (Bradow, 2012; La Joie, 2003; Schneider, 2009; Ying, 2000; Wieland, 1998) that has more specifically honed in on
secondary infertility.

**Psychological Impact of Secondary Infertility**

There are unique issues that surface for women with secondary infertility. For one, there is a lack of knowledge amongst individuals and even medical professionals that once a woman is fertile, she is always fertile (RESOLVE, 2013). This myth can deter a woman from seeking treatment (Fishman-Simmons, 1995). Regarding this issue, Jaffe & Diamond (2011), indicate that women with primary infertility are twice as likely to seek treatment, compared with women with secondary. Further, when women with secondary infertility do seek intervention, their concerns may be improperly assuaged with a “wait and see” approach. Individuals experiencing secondary infertility also “may feel set apart from other parents who are going on easily to have additional children; however, as parents… may not be readily accepted by the childless” (Fishman-Simmons, 1995, p. 5). Thus, those with secondary infertility experience the emotional suffering with less support from family and friends (Lieblum & Greenfeld, 1997), often being blamed for wanting more children and perceived as unappreciative of having at least one child (Fishman-Simmons, 1995; Kintner, 2009).

The following are other unique emotionally stressful aspects of secondary infertility: feelings of shock over the inability to conceive again, guilt over the inability to provide another sibling for the existing child, disillusionment of the larger family that was once idealized, overprotective parenting of the child at home and concern about the potential impact of their distress levels on that child, and feeling less united as a couple in the desire for another child (Fishman-Simmons, 1995). Lastly, if fertility treatment is ultimately pursued, women need to manage all of the daily appointments, monitoring, and injections, previously reported as extremely burdensome (Huisman, 2009), while already balancing care for a child. Even with the enormity of these issues, women with secondary infertility question why they are not coping better with their disappointment (Fishman-Simmons, 1995).

**Implications for Counseling Women with Secondary Infertility:**

Given the potential loneliness and frustration that women with secondary infertility endure, it is evident how psychotherapy could be of value. Few natural support systems exist for women experiencing secondary infertility, notes Fishman-Simmons (1995) thus, making it even more important to utilize the support of a professional. Psychotherapy intervention studies examining general infertility have proven to be helpful (Cousineau & Domar, 2007). There is evidence that cognitive behavioral therapy and, particularly, CBT in a group format can significantly reduce psychological distress (Clay, 2006; Domar et al., 2000). Support groups (Weinshel, Meyers, & Scharf, 2004) as well as treatments that emphasize social connectedness and modeling of empathy (Ferber, 1995; Gibson & Myers, 2000) have additionally proven to be beneficial. Psychotherapy could help to increase recognition of losses, improve communication with partners, decrease social isolation, and facilitate the grieving process (Jaffe & Diamond, 2011) as well as help normalize...
the infertility (Weinshel, Meyers, & Scharf, 2004).

With secondary infertility, counseling could also assist to reduce the self-blame these women often feel for not having started attempts at conception sooner, decrease stigma, validate feelings they may have about parenting the child at home during this stressful time in their lives, and “confronting the fantasy of an ideal family” (Fishman-Simmons, 1999, p. 318).

Fertility-related counseling is becoming a growing practice niche for mental health professionals (Dingfelder, 2006), one based on a need to help women alleviate stress, cope with perceived loss of control, and restore self esteem (Clay 2006; Dingfelder, 2006). Given that parents are putting off having children until later in life, secondary infertility can be expected to be a growing issue. (Fishman-Simmon, 1999). As such, it will be even more critical in the coming years for mental health specialists to expand their knowledge base and practice to assist women with the sensitive issues specific to secondary infertility. Making connections with gynecological offices to provide outreach and education could be essential, since women with this diagnosis may not seek further treatment at a fertility clinic (Cousineau & Domar, 2007).

Conclusions:

The purpose of this article is to enhance understanding of secondary infertility, considering that there is much less known about it. Furthermore, while there is acknowledgement that infertility is a couples issue, for which men could also experience tremendous emotional pain (Clay, 2006), this article places emphasis on the adjustment of women considering reports of more serious consequences for women medically, psychologically, and socially (Gibson & Myers, 2000). According to the Centers for Disease Control and Prevention (CDC, 2002), it is estimated that 16.6% of married, childless women in the United States experience infertility or 1 in every 10 women younger than 45 years old (HHS, 2013). Trantham (as cited by Gibson & Myers, 2000) notes that an additional 10-12% of women experience secondary infertility. Considering that many women with secondary infertility do not recognize their issue as a problem or do not seek help, these numbers could be higher. Though there is a growing body of literature examining the unique impact of secondary infertility, research in this area needs to continue. While primary and secondary infertility may share much of the same causes, treatment, and emotional impact, there are circumstances unique to women with secondary infertility that we still need to learn about.

References


Current Issues and Psychological Characteristics of Women in Corporate Workplace

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Abstract

One of the biggest challenges facing women in the corporate world today is the paradox of messages they receive about the choices they make. This article looks at challenges encountered by women in the workplace concerning attitudinal differences from multiple generations and family and cultural role expectations through research and field observation. Psychological characteristics of intellectual curiosity and self-knowledge are discussed as ways of navigating the corporate world. Further research on the conflicting external and unconscious messages women receive concerning career achievement and role conflict will provide women with the opportunity to be successful in the workplace and develop satisfying life and career plans.

Keywords: Women in the workplace, psychological characteristics, intellectual curiosity, self-knowledge, career planning, role conflict.
One of the challenges facing women in the corporate world today is the paradox of messages they receive. Sandberg (2013) tells women to “lean in” into leadership roles and be particular about choosing a partner who is supportive of a woman’s professional ambitions & direction. In response, Erin Callan (2013), the former CFO of Lehman Brother, wrote about her regrets of keeping a “singular focus” on her career, saying it wrecked her marriage and led her to forego having children.

The corporate world has more women than ever contributing their talents and energy to the organization’s bottom-line, yet women continue to encounter the glass ceiling or career off ramping for the choices they make (Eagly & Carli, 2007).

Of the many challenges women face in the corporate world today this article will focus on two: generations and roles. Multiple generations and roles women have in an organization and how those roles clash with their personal lives. This is the first time in history American corporations have had workforces made up of four different generations (Lancaster, L. & Stillman D., 2003). Five generations if you count Generation Jones born from the mid-fifties to the mid-sixties. Managers and co-workers are faced with five different generations at work each having different values, work styles, assumptions, ways of relating and with different views of how the genders, most especially women, “should” behave.

Additionally women are under constant pressure of role management. They have been richly steeped in the “role” of girls and women in their private life and in the world of work. The values and expectations instilled from the family of origin and environment in which women are raised has significant repercussions as to the way they respond to the roles they are in and think they are in (Hewett & Luce, 2005).

So what characteristics are necessary to navigate the corporate world? It has been my observation and experience as a mentor, department head, manager, employee and educator that what is paramount for women for success in the corporate world is intellectual curiosity and self-knowledge.

Intellectual curiosity incorporates intelligence, zeal, and the hunger for knowledge. It shows a desire for lifelong learning. The corporate world is filled with “undiscussables”, including undiscussed differences, attitudes and approaches. It takes a strong sense of intellectual curiosity in order to learn the structure, design and culture of an organization. An organization is the result of history, personalities and influence. It takes a skilled interviewer, investigator and researcher to discover these elements. One’s ability adapts to different situations and work with people is paramount. Another critical characteristic of a successful woman in the corporate world is emotional maturity gained.
through a strong sense of self-knowledge. This is gained through reflection, openness to constructive criticism and therapy. Foremost, it is important to have intellectual curiosity about one’s self. The expectations from parents, grandparents, siblings and others all have influence as to how women behave in a corporate environment. For women self-knowledge and awareness about how they were conditioned to think and behave will guide them in their responses and choices in the workplace. Kets de Vries (2005) state that women can end up feeling like a fake. That their gender socialization can cause inner confusion as they compare their chosen roles to the messages given to them.

References


Feminist Psychotherapy

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Abstract

This article describes feminist psychological theory, and feminist approaches to psychotherapy. First, sociopolitical biases embedded within psychological theories are discussed. Feminist theory is then outlined, and three foundational concepts at the basis of feminist psychology are discussed. How these foundational concepts leads to a unique approach to diagnosis and psychotherapy are then reviewed.

Keywords: Feminist psychology, psychotherapy
Through theories about human development, psychopathology, and psychotherapy, psychologists have helped to define what is “normal,” what is a “good” quality of life, what is “healthy” and what is “pathological” (Cushman, 1996; Prilleltensky & Prilleltensky, 2003). Feminist psychologists have been vocal critics of dominant theories in psychology because they are almost exclusively based on a white, middle class, European and American, patriarchal models of normalcy. Feminist and cultural psychologists have long argued that the dominant discourse of psychology excludes, marginalizes and pathologizes women and persons of color. The bias and discriminatory nature of many psychological theories are hidden below a surface of apparent “objectivity.” Impressive sounding jargon and technical terms often cloud the basic values being promoted by a theory, but every theory is based on cultural values. When this reality is ignored, the impact on clients can be profound. When psychologists use theories and techniques that reinforce the status quo, clients who are marginalized or discriminated against within the status quo can be harmed rather than helped by psychotherapy (Cushman, 1996; Helms and Cook, 1999; Prilleltensky & Prilleltensky, 2003).

Feminist therapy has set itself apart from other approaches by consciously including the analysis of socio-political context into the way they conceptualize mental illness and treat clients in distress. Feminist therapists start with the premise that our culture is a patriarchal, hierarchical structure, and this structure permeates the field of psychology as well (Brown, 1994). Brown (1994) outlines three foundational concepts that are common across feminisms. These serve as the basis for feminist therapy. They are (1) the personal is political, (2) gender and power as categories of analysis, and (3) the privileging of women’s experience.

The personal is political refers to the concept that a person must be understood as belonging to a context that has shaped their lives. In therapy, this means the clients presenting issues should not be seen as a picture of personal pathology, instead the therapist should be striving to understand the whole picture, what the client’s context has contributed to the client’s issues, how power and privilege have shaped the client’s experiences and how the client has learned to cope.

The second epistemological foundation of feminist therapy is the inclusion of gender and power as categories for analysis (Brown, 1994). The feminist psychology movement was justly criticized by feminist women of color for failing to recognize the importance of also including explicit analysis of how race, ethnicity, sexual orientation, and social class affect personal psychology. Feminist psychologists have since made a concerted effort to be less Euro-centric, and feminist therapists carefully consider the ways that all these different aspects of personal identity are socially constructed and defined, and how they
shape their client's lives and their own lives. Feminist therapists question to what extent the client's presenting issues and behaviors are a reaction to power dynamics relating to gender, race and other aspects of identity.

The final foundational epistemological concept is the privileging of women's experiences (Brown, 1994). In the dominant culture and in mainstream psychological discourse, human and male have become equivalent. Robert Carter notes that psychology also tends to infer that human is equivalent to white. Thus, this concept should be expanded to be more inclusive by stating therapists should privilege the experiences of those who are afforded less power.

With these concepts as the basic epistemological foundation of feminist therapy, it becomes clear that the goals and process of feminist therapy must differ from mainstream psychology. Mainstream psychology attempts to help clients fit comfortable into society. Feminist therapy has as one of its primary goals resistance to the oppressive forces of the status quo (Brown, 1994). Client's are taught to recognize the ways that patriarchal society has defined them and restricted them, and are encouraged to reject these restrictions and find their own voice.

Feminists also differ significantly from mainstream psychology in their methods of diagnosing and conceptualizing cases. Diagnosing should be a process of naming the problem in a way that is useful to the client. In mainstream psychology, diagnosing is a tool to label the symptomology of the client based on a medical model of understanding psychological distress. While feminist therapists sometimes use traditional, DSM labels, they are always mindful that DSM diagnoses are based in the Western perceptions of mental illness, and may not be universally applicable. In addition, feminist psychologists only diagnose if it is clearly beneficial for the client, and always within a contextual framework. Feminist therapists are interested in understanding the specific issues that a client presents with in relation to their life contexts, social and political forces, and gender roles.

In conceptualizing cases, feminists are concerned with understanding the client's own ways of thinking about their situation. Brown (1994) refers to this as "speaking the mother tongue." Rather than being overly reliant on psychological theories and the associated language of the theory, feminist therapists attend carefully to the clients own ways of thinking about and talking about their issues and use this language to conceptualize the case. Using the clients' own ways of describing their concerns in conceptualizing the case helps the feminist therapist avoid a deficit model of mental health and gain insight into their worldview. For this reason, symptoms are seen as signals about what clien-
ts experience in their lives and how they have learned to cope. Viewing symptomology as strategies of coping helps feminists avoid pathologizing the client and instead understanding the presenting issues within the sociopolitical contexts of the client's life.

A final important aspect of feminist therapy is the focus on empowerment. Empowering the client involves helping clients identify their strengths, increasing their knowledge about socio-political factors, rejecting ways of thinking about themselves that are disempowering and undermine their strength, and adopting behaviors that increase their sense of power in society. Thus, the inclusion of contextual consideration in the process of psychotherapy sets feminist therapy apart from most approaches, and provides path for helping clients heal by rejecting sociopolitical forces that have undermined their health and strength.

References


Rape Myth/Stereotype and the Media

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Abstract

This article reviews three critical issues for women dealing with the aftermath of rape. First, current research suggests that the trauma of rape does not end after the assault, rape victims suffered from a range of emotions as a result of rape. Second, rape myths and stereotypes are one way in which rape has been under reported. This paper elaborates on current manifestations of rape myths and stereotypes prevalent in society. Specifically, rape myths and stereotypes are kept alive in the media. The paper also delineates possible means for eradicating rape myths and stereotypes in the media.

Key Words: Rape, Trauma, Violence towards Women, Media portrayal of violence
A significant number of studies have shown that rape can have long term and short term effect on survivors (Kilpatrick & Acierno, 2003). Although the effects of rape are not the same for every woman, it is a life changing event for the survivors. Research and clinical practice have provided an understanding that sexual violence is a serious social problem among women. Studies have shown that 17% to 25% of women are raped in their adult lifetimes (Fisher, Cullen, & Turner, 2000). According to the National Intimate Partner and Sexual Violence Survey (NISVS), conducted by Black, Basile, Breiding, Smith, Walters, Merrick, Chen, and Stevens, 79.6% of rape victims were first rape before their 25th birthday (2011). The trauma of rape extends far beyond the actual assault. The aftermath of rape can take many forms, ranging from Self-harm, Substance Abuse, Depression, Sexual Transmitted Disease (STD), Eating Disorder, Sleep Disorder, and Post-Traumatic Stress Disorder (PTSD). Breslau, Kessler, Chilcoat, Schultz, Davis, and Andreski (1998) reported that rape produces one of the highest rates of posttraumatic stress disorder (PTSD). For example, studies have shown that rape victims were 3 times more likely to suffer from depression (Dickinson, de Gruy, Dickinson, & Candib, 1999), 4.1 times more likely to have contemplated suicide, 13 times more likely to have attempted suicide, had higher rates of drug and alcohol consumption than non-rape victims, National Women Study (NWS, 1995; Luster & Small, 1997).

Despite these studies rape remained one of the most underreported crimes in America (NISVS). It has been estimated that only five to fifteen percent of all rapes are reported. The percentage of rapes reported to authorities that result in a conviction is extremely small in the United States (Sinclair & Bourne, 1998). There are many reasons that could explain why the disparity between completed rapes and reported rapes exist. This could be the result of how rape is perceived in our society and might be explained by widespread rape stereotypes/myths, which in turn might affect decision-making of rape victims (Clay-Warner & Burt, 2005). Throughout this article, the terms "myth" and "stereotype" will be used interchangeably.

Rape myth is defined as prejudicial, stereotyped, or false beliefs about rape, rape victims, and rapists (Burt, 1980). Burt (1890) believed that rape myths are used to downplay the sexual assault. There are number of held beliefs (myths) about rapes that are untrue and these false beliefs can sometimes cloud the victim’s actual perception of the event due to a lack of understanding of the crime. These rape myths, as they are called, can directly or indirectly serve to stop the victims from reporting it. According to Burt, rape myths include suggestions that the victim deserved the sexual assault or asked for it. Other examples of these myths include, victims of sexual assault will have wounds and bruises on their bodies, the majority of sexual offences occur between people who do not know each other, women are raped only when they are alone in bad neighborhood (Brownmiller, 1975; Ward, 1995).
The media can influence how people view and respond to certain issues. This influence can have a positive effect on people by making them more informed on certain issues, but it can also have a negative effect. The media indirectly helps reinforce stereotypical notions of rape. Research has shown that the media tend to report stereotypical rapes than any other type of rape (Franiuk, Seefelt, & Vandello, 2008; Franiuk, Seefelt, Cepress, & Vandello, 2008; Gavey and Gow 2001; Korn & Efrat 2004; Marhia, 2008). Stereotypical rapes are more likely to be reported because of the following attributes: multiple perpetrator rape, the use of a weapon, and use of threats (Jordan, 2005). For example, 54.4% of media reports described attacks committed by strangers (Marhia, 2008). However, data have shown that most often the victim knows the attacker, and the incident takes place indoors, such as inside the victim’s home. Nearly 60% of sexual assaults occur at the victim’s home or the home of a friend or relative. Approximately 28% of rape victims are raped by their husbands, 35% by an acquaintance, and 17% by a relative other than spouse, National Sexual Violence Resource Center, NSVRC (Lewis, 2003).

Although more needs to be done to eradicate rape, it is also central to consider how we can help those already victimized to start the healing process. If the media continues to only report stereotypical rapes and leave out the overall circumstances in which rape typically occurs, it will likely make it difficult for victims of rape to report “real rape” when it happens. Studies showed that many victims of rape do not choose to seek help (Koss, 1993). According to Patterson, Greeson, Campbell (2009), rape victims feared that seeking help would cause them further psychological harm because they may not be believed. The authors found that rape victims who do not seek help may be attempting to protect themselves from perceived psychological harm (Patterson, Greeson, Campbell, 2009). It is very crucial that victims of rape receive appropriate information that can help them deal with their trauma. This can be done in such a way that promotes treatment options instead of doing so solely to attract viewers. Psychological treatment for victims can be helpful and our communities can be more effective in helping survivors heal from rape.

In conclusion, rape myths and stereotype are rooted deeply in our culture, and are prevalent today across various levels of society. It is hoped that this article will allow researchers and rape victims to gain a better awareness and understanding of these myths and stereotypes. Finally we hope this information will help stimulate further work toward removing these myths and stereotypes in the victims’ psyche when they are faced in determining whether or not they have been a victim of a “real rape”.

References


REQUEST FOR PAPERS

The Summer edition of *The Cultural Spotlight* will focus on the ageing population and ageism. We welcome clinicians, individuals working in public sector, academics, and students alike to offer submissions to this publication. Submissions should include an abstract, complete reference page, and the content of the article should range between 750-1500 words. The deadline for the Summer edition is June 15, 2013. If you are interested in submitting an article, please contact the editorial staff at DCREsubmissions@gmail.com.

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