



MIND PAD --- NOTES D'IDÉES

CANADA'S STUDENT PSYCHOLOGY PUBLICATION
PUBLICATION CANADIENNE SUR LA PSYCHOLOGIE ÉTUDIANTE

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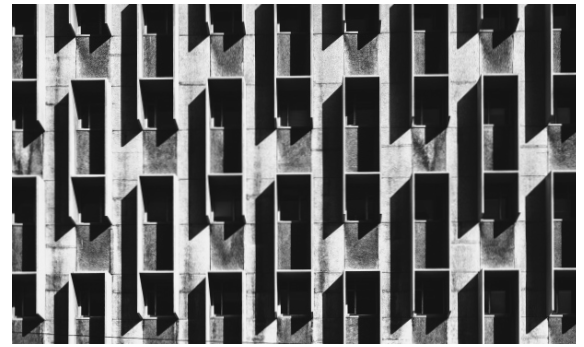
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2. It aims to offer studying psychology researchers and writers an opportunity to experience a formal submission process, including submission, review, and resubmission from the points of view of both submitter and reviewer/editor.

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1. Fournir un bulletin professionnel rédigé et évalué par les étudiants en psychologie qui sont membres affiliés de la Société canadienne de psychologie. Le contenu devrait être d'intérêt à tous les praticiens et étudiants en psychologie, mais les étudiants en psychologie sont les lecteurs cibles.
2. Fournir aux étudiants en psychologie l'opportunité de connaître le processus formel de soumission y compris la soumission, la révision, et la resoumission du point de vue d'auteur et d'évaluateur/rédacteur.

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TABLE OF CONTENTS

4

Sexual Health Education: Where are We Now? Understanding the State of Current Sexual Health Education (SHE) Curriculum in Ontario and Québec and its Effects on Teachers and Students

Enoch Leung / M.Ed., McGill University

7

Demonic Possession to DSM-5: A Historical Perspective on the Conceptualization of Mental Illness

Sarah A. Goegan / BSc., Ph.D. Candidate, McMaster University

10

The Complications of Diagnosing Autism Spectrum Disorder in Childhood

Candice Rubie / Soon to be BA, University of Waterloo

13

Examining Familial Culture and the Underutilization of Mental Health Services in Asian American Adolescents with Depression

Francesca B Santos / BSc, University of Waterloo

17

Shaping Adult Development and Ageing Through Neuroplasticity

Jared Cherry / BA, BFA, Athabasca University

20

Factors Helping Non-Traditional Women Students Persist in Counselling and Clinical Psychology Doctoral Programs

Courtney J.L. Andrysiak / M.A., Fielding Graduate University

Lauren Mizock / Ph.D., Fielding Graduate University

23

Let's Talk About Leta: L. Hollingworth's Contributions to Clinical Psychology

Samuel Freeze / Undergraduate Student, University of New Brunswick

26

References

36

Submitting to **Mind Pad**



Sexual Health Education

Where are we now? Understanding the state of current sexual health education (SHE) curriculum in Ontario and Québec and its effects on teachers and students

Enoch Leung / M.Ed., McGill University

Abstract

With sociopolitical shifts, LGBTQ-inclusive Sexual Health Education (SHE) is changing. These changes impact student's competency and their level of understanding of inclusive SHE. LGBTQ+ research reveals issues in education such as (1) the extent to which both pre- and in-service educators feel prepared to deliver SHE, (2) policy changes affecting the SHE curriculum, and (3) pre-service educator competency in teaching SHE. In particular, certain Canadian provinces have seen substantial changes to their SHE programs in recent years. The present review seeks to summarize relevant research surrounding the importance of supporting inclusive SHE curriculum and suggestions about educational policy changes to promote safe school environments for all students with focus on LGBTQ+ students. Two provincial educational systems will be discussed (Ontario and Québec) to differentiate student outcomes based on the structure of their SHE curriculums as will recommendations for time-sensitive research to push for political change to promote inclusive learning spaces.

Résumé

Avec les changements sociopolitiques, l'éducation sexuelle inclusive, où une place est faite aux personnes LGBTQ, est en train de changer. Ces changements ont un impact sur les compé-

tences des élèves et sur leur niveau de compréhension de l'éducation sexuelle inclusive. La recherche sur les personnes LGBTQ+ révèle des problèmes sur le plan éducatif, tels que (1) la mesure dans laquelle les futurs enseignants et les enseignants actuels se sentent prêts à donner des cours d'éducation sexuelle; (2) les changements de politique ayant une incidence sur le programme d'éducation sexuelle; (3) les compétences des futurs enseignants qui enseigneront l'éducation sexuelle. En particulier, certaines provinces canadiennes ont modifié substantiellement leurs programmes d'éducation sexuelle ces dernières années. Le présent compte rendu vise à résumer les recherches pertinentes entourant l'importance de soutenir les programmes d'éducation sexuelle inclusive ainsi que des suggestions de changements de politique éducative destinés à favoriser des environnements scolaires sûrs en mettant l'accent sur les élèves LGBTQ+. Deux systèmes d'éducation provinciaux seront examinés (Ontario et Québec) pour différencier les résultats des élèves en fonction de la structure des programmes d'éducation sexuelle qui leur sont dispensés; nous exposerons également des recommandations de recherches à mener à brève échéance afin d'encourager les changements de politique nécessaires pour créer des espaces d'apprentissage inclusifs.

Implementation of LGBTQ-Inclusive Sexual Health Education (SHE) Curriculum

Research has shown that elementary and high school students who receive higher quality sex education possess greater sexual knowledge, positive attitudes towards sexual health, and engage in lower levels of risk-taking behaviors (Byers et al., 2017). Particularly, the implementation of LGBTQ inclusive sexual health education (SHE) has shown positive outcomes on elementary and high school students' levels of knowledge and understanding of inclusive sexual health and has been shown to increase sense of safety in schools (e.g. Leung et al., 2020) including a decrease in LGBTQ-specific victimization and harassment (e.g. slurs), and other reductions in mental health risks specific for LGBTQ students (e.g. depression; Snapp et al., 2015). Sexual health education is a provincial responsibility. Given this, interprovincial curricula vary remarkably. Ontario and Québec are two provinces used to exemplify how curriculum changes have affected the inclusion and exclusion of certain sexual health topics. The purpose of this review seeks to: (1) Summarize relevant research on the importance of an inclusive SHE curriculum, (2) To compare and contrast research on educators' perceptions of implementing an inclusive SHE curriculum and its effects on student outcomes, and (3) To recommend both research and policy actions to appropriately sup-

port educators to effectively teach inclusive SHE curriculum.

Review of Inclusive SHE Curriculum

As educational curriculum differs across provinces in Canada, understanding how differences in inclusivity in SHE curriculum can affect student outcomes. In 2018, Québec has made advances to create a more inclusive SHE curriculum that incorporate a diverse range of topics and approaches to sexual health, including emotional awareness and regulation, inclusive dating relationships, comprehensive view of sexuality, gender identity and expression, respecting differences, and safer sex habits (MELS, 2018). On the other hand, Ontario has currently promoted a SHE curriculum that is exclusive of sexuality and gender identity (GLAAD, n.d.; Ontario Ministry of Education, 2018). The exclusion of such inclusive topics can alienate students from learning about critical topics relating to LGBTQ+ populations. Consequently, students will not have the opportunity to benefit from understanding the perspectives of students different from the norm of heterosexuality. This is known as Bishop's (1990) concept of mirror and window (Tschida et al., 2013). Curriculum acts as a window and mirror for students to explore and understand the world (Dinkins & Englert, 2015). Students who see themselves through the 'mirror' of LGBTQ-inclusive curriculum can make authentic connections and identify with the SHE curriculum to further understand how the information is relevant to their lives and experiences. This increases their learning, well-being, safety, hopefulness about their future, and fosters a safer school climate (e.g. Pingel et al., 2013; Snapp et al., 2015). For heterosexual students, having an inclusive SHE curriculum is the 'window' where they can have the opportunity to understand how information applies to different groups of students and foster an accepting school climate and positive social emotional learning skills (e.g. empathy, perspective taking; Snapp et al., 2015). Most importantly, an inclusive SHE curriculum highlights that all students, regardless of sexuality and gender identity and expression, are treated equitably through inclusion and representation of positive LGBTQ-inclusive information (e.g. Johns et al., 2019; Snapp et al., 2015).

Differential (LGBTQ+ and heterosexual) student outcomes based on different SHE curriculum

For LGBTQ students, SHE curriculum that is exclusive and not comprehensive highlights a recurring issue that there is a lack of LGBTQ content in the curriculum and instead it reflects and promotes a heteronormative school culture. These may have adverse effects on LGBTQ students leading to feelings of isolation, marginalization, and a problematic school climate that includes microaggressions about gender and sexuality and other negative mental health outcomes (Haley et al., 2019; Munro et al., 2019).

In schools with LGBTQ-inclusive SHE curriculum, students perceived their schools as safer, experienced fewer episodes of gender or sexuality-based victimization or harassment, perceived their peers as more supportive, and decreased reports of adverse mental health outcomes. Additionally, benefits were not specific to LGBTQ students, but all students perceived a safer school climate and decreased bullying incidents at school (e.g. Meyer et al., 2019; Kosciw et al., 2018; Rivero, 2019). Research suggests that for every 10% increase in school instructional time spent teaching LGBTQ-inclusive SHE curriculum, there was a 20% reduction in reported suicidal attempts (Proulx et al., 2018). Therefore, research related to LGBTQ-inclusive SHE curriculum in Canada shows the many educational benefits for all students, but particularly for those who identify as LGBTQ (e.g. Bodnar & Tornello, 2019; Proulx et al., 2018).

Pre-service and In-service Educators' Perceptions on Inclusive SHE Curriculum

Despite the difference in SHE curricula content between Ontario and Quebec, educators from both provinces perceive similar difficulties with implementing inclusive SHE curriculum. Survey research suggests that the difficulties stem from both internal and external factors: (1) their unwillingness due in part to their lack of preparation, self-competence, and training to teach various inclusive SHE topics (Bialystok, 2019; Richard, 2010; Rigby, 2017; Rodrigues, 2017) and (2) an opposition from families and communities to have their children learn sexual health content (Bialystok, 2019; Kitchen & Bellini, 2012; McKenzie, 2015; Rayside, 2014;

Rodrigues, 2017).

Currently, little is known about the extent pre- and in-service educators feel comfortable in their ability to teach sexual health education (Bialystok, 2019). However, the lack of sexual health knowledge being taught to educators have implications on students' sexual health knowledge as research has consistently indicated positive links between teachers' perceived confidence and student achievement (Zee & Koomen, 2016).

For Québec, educators are currently in a position where they have to teach SHE material that they are not trained in (Parker & McGray, 2015). Otis et al. (2012) found that 88.5% of the 78 high school teachers had not received any form of professional preparation specific to sexual health information. Only 39.3% of 84 teaching programs provided either a mandatory or optional course related to sexual health (McKay & Barrett, 1999). Even with changes at the training level, many Canadian educators are not adequately prepared to teach SHE as the curricula of most B. Ed. programs, both elementary and secondary, do not include sexual health education courses (Rigby, 2017). A lack of preparation and knowledge to teach effective SHE can lead to educators having low self-competence and efficacy to effectively teach inclusive SHE (e.g. Chitiyo et al., 2019; Meyer et al., 2015; Rigby, 2017).

For in-service educators, research indicated that some perceive specific topics within inclusive SHE curriculum to be sensitive or inappropriate to teach at certain grade levels (Cohen et al., 2004; Cohen et al., 2012) and that they must stay "neutral" in class and avoid controversial topics to minimize conflicts with outside stakeholders (ie. parents; e.g. Bialystok, 2019; Bryce, 2017). Additionally, they perceived that they would feel more comfortable to discuss inclusive SHE topics if they were teaching in an accepting school climate with supportive administration (e.g. Bryce, 2017; Cohen et al., 2012; Rigby, 2017). Lastly, in-service educators have mentioned that they are unwilling to incorporate SHE curriculum into their teaching as they lack the time or perceive that they either do not feel competent or comfortable to incorporate such topics, in fear of responses from their students, parents, and school administration (Otis et al., 2012; Parker

& McGray, 2015; Taylor et al., 2016).

Similarly in Ontario, educators realize the importance of implementing an inclusive SHE curriculum to support their students (Bialystok, 2019). However, as the current Ontario SHE curriculum promotes a more conservative and outdated education compared to their previous SHE curriculum, educators are now mandated to teach SHE that is exclusive of LGBTQ groups (e.g. Narushima et al., 2020). Bryce (2017) found that in-service educators perceived the need to have inclusive sex education as they acknowledged the dangers for students who do not receive proper SHE. Though educators perceived benefits to implement SHE curriculum, similar to Québec, Balter et al. (2018) revealed that 64.1% of Ontario pre-service educators reported a perceived lack of knowledge and skills to address sexual health. In both provinces, educators perceive similar difficulties when implementing inclusive SHE curriculum. Additionally, for educators in Ontario, they are now mandated to teach an exclusive SHE curriculum, barring them from incorporating inclusive SHE topics to include all students.

Other research has shown that with pre-service educator training to teach SHE, teachers were able to reframe their understanding of what SHE encompasses, such that educators trained to teach SHE believed that SHE is suitable for all ages (Sinkinson, 2009). This was due to their change in understanding of the topics surrounding inclusive SHE curriculum (Sinkinson, 2009). Therefore, by providing educators training on SHE during their B.Ed. program, this can change some of the barriers mentioned by in-service educators. In doing so, this can allow for educators to effectively teach inclusive SHE to provide learning opportunities through the 'mirror' and 'window' for both LGBTQ and heterosexual students (Weaver et al., 2005).

Research and Applied Recommendations Moving Forward

With ongoing changes in sexual health education, it is imperative to understand the extent to which both pre- and in-service educators feel prepared to deliver sexual health education across Canada. Both Ontario and Québec's SHE curriculum exemplify how varying levels of inclusivity can impact not only students' understanding and knowledge of this topic but also educators' beliefs

and competencies to teach SHE effectively. Moving forward, as inclusive education research grows, in some countries and provinces, inclusion is still conventionally understood as teaching and educating inclusively to support students with disabilities (Nind, 2014). However, the span of inclusive research and education can broadly include supporting all students (e.g. intersectional identities). Accordingly, several research and practical recommendations are mentioned to suitably support all students through the lens of LGBTQ-inclusivity in SHE curriculum.

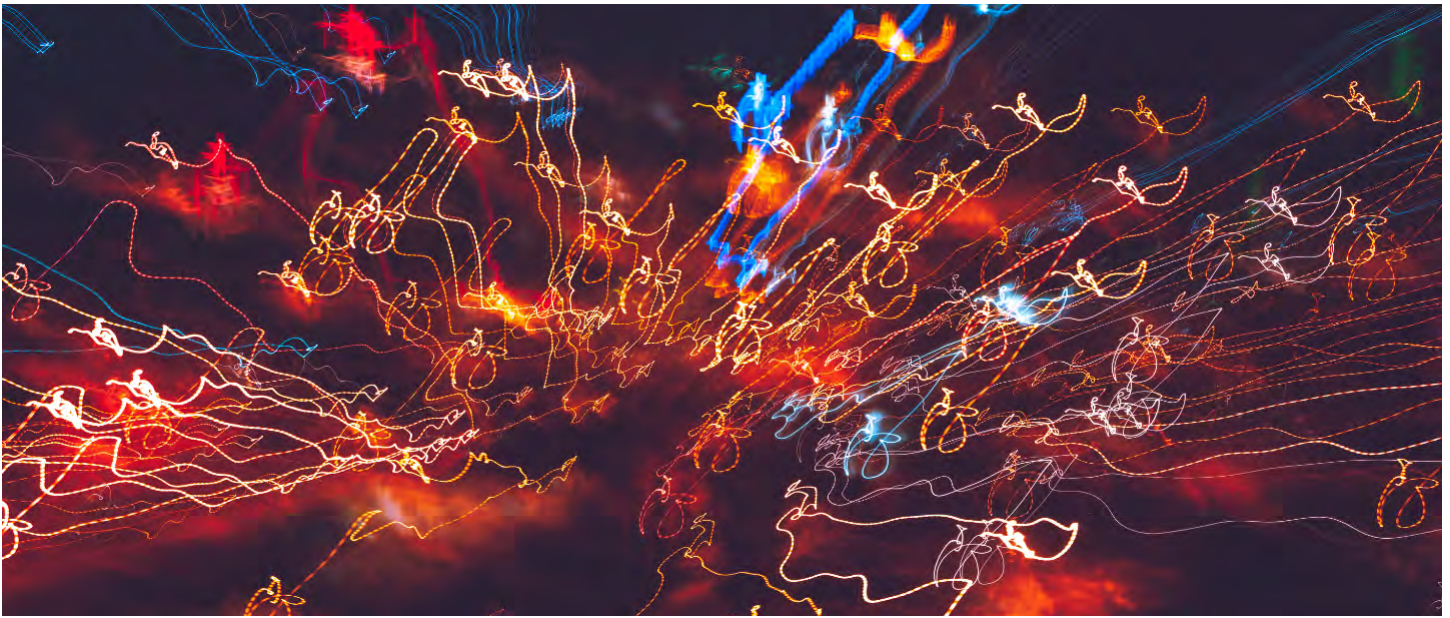
In terms of educators, current research has mentioned that their experiences in implementing LGBTQ-inclusive SHE curriculum differed and required adaptation such that families and communities understood the importance of such curriculum. For example, Carlile (2019) found that educators eased inclusive SHE curriculum through an anti-bullying focus, mentioned legal obligations as a reason to teach, and made transparent their pedagogical approaches to implement LGBTQ-inclusive SHE curriculum. The implementation of inclusive SHE curriculum varied due to educators' perceptions of comfort and competence towards LGBTQ inclusive material and perceptions of their own safety regarding the fear of mentioning comments that will lead to conflict (e.g. family, community; e.g. Ollivier, 2017; Olson, 2018; Snapp et al., 2015; Snapp, McGuire, Sinclair, Gabrion, & Russell, 2015; Tompkins et al., 2017). This finding was similarly found in other studies (Meyer et al., 2019) highlighting practical differences in application of LGBTQ-inclusive SHE curriculum. Future research can understand whether varying practices of LGBTQ-inclusive SHE curriculum from different educators leads to differing student outcomes, such that the effectiveness and importance of learning LGBTQ-inclusive SHE topics may be minimized due to varying pedagogical approaches.

Additionally, much of the research has mentioned the need for educator support to enable effective teaching of LGBTQ-inclusive SHE curriculum for their students (e.g. Snapp et al., 2015). Research has mentioned that providing teacher support through developing age-appropriate SHE topics, building confidence in topics through self-education and professional development, and overcoming fear (Meyer et al.,

2019) are important educational practices to ensure educators effectively incorporate and teach LGBTQ-inclusive SHE curriculum to their students. An avenue of research can thus be to investigate current pre-service teacher education programs in Canada with research focusing on the types of training pre-service teachers receive surrounding LGBTQ+ topics, in addition to this lens when considering culturally relevant approaches to this teaching (Brant & Willox, 2020).

However, the lack of LGBTQ-inclusive SHE curriculum, such is the case for Ontario's current SHE curriculum, has potential for negatively affecting LGBTQ students. For example, the importance of inclusive education, such as the concept of Universal Design for Learning, is to have all students be in a space where they can learn the best (e.g. Gargiulo & Metcalf, 2016; Katz, 2013). This includes a curriculum that students can connect to and understand its relevance, leading to increased student engagement (Burdge et al., 2013). Similarly, Roberts et al. (2020) found that LGBTQ students felt unrepresented in their class material, leading to thoughts of isolation, lack of acknowledgement, and did not fit in with their school. This is problematic, as Kosciw et al. (2018) has shown that schools with exclusive curriculum were increasingly homophobic and transphobic, perceived as unsafe, increased truancy, and were disengaged from academics with no plan to pursue post-secondary education. Therefore, current research supports using LGBTQ-inclusive SHE curriculum as a form of universal support for students.

There are several gaps in research and application surrounding this topic on how students perceive ineffective teaching of LGBTQ-inclusive SHE curriculum and whether current research recommendations to support educators are realistic and reflect their concerns and needs. As Garrett (2017) among other scholars have mentioned, current professional development to support educators in inclusive teaching has often been shown to be ineffective. Therefore, as it stands, it is imperative to understand the alignment between the changes in policies and the support educators receive to deliver effective sexual health education. This in turn will provide students the needed knowledge and understanding of inclusive sexual health to reduce health risks and promote a more inclusive school environment.



Demonic Possession to DSM-5

A historical perspective on the conceptualization of mental illness

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Abstract

How mental health practitioners conceptualize mental illness has far-reaching consequences. Contemporary conceptualizations of mental illness are influenced heavily by a complex interplay between psychiatry's history, the evolving zeitgeist, and the current social, cultural, and political forces. Thus, I posit that much can be gleaned from analyzing how mental illness has been conceptualized throughout history and the impact this historical context has on contemporary approaches. In this paper, I take a critical lens in reviewing the history of these conceptualizations from early supernatural explanations to the current DSM-5. I further explore some of the complexities and current challenges around conceptualizing and diagnosing mental illness. Ultimately, recognizing the role that psychiatry's history plays in contemporary conceptualizations of mental illness can assist in challenging our assumptions, refining our conceptual understanding, and promoting creativity in future developments.

Résumé

La façon dont les praticiens de la santé mentale conceptualisent la maladie mentale a des conséquences profondes. Les concepts contemporains de la maladie mentale sont fortement influencés par l'interaction complexe qui lie l'histoire de la psychiatrie, l'évolution de l'esprit de l'époque et les forces sociales, culturelles et politiques actuelles. Ainsi, je pense que, en analysant la façon dont la maladie mentale a été conceptualisée au cours de l'histoire et l'impact de ce contexte historique, nous apprendrons beaucoup. Dans le présent article, j'adopte un point de vue critique en examinant l'histoire de ces conceptualisations, depuis les premières explications surnaturelles jusqu'au DSM-5 actuel. J'explore en outre certains éléments complexes et défis actuels liés à la conceptualisation et au diagnostic de la maladie mentale. Enfin, la reconnaissance du rôle que joue l'histoire de la psychiatrie dans les concepts contemporains de la maladie mentale peut contribuer à remettre en

question nos postulats, à peaufiner notre compréhension conceptuelle et à promouvoir la créativité dans nos futurs travaux.

How we conceptualize mental illness has far-reaching consequences. It can impact everything from diagnosis and treatment, research pursuits, stigma, access to funding, and the global response. Our contemporary conceptualizations of mental illness are influenced heavily by a complex interplay between psychiatry's history, the evolving zeitgeist, and current socio-cultural forces. By considering our conceptualizations of mental illness in this way, we can begin to reflect on our assumptions of mental illness, critique our classification systems, and promote creative approaches to future pursuits. Thus, I contend that much can be gleaned from analyzing how mental illness has been conceptualized throughout history and the impact this historical context has on modern conceptualizations.

Historical Overview

Conceptualizations of mental illness have varied dramatically throughout history and continue to be debated (Clegg, 2012; Shorter, 2013). Throughout the middle ages, the supernatural tradition drove our conceptualizations. For example, mental illness was thought to be due to possession by evil spirits or witches' work (Barlow & Durand, 2011). Thus, religious ceremonies, exorcisms, and sorcery were commonly evoked 'treatments' for deviant behaviour. Fortunately, these supernatural conceptualizations were tempered by more natural explanations, which posited that mental illness was caused by mental or emotional stress. Today, these supernatural explanations have been replaced by biological and psychological conceptualizations; although even today, individuals born outside of North America are more likely to endorse supernatural causes of mental illness (Chiles, Stefanovics, & Rosenheck, 2017), illustrating the role that one's cultural milieu can have on mental illness conceptualizations.

Biological conceptualizations of mental illness have been prevalent to varying degrees since Hippocrates (Barlow & Durand, 2011). Vastly ahead of his time, he thought that mental illness could be caused by brain pathology, influenced by heredity, and treated like any other medical disease. Hippocrates and his successor, Galen, developed humoralism, which dominated Western medicine well into the 19th century. Humoralism posited that brain functioning was made up of four bodily fluids or humors, with psychological disorders arising from imbalances in one or more humors (Jouanna, 2012). Humoralism is perhaps one of the first examples of mental illness being conceptualized as chemical imbalances, a perspective that remains prevalent today (Barlow & Durand, 2011). The Hippocrates-Galenic approach had other lasting influences, including recognizing the importance of psychosocial factors in mental illness and inspiring some of our current diagnostic labels, such as depression originating from melancholia and somatoform disorders finding roots in hysteria. Similarly, psychological conceptualizations can also be traced back to early philosophers. For instance, Plato theorized that one's learning history and socio-cultural factors were the cause of maladaptive behaviour (Barlow & Durand, 2011). Plato's theories

are considered important precursors to modern psychosocial approaches and conceptualizations of mental illness.

The biological and psychological traditions varied in their degree of prominence throughout the years, often being propelled or stifled in response to ongoing political and social influences. The ongoing struggle between these approaches, I will argue, highlights an important theme in psychiatry's history. Rectifying this dichotomy and adequately integrating these two perspectives into a cohesive conceptualization has proven challenging.

From the 18th century to the mid-19th century, psychological conceptualizations of mental illness guided the development of more humane ways to treat individuals in asylums (Barlow & Durand, 2011). Adolph Meyer was a strong advocate for this approach and conceptualized mental illness as falling on a continuum, citing childhood experiences and psychosocial stressors as contributing causes (Pierre, 2013). Today, we see many of his basic tenets reflected in our current conceptualizations of mental illness, including the tendency to view psychological functioning on a continuum that responds dynamically to distressing circumstances.

As numerous medical advancements were made, this predominant psychosocial approach was greatly overshadowed in the mid-19th century by a more biological approach. For instance, the discovery that advanced syphilis could cause behavioural and cognitive symptoms, such as delusions, reinforced the idea that mental illnesses had biological etiologies (Barlow & Durand, 2011). Thus, the notion that yet undiscovered brain pathologies caused mental illnesses reduced the emphasis on finding adequate treatments. Instead, the focus shifted to developing a nosology that was able to identify unique mental disorders with greater objectivity (Shorter, 2013).

At the forefront of this endeavor to develop objective nosological systems, Emil Kraepelin sought to identify and classify homogenous groups with "the same etiology, course, duration, and outcome" (Shorter, 2013, p. 5). He conceptualized mental illness under a medical and biological model whereby real diseases have causal mechanisms that can be understood

and result in specific and consistent symptoms (Porter, 2013). In many ways, these nosological characteristics (i.e., etiology, course, duration, and outcome) remain the hallmark of our current diagnostic classification system and continue to guide research into and treatment of mental illness. Further, several of Kraepelin's diagnostic distinctions are still used in the American Psychiatric Association's (2013) Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5; Shorter, 2013). Critically, this begs the question of whether these distinctions are still relevant today.

The medicalized approach persisted until Freud's psychoanalytic theories drastically overhauled how mental functioning was theorized, diagnosed, and treated. Freud had an extensive theory to conceptualize mental illness that placed the role of the unconscious mind in the forefront. Neurotic disturbances were characterized as being due to such things as early sexual trauma, being stuck in an earlier psychosexual stage, an imbalance between the id, ego, and superego, or over-reliance on defense mechanisms (Schultz & Schultz, 2015). Despite an overall lack of empirical support for many of Freud's original theories, his psychoanalytic approach has had an immense and long-lasting impact on how we conceptualize mental illness. His approach paved the way for modern psychodynamic theories, social psychology, and humanistic approaches.

Around the time of WWII, psychoanalytic theories were thriving (Clegg, 2012). Dissatisfied with the existing biological-based classification system, William Menninger created an alternate approach, Medical 203, that drew influence from psychoanalytic theory and the earlier work by Adolf Meyer (Clegg, 2012; Office of the Surgeon General, 1946; Shorter, 2013). Diagnoses were named reactions and were thought to be dynamic responses to distressing experiences. Menninger conceptualized mental illness as continuous rather than binary, explaining that most people will have some degree of mental illness during their life (Pierre, 2013).

The DSM Series

The DSM series was eventually designed to integrate the multiple existing classification manuals. Earlier ver-

sions of the DSM resembled Menninger's Medical 203 by continuing its psychoanalytic orientation (Clegg, 2012; Kawa & Giordano, 2012). Altogether, psychoanalytic theories held a predominant position in the conceptualization of mental illness from the Medical 203 (1946) until the publication of the DSM-III (American Psychiatric Association, 1980). Today, the lasting impact of Freud and psychoanalysis is undeniable. Though much has been refuted, the notion that early traumas and processes outside our immediate awareness can impact one's mental health remains quite relevant. Indeed, research continues to uncover the role of trauma in psychopathology (McLaughlin & Lambert, 2017) and the neurobiology of the unconscious mind (Solms, 2018).

A driving force in the fall of psychoanalytic theory was the rising use of psychotropic medications to effectively treat severe mental illnesses in the 1950s. The compatibility between psychopharmacological interventions and biological conceptualizations—coupled with the economic advantage of medications over psychoanalytic therapies—greatly influenced the broader scientific and social zeitgeist around mental illness as a biological disorder (Barlow & Durand, 2011; Schultz & Schultz, 2015). There was a push for empirically validated and atheoretical conceptualizations of mental illness (Clegg, 2012). This shift in priority prompted the DSM's profound overhaul for the third edition (American Psychiatric Association, 1987). Here, we saw a return to a medical model with mental illnesses captured as discrete diagnostic entities, rather than continuums of reactions (Clegg, 2012; Kawa & Giordano, 2012). The medical model's dominance has remained in later revisions of the DSM, and further changes have not deviated greatly from this overall model.

DSM-5 and Beyond

Scientific advancements have underscored the limitations of parsing mental illness into narrow diagnostic categories (Kamens et al., 2018). The narrow DSM categories fail to capture the heterogeneity of symptoms within a disorder, shared symptoms between disorders, high comorbidity rates, or the dynamic influence of biopsychosocial factors. Thus, for almost two decades, the field has been calling for a much-needed paradigm shift in how mental illness is

conceptualized, classified, and approached (Phillips, 2013). Extensive research was conducted in an attempt to address the multitude of justified criticisms concerning the DSM-IV-TR (American Psychiatric Association, 2000) and the series in general (Blashfield et al., 2014). However, despite considering drastic changes to this classification system's structure, relatively little was ultimately different in the DSM-5 (Paris & Phillips, 2013).

Philosophically, the DSM-5 rejects the notion that mental disorders are discrete entities with clear boundaries (American Psychiatric Association, 2013) and attempts to present a theory-neutral, research-oriented medical model (Kawa & Giordano, 2012; Paris & Phillips, 2013). This approach supports etiological pluralism. It recognizes that different disorders may be due to different types of or combinations of etiologies. It also acknowledges that complex interactions between many factors may underly different presentations of disorders. However, the categorical nature of the DSM-5 continues to implicitly support the conceptualization of mental illness as functionally distinct entities (Clegg, 2012).

Unfortunately, it has proven challenging to establish a suitable alternative to the current model that addresses the limitations and integrates recent scientific findings into a comprehensive nosology. A review of existing and proposed alternative models is beyond the scope of this paper. However, alternatives range from well-established comparable diagnostic systems (e.g., ICD-10), to novel theoretical models of psychopathology (e.g., Venuleo et al., 2020), to statistical-based models (e.g., Levinson et al., 2018), and modality-specific conceptualizations (e.g., Hoffart & Johnson, 2017).

Final Thoughts

Continued debate on the best way to conceptualize mental disorders and the unequal attention that is given to research on certain disorders is partially responsible for the seemingly slow progress. Fortunately, progress is being made. For instance, interdisciplinary research into the neurobiological underpinnings of mental illness provides critical new insights (e.g., Dean & Keshavan, 2017). Advancements in statistical procedures, such as machine

learning, help explore alternative ways to cluster symptoms and classify patients (e.g., Kanchanatawan et al., 2018). It has become increasingly clear that mental health and illness cannot be neatly parsed into clean and distinct diagnostic categories. More and more, mental illness is being recognized on continuums rather than discrete categories, and resulting from complex interactions between multiple etiological factors, including genetic (and epigenetic) processes, neurobiological changes, environmental factors, and early-life experiences (e.g., Smigielski et al., 2020). And broader conceptualizations have permeated into the current zeitgeist, with mental illness no longer reflecting a discrete entity reserved for the severely ill but an experience that can hold relevance to every individual (Haslam, 2016).

Although many elements of our current understanding are reminiscent of antiquated mental illness approaches, significant progress has been made. Indeed, we have come a long way from citing a wandering uterus as the cause of hysteria or using lobotomies to treat mental disorders. Still, it seems that the more we delve into the question of how to conceptualize mental illness best, the more we recognize how little we collectively understand and how far from a consensus we are as a field. This fact is clearly illustrated by the degree of variability we see in how mental illness is conceptualized cross-culturally, across (and within) subfields of psychiatry and psychology, across treatment modalities, and in society (e.g., Hoffart & Johnson, 2017; Lopez & Guarnaccia, 2000).

Conceptualizing mental illness is incredibly complex. Our conceptualizations are often a greater reflection of our predecessors' ideologies, current socio-cultural zeitgeist, and the evolving scientific landscape than absolute truth. Thus, understanding the historical contributions to modern mental illness conceptualizations provides insight into where we have been and areas we may pursue. It helps to temper overly reified conceptualizations of an incredibly complex and abstract concept. Lastly, viewing mental illness conceptualizations as a complex interplay between current scientific knowledge, historical influences, and the ever-evolving cultural milieu can foster greater creativity and patience in this formidable pursuit.



The Complications of Diagnosing Autism Spectrum Disorder in Childhood

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Abstract

Many factors continue to complicate the assessment process for Autism Spectrum Disorder (ASD). This report examines two factors that impact the diagnosis and assessment of ASD in children: the array of overlapping and similar symptoms between ASD and attention-deficit hyperactivity disorder (ADHD), and societal misconceptions about ASD and its presentation. Failure to properly discriminate between symptoms of ASD and ADHD can lead to a missed diagnosis of ASD, or a misdiagnosis of only ADHD. As well, parents and teachers show a general tendency to overlook ASD in females and to misattribute symptoms of ASD to ADHD. These complications with ASD's assessment process lead to delayed diagnosis and treatment of the disorder, which severely impacts the effectiveness of treatment and the child's long-term outcomes. Areas for future research and changes that could potentially reduce these complications are recommended.

Résumé

De nombreux facteurs continuent de compliquer le processus d'évaluation du trouble du spectre de l'autisme (TSA). Le présent rapport se penche sur deux facteurs qui influencent le diagnostic et l'évaluation du TSA chez les enfants : l'éventail de symptômes qui se chevauchent et se ressemblent entre le TSA et le trouble déficitaire de l'attention avec hyperactivité (TDAH), et les idées fausses qui circulent dans la société sur le TSA et ses manifestations. Le fait de ne pas distinguer correctement les symptômes du TSA et du TDAH peut conduire à un diagnostic manqué de TSA, ou à un diagnostic erroné de TDAH uniquement. De plus, les parents et les enseignants montrent une tendance générale à négliger le TSA chez les femmes et à attribuer à tort les symptômes du TSA au TDAH. Ces complications liées au processus d'évaluation du TSA retardent le diagnostic et le traitement du trouble, ce qui a des

répercussions graves sur l'efficacité du traitement et sur ses effets à long terme sur l'enfant. Nous recommandons d'envisager des recherches futures et des changements susceptibles de réduire ces complications.

As mental health has grown to be a more recognised and understood topic in society, the assessment of mental health disorders has changed and developed with it. For example, significant advancements have been made in defining and identifying Autism Spectrum Disorder (ASD). Society as a whole has gained a better awareness and understanding of ASD, which has led to earlier referrals and initiation of treatment for children with ASD (Happé & Frith, 2020). Despite the many promising changes in the diagnosis and treatment of ASD, many concerning issues continue to complicate the assessment process. The overlap between ASD and attention-deficit

hyperactivity disorder (ADHD) symptoms and the abundance of societal misconceptions about both disorders contribute to the difficulty of assessing ASD. This, in turn, can negatively impact the effectiveness of treatment and expected outcomes for a child with ASD, therefore it is clear that measures need to be taken to improve the assessment and diagnosis of the disorder (Clark et al., 2018; Dawson et al., 2010; Miodovnik et al., 2015).

Brief Introduction to ASD

ASD is a neurodevelopmental disorder outlined in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) that is characterized by social and communicative deficits as well as restrictive, repetitive behaviors and interests (American Psychiatric Association, 2013). However, as ASD is a spectrum disorder, the presentation, intensity, and types of symptoms experienced differ for every child with the disorder. Worldwide, approximately one in 160 children is diagnosed with ASD, but this number increases in countries with greater access to mental health resources (Elsabbagh et al., 2012). In Canada, approximately one in 66 children have been diagnosed with ASD (Government of Canada, 2018). Currently, no biological or medical tests exist to detect or diagnose ASD (Elder et al., 2017). Instead, clinician-administered diagnostic questionnaires are the most common assessment tools for ASD, such as the Autism Diagnostic Observation Schedule (ADOS-2; Lord et al., 2000) and the Autism Diagnostic Interview-Revised (ADI-R; Charman, 2008; Lord et al., 1994). However, given that these tools are typically only used for children with more recognisable presentations of the disorder, they are unlikely to help in the case of a missed or misdiagnosis (Matson et al., 2010; Ventola et al., 2006).

FACTORS COMPLICATING THE ASSESSMENT PROCESS

Similarities between ASD and ADHD

The core symptoms of ADHD are seen in children with ASD to varying degrees. Children with ASD and children with ADHD show similar social and communication impairments, such as difficulties with creating and maintaining relationships, being affectionate, and properly

reciprocating in conversations (Kern et al., 2015; Oerlemans et al., 2014). Furthermore, there are many overlapping and shared features in the associated genetics, brain functioning, and executive functioning of children with ASD and ADHD, so biological assessments cannot be used to differentiate between the two disorders (Antshel et al., 2016). It is estimated that 31–95% of children with ASD present substantial symptoms of inattention, hyperactivity, and/or impulsivity (Antshel et al., 2013). Studies have found that on average, children with ASD score six times higher for symptoms of inattention than control groups on the Swanson, Nolan and Pelham Teacher and Parent Rating Scale (SNAP-IV; Swanson et al., 2001), a self-report scale for measuring symptoms of ADHD, and that children with both ASD and ADHD score higher for inattention and hyperactivity compared to children with either ASD or ADHD (Craig et al., 2015). Thus, the symptoms of ASD and ADHD are difficult to distinguish between, which can lead to a misdiagnosis of ADHD or missed diagnosis of ASD.

Children with lower severity ASD symptoms are particularly prone to being misdiagnosed, as their ASD symptoms are more likely to be overlooked or misclassified (Kaland, 2011; Miodovnik et al., 2015). The heightened symptoms of ADHD in children with comorbid ASD and ADHD can cause the presenting symptoms of ASD to be overlooked, which can in turn cause a delayed or missed diagnosis of ASD due to the initial misdiagnosis of ADHD alone (Gargaro et al., 2010; Kentrou et al., 2018; Miodovnik et al., 2015). While children with ASD alone are typically diagnosed at around three years of age, children with ASD who first receive a diagnosis of ADHD are typically diagnosed approximately two to three years later than those diagnosed with ADHD at the same time or after ASD (Kentrou et al., 2018; Miodovnik et al., 2015). This delay in diagnosis can have detrimental consequences on the long-term prognosis of a child with ASD (Clark et al., 2018; Dawson et al., 2010), which will be discussed later in this paper. The degree and complexity of symptom overlap between ASD and ADHD increases the need for careful and thorough assessment of the disorders (American Psychiatric Association, 2013).

Influence of Teacher and Parental Perceptions

The fixation of parents and teachers on ADHD-related symptoms and diagnoses can also have a profound impact on the diagnosis of ASD. While parents and teachers using the Checklist for Autism Spectrum Disorder (CASD; Mayes, 2012) tend to overrate symptoms of ADHD in their children compared to psychologists' ratings, they also tend to significantly underrate symptoms of ASD in their children (Mayes & Lockridge, 2018). Likewise, parents tend to classify stereotyped, repetitive behaviors as hyperactivity on the Children's Social Behavior Questionnaire (CSBQ; Hartman et al., 2015) and often view symptoms of ASD through the lens of ADHD (Mayes & Lockridge, 2018; Sokolova et al., 2017). Research suggests that parents and teachers are more likely to notice and focus on externalized symptoms in children, such as hyperactivity, rather than symptoms that are internalized or more difficult to observe in children, such as social deficits; this can cause them to overlook many of the symptoms of ASD in children, and mislabel the more observable symptoms of ASD as ADHD due to this perceptual bias (Miyasaka, 2018; Pearson et al., 2012). These perceptions can influence the direction of the assessment and further complicate the diagnosis of ASD, with or without comorbid ADHD.

Furthermore, the gender stereotypes held by parents, teachers, and even clinicians can often complicate the assessment of ASD in females. Many young women with ASD report that when they were children, their parents and clinicians ignored the possibility of them having ASD because of their gender, which led to later ages of diagnosis and an identity conflict between their ASD and femininity (Bargiela et al., 2016). This gender disparity can be seen in the DSM-5 diagnostic criteria for ASD; while ASD often presents differently in females than in males, the diagnostic criteria are heavily oriented to a masculine presentation of the disorder and only specifies the ways in which the disorder may present differently in females in a brief note. This lack of specificity in distinguishing between gender-specific symptom presentations can further complicate the assessment of ASD (American Psychiatric Association, 2013; Bargiela et al., 2016; Giarelli et

al., 2010).

Impact on Treatment and Expected Outcomes

While many uncontrollable factors impact the outcomes of a child with ASD, such as their IQ or natural language ability, the age when a child is diagnosed and begins treatment is potentially the most significant controllable factor that can influence long-term outcomes due to the neuroplasticity of young children's brains (Miodovnik et al., 2015; Orinstein et al., 2014; Zwaigenbaum et al., 2019). An over-complicated assessment process can cause a child's diagnosis and treatment to be delayed due to an initial misdiagnosis of ADHD or missed diagnosis of ASD; this can have a severe impact on the child's long-term outcomes and the effectiveness of treatment (Dawson et al., 2010; Orinstein et al., 2014). When children are diagnosed with ASD before age three, they receive more interventions, show stronger verbal and general cognition, and eventually require less ongoing support than children who are diagnosed at a later age (Clark et al., 2018). However, when diagnosed and treated at a later age, children with ASD make significantly less improvement in their language abilities, cognition, and adaptive behaviors (Dawson et al., 2010; Vivanti et al., 2016). The advantages and progress from starting treatment at an earlier age can very rarely be attained if treatment is delayed, regardless of how intensive, personalized, or thorough the treatment may be (Clark et al., 2018; Dawson et al., 2010; Miodovnik et al., 2015). Given that ASD typically presents in children around twelve months of age (Johnson et al., 2007), it is plausible that children with ASD could be regularly diagnosed and begin treatment before age three if properly assessed (Zwaigenbaum et al., 2019). An effective, unbiased assessment is a

crucial first step in the treatment process.

Effective diagnosis of ASD is also necessary to prevent children from receiving and experiencing consequences from improper treatment. In the case of a misdiagnosis of ADHD, treatment involving the use of ADHD medications is common (Cortese, 2016). Currently, treatment of ADHD with medication is the most recommended and accepted initial treatment option (Cortese, 2016). However, ADHD medications are not nearly as effective in children with only ASD, and children with ASD are less likely to seek help when they are experiencing negative side-effects, which can cause unnecessary and prolonged distress in the child (Cortese, 2016). Furthermore, the rates of negative side effects experienced from ADHD medication use, specifically symptoms of social withdrawal and irritability, are higher in children with ASD than in children with ADHD only (Cortese, 2016). It is therefore crucial to properly assess for ASD to ensure the child receives the best possible treatment for their health and wellbeing.

Areas for Future Improvement

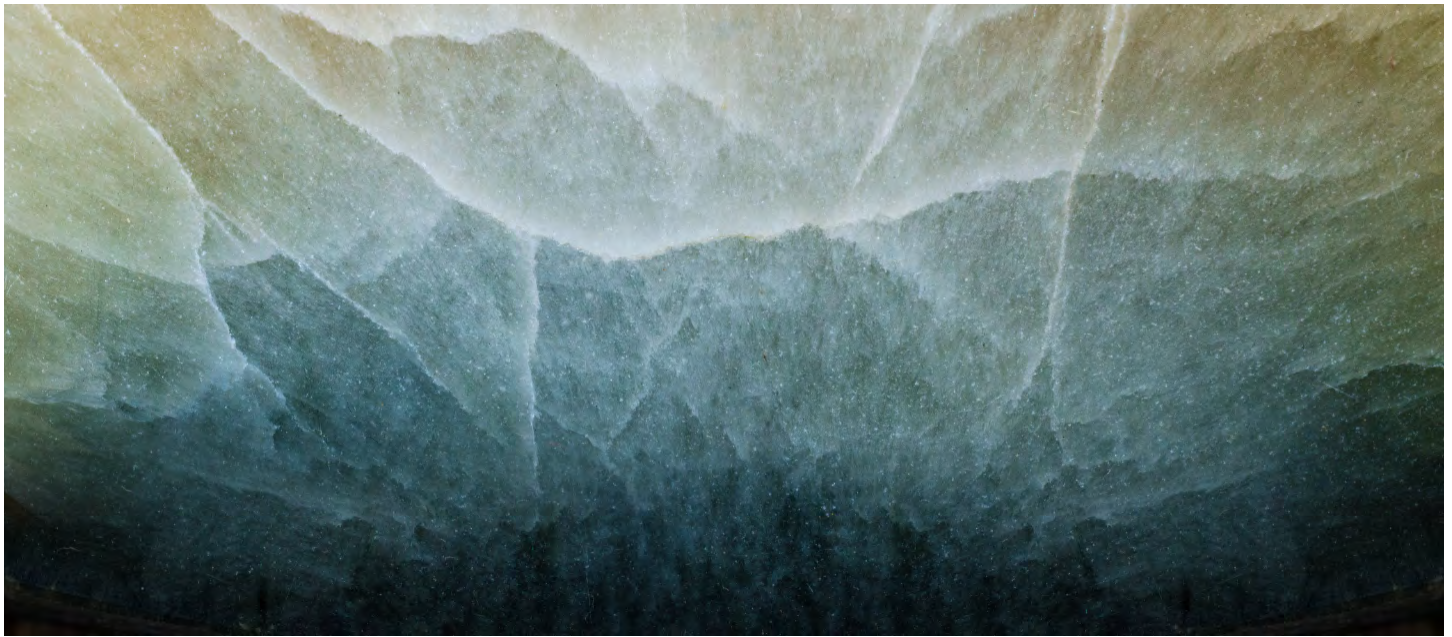
As the assessment and diagnosis of children with ASD has a significant influence on their treatment and potential outcomes, it is important that the complications and confusing factors associated with assessment be effectively managed as soon as possible. While research has begun to show that the symptoms associated with ADHD are present to varying degrees in a wide range of children diagnosed with ASD, further research into the connection and relationship between ASD and ADHD is necessary (Antshel et al., 2013). However, until this complicated relationship is better understood, the diagnostic criteria and

assessment guidelines for ASD should be expanded upon to include more explicit directions for distinguishing between symptom of ASD and ADHD (Miodovnik et al., 2015). As well, further research and updates to the diagnostic criteria and assessment guidelines for ASD should be made to better represent females with ASD and to expand upon the current understanding of how their presentation differs from that of males with ASD. This would help to reduce the number of young girls whose presentation is excluded by the current diagnostic criteria for ASD, which may lead to earlier diagnosis and more positive treatment outcomes (Bargiela et al., 2016). Finally, the assessment tools for children with co-occurring ASD and ADHD must be updated, as presently the diagnostic tools for ADHD do not include any measures or adaptations for assessing children with comorbid ASD (Cortese, 2016).

Conclusion

The assessment process and diagnostic criteria provide the foundation for diagnosing children with ASD. A child with ASD's treatment, self-perception, and potential outcomes are heavily influenced by the age at which they are diagnosed with ASD. Therefore, an efficient and accurate assessment process is necessary to diagnose ASD in children with varying symptom presentations, comorbid disorders, or genders. However, the current assessment process and diagnostic criteria for ASD continue to be impacted by the disorder's similarities to ADHD and societal misconceptions about ASD. This can lead to missed and misdiagnoses, which make it extremely difficult to treat children with ASD as early as possible. Overall, it is clear that further research should be done, and further action be taken, to decrease the complications of assessing and diagnosing ASD.





Examining Familial Culture and the Underutilization of Mental Health Services in Asian American Adolescents with Depression

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Abstract

Major depressive disorder (MDD) is a debilitating mental illness that is pervasive across cultures. Despite tending to experience more depressive symptoms, Asian American adolescents are substantially less likely than other racial groups to seek assessment and treatment. This paper explores the role that cultural perceptions of mental illness might play in the recognition, understanding, and treatment of Asian American adolescents with depression. Specifically, Asian Americans' cultural perceptions of psychopathology might clash with traditional Western practices, which may hinder the assessment and

treatment of Asian American adolescents with MDD. Finally, in light of these cultural considerations, this paper proposes actions to address the underutilization of mental health services in Asian American adolescents with MDD.

Résumé

Le trouble dépressif majeur (TDM) est une maladie mentale débilatante qui est omniprésente dans toutes les cultures. Bien qu'ils aient tendance à éprouver plus de symptômes dépressifs, les adolescents asiatiques américains sont beaucoup moins susceptibles que les membres des autres groupes raciaux de consulter et de se faire soigner. Le présent article

explore le rôle que pourraient jouer les perceptions culturelles de la maladie mentale dans la reconnaissance, la compréhension et le traitement des adolescents asiatiques américains souffrant de dépression. Plus précisément, il se peut que la conception culturelle de la psychopathologie partagée par les Américains d'origine asiatique entre en conflit avec les pratiques occidentales traditionnelles, ce qui risque d'entraver l'évaluation et le traitement des adolescents asiatiques américains souffrant de TDM. Enfin, à la lumière de ces considérations culturelles, nous suggérons dans notre article des mesures visant à remédier à la sous-utilisation des services de santé mentale chez les adolescents asiatiques américains souffrant de TDM.

Major depressive disorder (MDD) in adolescents is an important public health concern, as it is one of the most prevalent psychiatric disorders affecting adolescents globally (Mullen, 2018). In addition, early onset of depression can increase risk for later life problems and suicide (Wyatt et al., 2015). This is particularly concerning for Asian American adolescents, as they tend to experience higher levels of depressive symptoms compared to their Caucasian peers (Chen et al., 2011; Choi et al., 2020; Lorenzo et al., 2000). Despite the persistence of such symptoms, studies have shown that Asian American adolescents are less likely to seek assessment and treatment than any other racial group (Lee et al., 2014; Kalibatseva & Leong, 2011). In fact, one study by Yeh and colleagues (2003) found that 72% of their Asian American adolescent participants forwent any type of clinical intervention for their depression.

It has been posited that this underutilization may be attributed to the cultural background of Asian American families, as culture may influence one's understanding of the etiology of depression and affect their decision to seek treatment (Gopalkrishnan, 2018; Kraemer et al., 2002; Wang et al., 2019). More specifically, the stigmatization and somatization of mental illness within collectivist cultures, and the perceived nonutility of traditional Western mental health services (e.g., medication, psychotherapy) may impact decisions on whether to seek treatment. As such, this report aims to examine how the cultural concepts of (a) stigmatization, (b) somatization, and (c) perceived nonutility of services in Asian families may contribute to the underutilization of mental health services by Asian American adolescents with MDD. Finally, this report will propose future clinical and research directions that can better support this population.

The Role of Familial Culture in Understanding Underutilization of Mental Health Services, Collectivism and Stigmatization

One cultural concept emphasized in many Asian communities is collectivism over individualism (Chadda & Deb, 2013; Miyawaki, 2015; Triandis, 1993). Individualism, common to Western communities, is defined by a culture

valuing self-expression and personal independence (Triandis, 2001). In comparison, collectivist cultures value group harmony and collaboration towards a shared goal (Triandis, 2001; Yates & de Oliveira, 2016). This is demonstrated in one longitudinal study, where Asian American adolescents displayed more collectivist values, as they reported a stronger sense of familial obligation (i.e., putting family over individual interests) than other racial groups (Gee et al., 2020). To highlight the influence of collectivism in Asian American adolescents' experience with MDD, it may be useful to compare these two cultural lenses of individualism and collectivism. When interpreting from these two different cultural lenses, characteristic symptoms of MDD like depressed mood (i.e., negative affect) or loss of interest in almost all activities (i.e., anhedonia), as defined by Kennedy (2008), may have different social implications (Triandis, 2001).

Specifically, in individualist cultures, depression may be seen as experienced solely by the individual, without having social consequences for one's family (Keller et al., 2019). In comparison, depression may strain collectivist family systems, as one's ability to contribute to the group is perceived by the community as being impaired (Keller et al., 2019; Ran et al., 2021). This perception creates a stigma where individuals experiencing depressive symptoms may be seen as "weak" or "dangerous" to the family system (Griffiths et al., 2006). In turn, stigmatization can create a powerful obstacle to assessment and treatment for Asian American adolescents with depression (Li & Seidman, 2010; Papadopoulos et al., 2013). Two reviews aptly suggest that the stigma of being publicly associated with depression and the social risks to the family reputation may compel parents to minimize the depressive symptoms experienced by Asian American adolescents (Kim et al., 2001; Li & Seidman, 2010). As such, the collectivist values adopted by many Asian families may be a formidable barrier to the assessment of Asian American adolescents because of their association to the stigmatization of depression.

Somatization

Somatization, the tendency to express

psychological distress as somatic or bodily complaints, is another key concept that is prevalent in Asian cultures (Kawanishi, 1992; Liu et al., 2020). Several studies have shown that Asians are more likely than Caucasians to communicate depression as only physical symptoms, rather than in possible combination with psychosocial or psychological symptoms (Gureje et al., 1997; Liu et al., 2020; Maeno et al., 2002; Wong et al., 2014; Li & Seidman, 2010). This was demonstrated by Dreher and colleagues (2017), who found that Vietnamese patients were more likely to communicate depressive symptoms as physical disturbances like 'headaches' or 'chest pain' compared to German psychiatric patients. This somatization that is common amongst collectivist cultures may represent an incongruence with the Western understanding of depression (Arnault et al., 2006). Western characterizations of MDD that prioritize symptoms such as anhedonia or negative affect may not be seen as relevant to Asian families who may present symptoms of depression as abdominal distress, neurological symptoms, or muscular pain (Arnault et al., 2006; Wong et al., 2014). Thus, somatization in Asian cultures may represent a barrier to assessment and treatment, not from parents' willful ignorance, but rather from immense cultural disparity. If parents and clinicians have different understandings of the etiology and urgency of depressive symptoms, these cultural barriers may create challenges for clinicians to accurately recognize depression in Asian American adolescents (Bhui et al., 2001; Jacob et al., 1998; Kirmayer et al., 1993).

Perceived Nonutility of Mental Health Resources

Stigmatization and somatization are not only common in many Asian American families, but might also contribute to these families' negative perceptions of mental health services, or the belief that seeking out professional Western intervention for the treatment of depression has no benefit (Martinez et al., 2020; Straiton et al., 2018). Common Western techniques to treat MDD, like psychotherapy, may be stigmatized in Asian American communities as they often require patients to share deeply personal experiences with an effective stranger (Carty & Escalona, 2016).

These techniques can clash with the private and family-oriented culture of collectivism, which may contribute to Asian communities' lack of belief in Western mental health services and their subsequent underutilization of such services (Carty & Escalona, 2016). This is demonstrated by one study examining 100 Filipino Americans, which showed that higher mistrust of common Western mental health institutions was associated with lower probability of seeking out those resources (David, 2010). Thus, this higher mistrust of common Western mental health institutions, as examined in David's (2010) study, may demonstrate how stigmas on MDD contribute to Asian American's negative attitudes towards seeking professional help. As a result, stigmatization may play an important role in creating a perception of nonutility of mental health services in Asian families, which may further contribute to their underutilization of mental health services.

Secondly, like stigmatization, somatization can further contribute to the Asian family's perception of nonutility of mental health services (Suka et al., 2016). In one study comparing the differences in South Asian and Caucasian patients, South Asians were more likely to rationalize depression as a transient emotional state rather than a clinical problem that should be treated (McClelland et al., 2014). In another study, Asian parents believed their children's depression was caused by mental weakness and thus should be treated by changes in lifestyle or diet, rather than by seeking professional psychological help (Li & Seidman, 2010). As such, somatization may contribute to this perception of nonutility as parents might prefer addressing their children's depression within the family rather than by seeking out traditional mental health services (Straiton et al., 2018; Suka et al., 2016).

To summarize, stigmatization and somatization alone can be formidable challenges to the assessment and treatment of Asian American adolescents with depression (Triandis, 2001; Arnault et al., 2006). However, these two concepts can also contribute to familial perceptions of the nonutility of Western treatments for depression, which may further reinforce the underutilization of mental health

services by Asian American adolescents with MDD (Straiton et al., 2018; Suka et al., 2016). Understanding the perceptions that may inform Asian parents' decision making is important, as this may aid in the development of culturally specific strategies to address the underutilization of mental health services by Asian American adolescents with depression.

Future Clinical Directions for Asian American Adolescents with Depression

Western perceptions have been the foundation of mental health research and treatment for many years (Gopalkrishnan, 2018). Though this monocultural focus has been useful in developing foundational frameworks for Western psychiatry (Office of the General Surgeon (US) et al., 2001), it can be insufficient in the face of a diverse patient population (Fernando, 2014; Shorter, 1997). As such, it is important to examine possible cultural considerations for mental health services and how they may be applied to the treatment of depression for Asian American adolescents.

Clinical Considerations for Patients from Collectivist Cultures

As aforementioned, collectivism plays an important role in contextualizing the social world of Asian communities. Healthcare providers should work to enhance their cultural sensitivity in order to more effectively serve their patients from different cultures. For example, it may be important for clinicians to understand the potential merit in collaborating with the patient's family, particularly when patients are from collectivistic cultures (Miyawaki, 2015; Lewis-Fernandez & Diaz, 2002; Lin et al., 1999). Working with culturally sensitive healthcare providers may increase parental engagement, as these clinicians can identify and navigate the many stigmas related to depression (Huang et al., 2014). For example, treatment options for MDD in many Western-based clinics often include psychotropic medication (Kennedy, 2008). As purported by Ratzliff and colleagues (2013), individuals from Asian cultures may experience more stigma against taking psychotropic medications than their Caucasian peers. Culturally sensitive providers should be aware of such stigmas to be in a position to effectively address such concerns while educating

patients or offer alternative solutions, such as group psychotherapy (Ratzliff et al., 2013; Chen et al., 2002).

Another important consideration for patients from collectivistic cultures might be to increase the availability of more culturally-specific resources, such as spiritual healers and community leaders. Studies have shown that many Asian families are more likely to engage with such culturally specific resources (Augsberger et al., 2015; Gopalkrishnan, 2018). Indeed, one study found that South Asian patients with mental health issues regularly attending their local temples in India showed significant symptom improvements over time (Raguram et al., 2002). Therefore, it may be useful for Western clinical practices to collaborate with these culturally specific institutions that can provide additional treatment options to Asian American adolescents and their parents.

Clinical Considerations for Somatization

Given that individuals from Asian communities tend to express psychological symptoms as bodily complaints (Liu et al., 2020), it may be important for care providers to speak openly with Asian American adolescents and their families about their beliefs about depression. A baseline understanding of these beliefs may help providers adjust their therapeutic strategies based on their patients' unique cultural context and worldview (Office of the Surgeon General (US) et al., 2001). One consideration is that some Asian languages are somatic-centered and may lack analogous English expressions for depression (Mooney et al., 2016). In China, for example, the literal translation for "depression" is yi ("restrain" or "repress") or yu ("gloomy"), which is less accepted socially in some Chinese communities (Parker et al., 2001). In comparison, the lay term shenjing shuairuo, which means "neurological weakness," is less stigmatized and characterized as a nervous system disorder encompassing a wide variety of somatic, cognitive, and emotional symptoms (Parker et al., 2001). Clinicians' existing systems for assessing depression may not adequately assess for experiences like shenjing shuairuo, which is more common in Asian populations (Mooney et al., 2016; Bhugra & Mastrogianni,

2004). Actively inquiring about somatic symptoms may therefore provide valuable diagnostic information as this uses language that more accurately describes the depressive experiences as they are understood by Asian American adolescents and their families (Wong et al., 2010).

Most importantly, clinicians should be flexible to these different perspectives. In one case study where the clinician focused on addressing somatic concerns, the patient became more receptive to trying psychotherapy (Kawanishi, 1992). Moreover, Kawanishi (1992) noted that over time, due to their consistent dialogue with the physician, the patient eventually overcame the stigma they felt about their diagnosis because they were able to learn more about the nature of their depression. As such, acknowledging somatization may facilitate important dialogue with parents about how to better treat and address their children's depression (Masuda et al., 2014; Tylee & Gandhi, 2005).

Clinical Research Considerations

Advocating for further research into

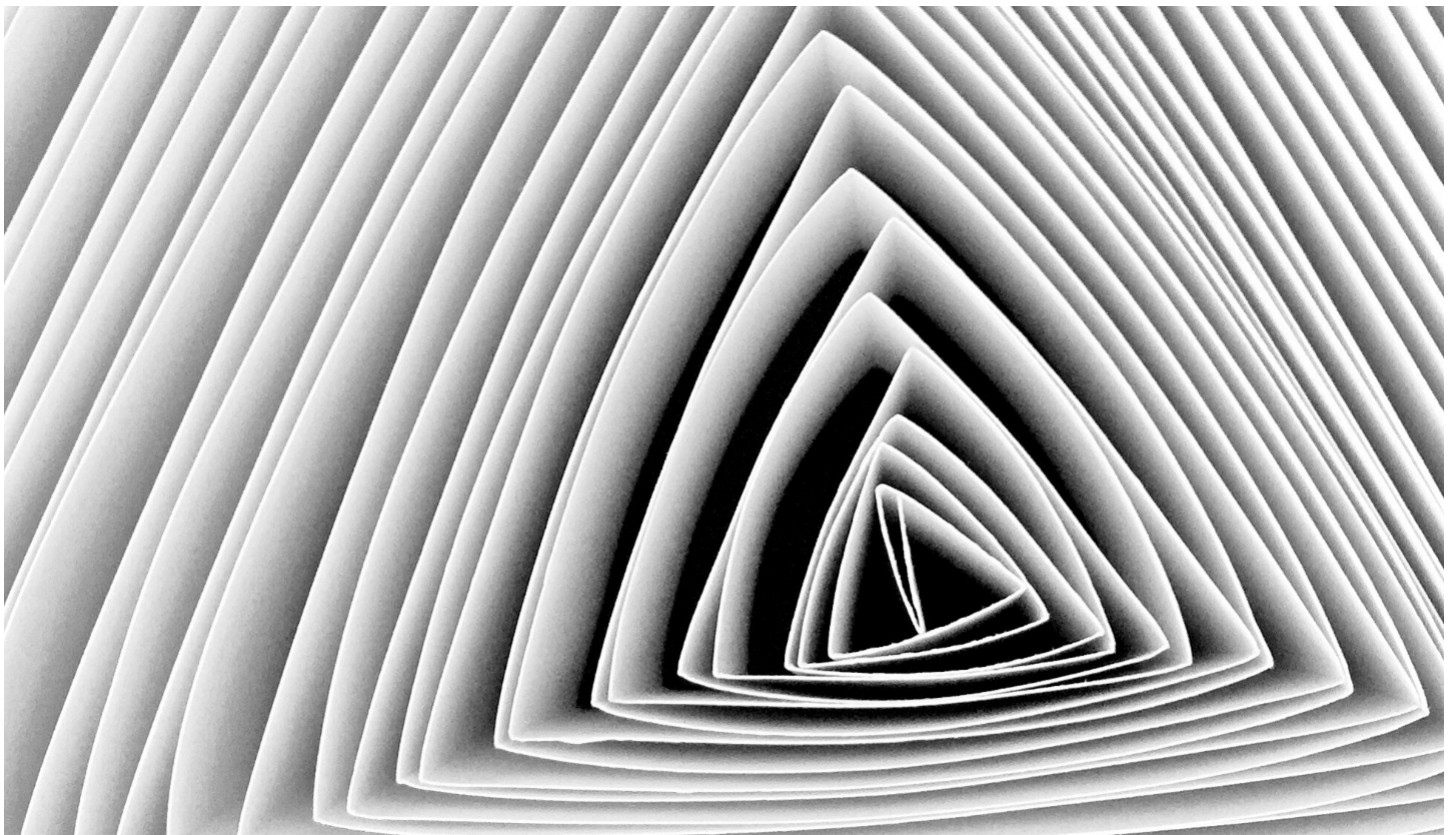
treatment practices that acknowledges the cultural perceptions of many Asian communities is essential (Augsberger et al., 2015; Sue et al., 2012). For example, it is important to acknowledge the barriers that prevent Asian Americans' participation in research on adolescent depression. Parental stigma against depression limits the available sample population and may produce results that are unreflective of the actual needs of this target community (Lauber & Rossler, 2007; Liu et al., 2019). As such, care providers should increase patients' and parents' awareness of research opportunities and their potential benefits to Asian American adolescents (Chen et al., 2005). Additionally, clinicians should also acknowledge that most research on depression in Asian Americans focuses on prevalent Asian ethnicities (e.g., Chinese, Korean, Japanese, etc.), and data are lacking for underrepresented Asian subgroups like Cambodian, Laotian, or Thai people (Hong, 2019; Kim et al., 2015; Kim et al., 2020; Trinh & Ahmed, 2009). Future research should reflect the heterogeneity of Asian American populations to better understand and address the needs of Asian American adolescents with

depression (Lee et al., 2000).

Conclusions

To address mental health service underutilization in Asian American adolescents, clinicians must understand the important role that familial culture plays in the assessment and treatment of adolescents with depression (Mullen, 2018). To do so effectively, they should accommodate their patients' collectivist values and tendencies to somaticize mental disorders, and address the perceptions of nonutility that are pervasive in Asian American communities. Understanding these cultural perceptions and noting how they may conflict with Western practices is imperative to overcome underutilization of services for depression by Asian American adolescents. Finally, clinicians should collaborate with important systems within Asian American communities, like parents, cultural leaders, and primary care providers to develop assessment and treatment options that effectively address the needs of this diverse patient population.





Shaping Adult Development and Ageing Through Neuroplasticity

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Abstract

Throughout scientific history, the human brain was viewed as a fixed and hardwired organ. However, in modern times, the phenomenon of neuroplasticity suggests that environments and activities can induce structural and functional changes in the brain. For example, disciplined and consistent educational activities, like music learning, or compulsive behaviours, like chronic pornography usage, can directly affect the brain's structure and functioning. On the one hand, music learning/making can induce neuroplastic changes in the brain that may be positive, such that they counteract cognitive and motor declines experienced throughout ageing. On the other hand, chronic pornography usage can contribute to negative neuroplastic alterations that may induce behavioural cravings and diminished sexual satisfaction. This article aims to discuss the evidence

suggesting positive and negative neuroplastic changes can indeed occur in the adult brain, as evidenced by music making and pornography use, to support the ability of adults to shape their lifestyle choices.

Résumé

Tout au long de l'histoire scientifique, le cerveau humain a été considéré comme un organe fixe et programmé. Cependant, à l'époque moderne, le phénomène de la neuroplasticité donne à penser que les contextes et les activités pourraient induire des changements structurels et fonctionnels dans le cerveau. Par exemple, la pratique d'activités rigoureuses et régulières, comme l'apprentissage de la musique, ou les comportements compulsifs, comme la consommation chronique de pornographie, peuvent directement influencer la structure et le

fonctionnement du cerveau. D'une part, l'apprentissage de la musique ou la composition musicale peut induire des changements neuroplastiques dans le cerveau susceptibles d'être positifs, de sorte qu'ils neutralisent le déclin cognitif et moteur vécu tout au long du vieillissement. D'autre part, la consommation chronique de pornographie peut contribuer à des altérations neuroplastiques négatives, qui sont susceptibles d'induire des envies impérieuses de comportements sexuels et une diminution de la satisfaction sexuelle. Le présent article vise à examiner les preuves indiquant que des changements neuroplastiques positifs et négatifs peuvent effectivement se produire dans le cerveau adulte, comme en témoignent la composition musicale et la consommation de pornographie, afin de renforcer la capacité des adultes à façonner leurs choix de vie.

For at least 400 years, mainstream medicine and science throughout the world operated under the assumption that both brain anatomy and function were permanently fixed (Doidge, 2007). Under this framework for understanding the human brain, it was believed that alterations in brain function and structure could only be induced by a permanent, traumatic injury or through deterioration that is associated with typical healthy brain ageing (e.g., subtle declines in speed and attentional control; Gonzalez Catalan et al., 2019). However, this understanding has since been challenged and is no longer supported. Instead, research has backed the adoption of a new framework known as neuroplasticity, which is defined as the brain's ability to develop new neurons or new synapses in response to stimulation and learning (Law & Martin, 2020). Evidence suggests that neuroplasticity can be induced by the stimuli, behaviours, and environments that an individual interacts with and that these changes can occur throughout one's lifespan, rather than just during childhood or adolescence (Castaldi et al., 2020; Sasmita et al., 2018; Smith et al., 2021). Indeed, modern health concerns like rising obesity rates (Casquero-Veiga et al., 2021; de Sousa Fernandes et al., 2020), neurological diseases (Hortobágyi et al., 2021) and mood disorders, such as depression (Guo et al., 2020), are now understood as being linked with various forms of neuroplasticity.

Promoting healthy brain development in adults requires pinpointing environments in which opportunities for positive neuroplasticity (e.g., observable increases in neurotrophic growth factor, dendritic branching, or grey matter thickness) can occur (Vance & Wright, 2009; Bar & DeSouza, 2016; Koshimori & Thaut, 2019; Kühn & Gallinat, 2014). The following paper will review modern research in neuroscience and neuropsychology to examine the evidence suggesting the positive effects of neuroplasticity in the adult brain, as well as the potential negative behavioural and psychological consequences of neuroplasticity, depending on the type of stimuli. Specifically, this paper will review the literature examining how music making and pornography use can differentially induce positive and negative neuroplasticity, respectively, by cre-

ating structural and functional changes throughout multisensory integration systems, learning systems, reward systems, and cognitive systems within the brain.

Music Making and Learning

Research on the positive neuroplastic consequences associated with music making and learning has highlighted the potential for this task to be used as a tool to promote positive brain development and psychological well-being. Music learning and making are considered multimodal forms of education, defined as learning situations that engage multiple sensory systems and the learner's motor networks within the brain (Papadopoulou & Avgerinou, 2019). More specifically, it is believed that the processes involved in creating and learning music likely place a demand on the brain's multisensory integration systems, learning systems, reward systems, and cognitive systems, which, together, promote positive neuroplasticity in these systems (Sutcliffe et al., 2020). Given that research on the neurodegeneration attributed to typical healthy brain ageing reveals a correlation with motor/cognitive decline throughout an adult's life span (Bernard & Seidler, 2014), this distinction in learning style is critical because multimodal music education may promote positive neuroplasticity in the very brain networks associated with healthy ageing. For example, research has demonstrated that multimodal learning is linked to neuroplastic benefits in the cerebellum, an area of the brain integrated with motor and cognitive ability and often implicated in atypical age-related neurodegeneration (Bernard & Seidler, 2014; Sutcliffe et al., 2020). Another study by Bugos and Kochar (2017) used multimodal training methods to teach adult piano students and found that intense piano training in adults may increase connectivity between the frontal cortex and the cerebellum via the pontocerebellar tract.

It is important to note that most research analyzing the positive neuroplastic effects of music learning strongly emphasizes providing training lessons that become progressively more difficult over time (Sutcliffe et al., 2020). This principle for activating positive neuroplasticity in the brain is supported by Diamond (2013), who reviewed a series of experiments studying executive functions; skills that incorpo-

rate cognitive processes that enable planning, focused attention, remembering instructions, and engaging in multiple tasks simultaneously. In this review, Diamond claims that highly demanding tasks that progressively tax one's executive functions will be most successful in improving adult cognitive development. This claim is also supported by the neuroimaging research of Draganski and colleagues (2004), who demonstrated that learning to juggle (a multimodal task requiring executive functions) can increase grey matter volume in the temporal and parietal areas of the brain. Similarly, modern neuroimaging has shown links between progressive difficulty increases during learning and positive corticospinal plasticity (Christiansen et al., 2018, 2020). Still, Draganski and colleagues (2004) caution that although positive neuroplastic alterations in the brain usually occurred within one week of training, the effects atrophied and returned to baseline levels without a continuous training regimen. Based on these results, it is possible that a progressively challenging and taxing education in music that integrates both cognitive concepts (e.g., key signatures, rhythmic counts, harmonics, etc.), and physical demands (e.g., embouchure, breathing technique, finger strength/dexterity, etc.), may be an effective method for maintaining both cognitive and motor health throughout the ageing process (Sutcliffe et al., 2020).

In sum, learning to create and perform music is a multimodal task that utilizes several systems within the brain. The evidence presented implies that multimodal learning activities can promote neuroplastic changes in the brain, suggesting that such tasks may be beneficial to promote healthy ageing and brain development in adults. Specifically, the progressive increase in the difficulty of training lessons and the multimodal nature of music learning offers adults a uniquely engaging method for targeting and strengthening brain regions often associated with motor and cognitive dysfunction, like the cerebellum (Sutcliffe et al., 2020). However, as mentioned earlier, a consistent practice schedule might be necessary to maintain these positive alterations.

Chronic Pornography Usage

While music learning/making highlights the potential positive applications of

neuroplasticity, it is important to recognize that harmful or detrimental brain alterations can also occur due to neuroplastic events (Doidge, 2007). For example, chronic pornography use demonstrates a potential link between compulsive behaviour and negative neuroplasticity in the brain (e.g., noticeable gray matter decline, decreased neuronal connections or a diminished potential for remaining neuronal connections to reroute; Vance & Wright, 2009). Specifically, when an individual chronically uses pornography, the novelty, immediacy, and potential for easy escalation can condition an exclusive and highly specified type of sexual arousal in the user's brain (de Alarcón et al., 2019). Consequently, this problematic type of arousal might have adverse effects in sexual development and sexual functioning (e.g., psychosexual dissatisfaction, erectile dysfunction, and comorbidities with anxiety disorders, de Alarcón et al., 2019).

Historically it has been challenging to define what exactly entails “chronic” or “addictive” pornography use as only recently did the International Classification of Diseases, 11th Revision (ICD-11; World Health Organization, 2019) begin to include a section on compulsive sexual behaviour disorder. At the same time, the concept continues to remain absent in the latest editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013), the primary diagnostic tool used in North America. Still, Alves and Cavallieri (2019) emphasize that an individual's negative self-evaluation of pornography use, termed self-perceived problematic pornography use, can produce changes in the molecular, circuit, and behavioural functions of a user's brain. These findings are supported by evidence that individuals with perceived problematic pornography use may experience declines in working memory performance during multitasking situations (Schiebener et al., 2015), and an increased desire for pornographic stimuli (Hilton, 2013).

In a study with 64 healthy male participants, Kühn and Gallinat (2014) analyzed the effects of pornography use on neurological function. A negative correlation between self-reported pornography usage and grey matter volume in the right and left striatum was found. Additionally, they observed a deterioration of functional connectivity between the right caudate nucleus to the left dorsolateral prefrontal cortex, thought to result in the downregulation of the brain's natural neural responses to sexual stimuli. This downregulation is believed to create a need for more intense sexual experiences to achieve satisfaction. It is hypothesized that these changes could reflect alterations in neuroplasticity from intense stimulation in the brain's reward system due to repeated pornography use. These findings mirror that of Hilton (2013), who found that chronic pornography usage may facilitate neuroplastic changes that operationalize addictive behaviour and cravings. Moreover, Cotigă and Dumitrache (2015) note that the overuse of pornography leads to excess dopamine production and can dull the reward system over time. In men specifically, this can lead to decreased satisfaction and the need for more intense sexual stimuli to become aroused.

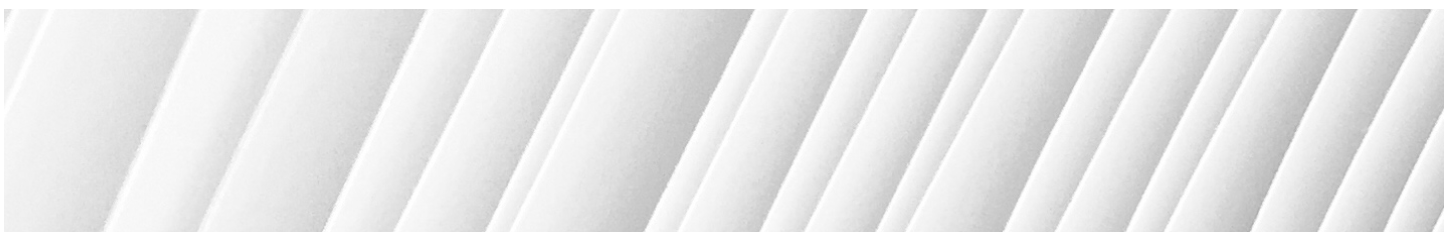
In sum, as a result of neuroplastic alterations in both neurological function and neuroanatomical structure, pornography users with self-perceived problematic pornography use may experience neuroplastic changes in their brain that may further compel them to engage in continued and chronic use of pornography to achieve sexual satisfaction (Alves & Cavallieri, 2019). Therefore, the negative behavioural consequences of neuroplasticity experienced by chronic pornography users highlights the potential detrimental role of neuroplastic alterations in the brain. (Alves & Cavallieri, 2019; Cotigă & Dumitrache, 2015; Hilton, 2013; Kühn & Gallinat, 2014).

Conclusion

Comparing the neurological and neu-

roanatomical effects of learning and playing music versus engaging in chronic pornography use demonstrates a distinction between the potential positive and negative impacts of neuroplasticity. On the one hand, positive neuroplasticity from learning/playing music in an environment with multimodal education and progressive increases in difficulty may increase grey matter volume and improve synaptic connectivity in key brain regions associated with ageing. Conversely, by engaging in chronic pornography, the brain may undergo structural and functional changes that produce negative behavioural consequences in the form of increased cravings and progressively diminishing sexual satisfaction. With this understanding of adult neuroplasticity in mind, further research should assess other behaviours, environments, and stimuli that could positively and negatively affect an adult's brain throughout ageing. Moreover, future work should examine whether a professional clinical diagnosis of compulsive sexual behaviour disorder accurately predicts modulations in negative neuroplasticity reported in self-perceived problematic usage. Lastly, this manuscript is limited by solely focusing on the negative consequences of chronic pornography use and self-perceived problematic pornography use, and therefore did not assess whether pornography use can also induce positive neuroplastic changes in the brain.

In conclusion, through advances in neuroscience and neuropsychology, researchers have demonstrated that adult ageing and brain development can no longer be understood as a fixed or rigid process. Instead, throughout ageing, the brain continuously undergoes complex neuroanatomical and neurological changes based on the stimuli, environments, and behaviours with which an individual engages. With this understanding in mind, an adult can choose to partake in life choices that purposefully and positively impact their brain's development and psychological wellbeing.





Factors Helping Non-Traditional Women Students Persist in Counselling and Clinical Psychology Doctoral Programs

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Abstract

In this literature review, the authors provide an overview of the research on factors related to re-entry or non-traditional women students' persistence in doctoral programs in counselling and clinical psychology. Re-entry women have a unique set of challenges beyond the challenges that regular graduate students face (e.g., role conflict, work commitments, and doubts related to abilities; Thomas, 2010). Furthermore, clinical and counselling psychology programs require practical training in addition to the classes and research required for traditional doctorates. As a result of these additional stressors, re-entry women students are at a higher risk of dropping out (Gittings et al., 2018). The purpose of this literature review is to provide an updated synthesis of the research findings to date focusing on resiliency factors for re-entry women.

Résumé

Dans la présente revue de la littérature, les auteurs donnent un aperçu de la recherche sur les facteurs liés au retour aux études ou à la persévérance des étudiantes non traditionnelles dans les programmes de doctorat en counseling et en psychologie clinique. Les femmes qui reprennent le chemin de l'université doivent faire face des difficultés particulières, en plus de celles auxquelles sont confrontés les étudiants diplômés réguliers (p. ex., conflit de rôles, obligations professionnelles et doutes quant aux capacités; Thomas, 2010). En outre, les programmes de psychologie clinique et de counseling exigent une formation pratique en plus des cours et des activités de recherche exigés par les doctorats conventionnels. En raison de ces facteurs de stress supplémentaires, les femmes qui retournent aux études risquent davantage de quitter leur programme (Gittings et coll., 2018). Le

but de cette revue de la littérature est de fournir une synthèse actualisée des résultats des recherches menées à ce jour, en mettant l'accent sur les facteurs favorisant la résilience chez les femmes qui retournent aux études.

The demographic landscape of graduate education is changing (Thomas, 2010). Towards the end of the 20th century, women began to make up the majority of graduate students. This was drastically different from previous periods in history, such as the 1960s, when women were often not allowed entrance into higher educational institutions, resulting in men making up the majority of graduate students (Parker, 2015). The radical social change brought on by the feminist movement of the 1970s afforded women new opportunities in the workforce, which resulted in women re-enrolling in higher education to pursue jobs that were traditionally reserved for men only. This

created a group of students referred to as “re-entry women,” or women who have re-entered higher education after an absence of two to 35 years (Thomas, 2010). Re-entry women are a special population of female graduate students. There are a number of different paths that they may take upon returning to school; for example, re-entry women with a previous undergraduate degree may be returning to school to obtain their first graduate degree, or they may choose to return to graduate school for a second time to pursue a new field of interest. In addition to managing the added psychological stress of graduate school, the majority of these women also manage the daily stressors of family, children, work, and adult life (El-Ghoroury et al., 2012). Furthermore, they must manage the extra responsibilities that clinical and counselling psychology programs place on students, including fieldwork beyond research and class requirements (Delany et al., 2015). These heavy demands may cause conflict within the already busy lives of re-entry women.

Research has shown that re-entry women, in contrast to re-entry men, are at an increased risk of dropping out (Lin, 2016). Failure to graduate results in significant losses for the student, both financially and emotionally (Gittings et al., 2018). Furthermore, it can also adversely impact the institution; for example, attrition rates can impact prospective students’ decisions to enroll (Gittings et al., 2018). Consequently, an understanding of how to support re-entry women and how to prevent attrition is valuable. While there have been a handful of literature reviews on the challenges for re-entry women (Lin, 2016; Osam et al., 2017; Padula, 1994; Tittle & Denker, 1977), half are over 20 years old, and the literature to date has not reviewed factors that aid re-entry women in persisting with their graduate programs. Additionally, most existing literature does not specifically look at re-entry women in counselling and clinical psychology programs (Pakenham & Stafford-Brown, 2012). There are unique challenges that are specific to these programs, to be discussed, that re-entry women face. The aim of this literature review is to consolidate the findings from the literature on factors supporting the persistence of re-entry women students and to apply the findings to clinical and counselling psychology re-entry women.

Characteristics of Re-entry Women

and the Stressors They Face

To provide a better context for understanding re-entry women’s persistence in graduate programs, it is essential to review the characteristics of re-entry women and the unique challenges they face. Researchers have noted several differences between re-entry female students, re-entry males, and “traditional students” (i.e., single, under 25, and financially dependent on their caregivers; Iarovici, 2014). In contrast to their traditional counterparts, re-entry women are more likely to attend school part-time than full-time (Brown & Watson, 2010; Thomas, 2010). The need to study part-time can act as a barrier for some re-entry women pursuing a doctorate in counselling and clinical psychology, specifically because of the Canadian Psychology Association’s accreditation standards requiring the timely completion of the degree.

Further, despite the fact that re-entry women are more likely to have higher grades (Lin, 2017) and more real-world experience than traditional students (Offerman, 2011), re-entry women often experience difficulties with self-concept, believing that they need to prove their value in graduate school (Lin, 2017; Padula, 1994). The self-doubt and high expectations that women, in general, tend to struggle with (Clance & Imes, 1978) can exacerbate the stress that re-entry women experience. These stressors may be higher in programs that have additional requirements. For example, clinical psychology students also have the added stress of factors in their work-practice (e.g., time constraints and balancing caseloads) and challenges specific to their clinical work (e.g., ethical dilemmas or dealing with complicated symptom presentations that do not neatly fit into the DSM’s diagnostic criteria; Pakenham & Stafford-Brown, 2012). These additional stressors may negatively impact the well-being of re-entry women in these programs.

Re-entry women are also less likely to be involved in campus activities (Osam et al., 2017), likely due to the need to maintain other non-academic responsibilities, such as childcare, caring for aging parents, and non-academic work (Deutsch & Schmertz, 2011; Offerman, 2011). As such, re-entry women typically have many different roles that compete for a finite amount of their time, which is what researchers refer to as “role conflict” (Anderson & Mieztis, 1999). Role

conflict can have several impacts on women and re-entry women specifically. For example, re-entry women who have children feel responsible for meeting their children’s needs, which may result in feelings of guilt about returning to school (Webber, 2017). Cultural normative conceptions of “idealized” mothers and “devoted” academics may increase the pressure that some women face to be both a “perfect” mother and a “perfect” graduate student (Springer et al., 2009). These demands create a strain on work-life balance for re-entry mothers. Furthermore, COVID-19 has significantly impacted mothers’ experiences with role strain (Blundell et al., 2020). Research found that mothers have had to combine increases in domestic responsibilities, like home-schooling children, with the demands from paid work (DesRoches et al., 2021). Several personal narratives from academic mothers have described such challenges, also noting that policies or guidelines to support academic mothers are needed (Miller, 2020). This is yet another unique challenge that re-entry women may experience.

Role conflict intersects with the multiple demands of counselling and clinical psychology programs. Studies examining stress and coping among graduate psychology students found that students were affected by multiple barriers and stressors (El-Ghoroury et al., 2012; Pakenham & Stafford-Brown, 2012). In one study, graduate psychology students identified multiple challenges, including work-life and school-life balance, family issues, research pressures, burnout or compassion fatigue, professional isolation, depression, physical health difficulties, marital or relationship issues, and grief or loss (El-Ghoroury et al., 2012). Additionally, students identified a lack of time as the most common barrier to personal wellness, followed by financial constraints, shame, privacy concerns, lack of awareness of available resources, and inadequate social supports. If these are the types of difficulties faced by “traditional” graduate students in clinical psychology programs, it is reasonable to expect that these difficulties would be exacerbated for re-entry women.

Factors Aiding Student Persistence

As highlighted above, re-entry women encounter many stressors along the pursuit of their degree, and exploring factors related to their persistence is

essential. However, the research on re-entry women is limited. While there have been two literature reviews on the challenges for re-entry women (Padula, 1994; Tittle & Denker, 1977), they are over 25 years old, and none of the literature to date has reviewed factors that aid re-entry women in persisting with their graduate programs. Consequently, the findings below are extrapolated from studies examining non-traditional students, which is a broader population referring to students who do not fit the traditional student stereotype of single, under 25, and financially dependent on their caregivers (Iarovici, 2014). Given that re-entry women are one segment of the larger non-traditional student population, it is likely that the findings on persistence factors will be applicable to most re-entry women. Additionally, two studies specifically examining coping for clinical and counselling psychology graduate programs have also been included. As highlighted above, it is reasonable to expect that some of these coping strategies may be helpful to re-entry women who are also enrolled in similar programs.

First, social supports are essential to non-traditional women's perseverance in graduate programs (Castro et al., 2011; Shepherd & Nelson, 2012; Thomas, 2010). Social supports can come in the form of family, friends, school peers, and faculty (Thomas, 2010). One study examining non-traditional women undergraduate students found that family, in particular, can play an important role in facilitating women's perseverance (Webber, 2017). For example, one form of family capital is cultural capital, which describes the skills and behaviours that students acquire, such as study skills or knowledge about higher educational systems. Partners can also help women persist in higher education by helping them with their academic work, such as proofreading, essay planning, or studying. Relationships with faculty can also be helpful in aiding women to persist. Students' relationships with their advisors are a critical variable that distinguishes those who complete their doctoral program from those who do not (Gittings et al., 2018). Faculty working with non-traditional students need to act as a facilitator, a coach, and a colleague, which is different from the role that they may take with traditional students (Offerman, 2011). For instance, faculty can also expect to learn from non-traditional students who bring in a

wealth of real-world and career experience. Valuing this pre-existing knowledge can benefit the student's confidence while also increasing respect within the relationship. Peer support can also help buffer the stressful transition into graduate school (Gittings et al., 2018). The transition into graduate school can be a significant period of stress and peer support during this time can help to buffer the potential adverse effects (Gittings et al., 2018). Peers can also aid in student integration within their campuses by connecting academic experiences with social ones.

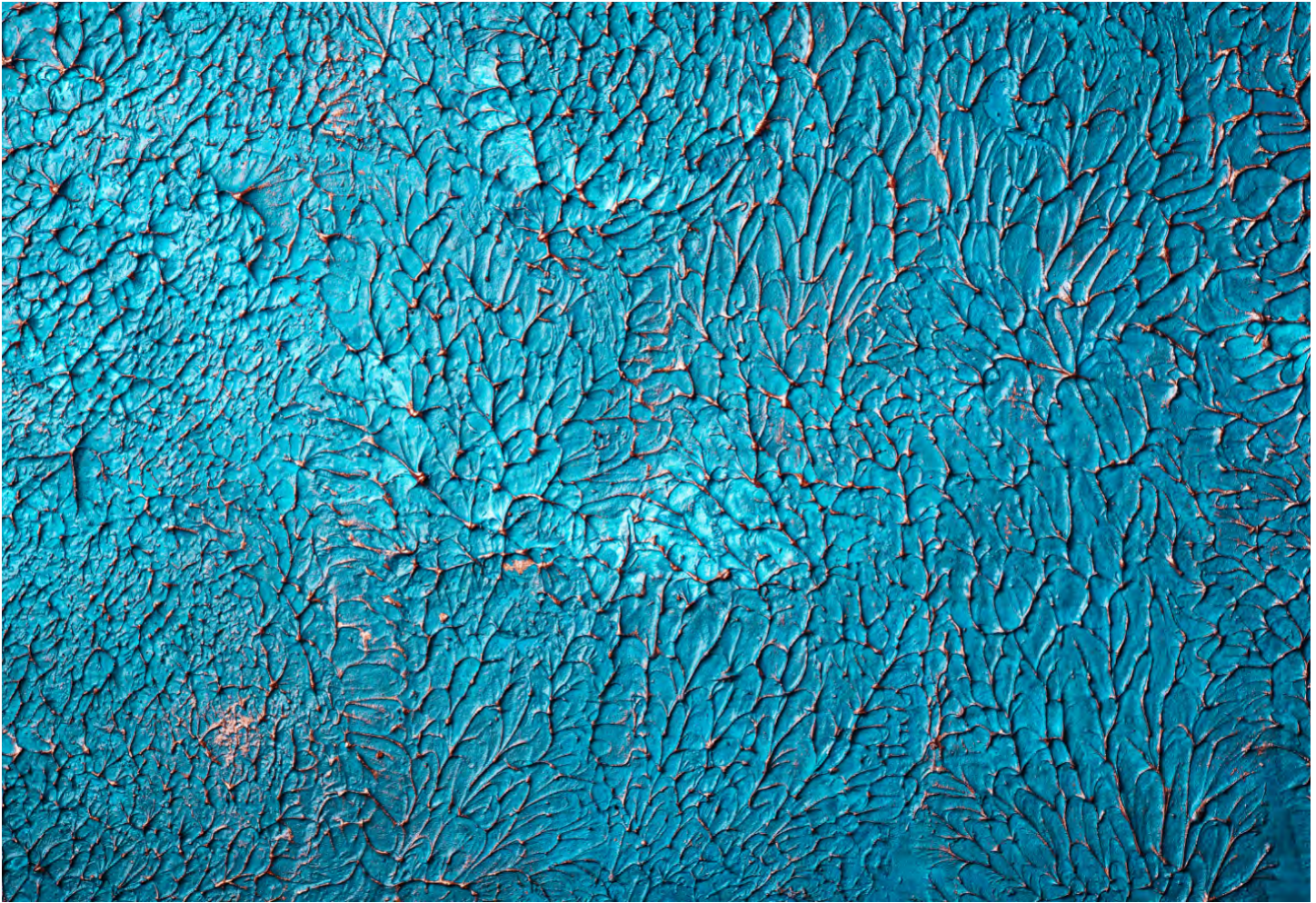
Persistence of non-traditional graduate students is also influenced by attitudes and self-perceptions about their abilities as a learner (Shepherd & Nelson, 2012). For example, having self-confidence in one's abilities can help women persevere in the face of academic challenges. Self-confidence can be enhanced by drawing on past experiences and reframing negative thinking patterns (Holdsworth et al., 2018). Time within the program can also contribute to confidence-building; for instance, as hurdles are overcome, confidence increases (Shepherd & Nelson, 2012). Thus, increasing confidence may be helpful in aiding re-entry women to persist through the struggles with self-concept that many students experience (Pakenham & Stafford-Brown, 2012). Motivation also predicts non-traditional women's persistence, which could include motivation derived from the intrinsic value of accomplishing a meaningful goal or career aspiration, setting an example for their children, or increased wages associated with earning the title of psychologist (Novotný et al., 2019; Patterson-Stephens et al., 2017). Thus, it is likely that dispositional factors can also contribute to re-entry women's success in persisting.

Resilience is emerging as another valuable construct that informs persistence in learning and professional practice (Delany et al., 2015). One essential building block of resiliency is adaptive coping strategies. A study examining psychology students' coping skills found that seeking out social supports, exercising regularly, engaging in hobbies, participating in psychotherapy, and talking with physicians are helpful strategies to promote resilience (El-Ghoroury et al., 2012). Venting emotions, positive reinterpretations, acceptance, humor, suppression of competing

activities, and mental disengagement have also been endorsed by clinical psychology graduate students as helpful coping strategies (Nelson et al., 2001). Nelson and colleagues also found that emotional and practical support were essential in helping non-traditional women have a positive return to school, which further supports existing evidence that social supports are an essential building block of resiliency (Beri & Kumar, 2018). Finally, a study examining non-traditional women demonstrated that participating in multiple roles can sometimes be a protective factor that contributes to psychological health (Anderson & Mieztis, 1999). This protective factor occurs when the positive aspects of one role moderates the negatives aspects of another role, thus contributing to women's resiliency in the face of difficult challenges that doctoral programs in clinical and counselling psychology can present. Given that re-entry women also juggle multiple roles, it is likely that they would also benefit from this protective factor.

Conclusions

Re-entry women are a unique population of graduate students with unique challenges to student persistence. These challenges are exacerbated by the additional practicums and internships that clinical and counselling psychology students must complete (Delany et al., 2015). Only a few studies have focused on ameliorating the unique challenges of re-entry women in clinical or counselling psychology programs. Studies examining the broader population of re-entry women have found several themes that are essential to persistence, including social supports, motivation, resiliency, and other coping skills. More research is required to identify strategies and resources to facilitate persistence among re-entry women. More nuanced strategies may be needed for this particular student population, like how to cope with managing competing roles. Furthermore, because the unique experiences of re-entry women in clinical and counselling psychology programs are not reflected in the experiences of students in general and this particular student group is at-risk for not completing their programs, it is necessary to conduct both qualitative and quantitative research on this specific population of students to understand what factors help re-entry women to persist (Patterson-Stephens et al., 2017).



Let's Talk About Leta

L. Hollingworth's Contributions to Clinical Psychology

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Abstract

Leta S. Hollingworth made major contributions to psychology despite living in a time in which women were largely oppressed in academic settings. One relevant, but often overlooked, area that Hollingworth conducted seminal work in is clinical psychology. Hollingworth initiated and organized the formation of the American Association of Clinical Psychologists (AACP), known today as the Society of Clinical Psychology (Division 12) of the American Psychological Association (APA). Her work with the AACP led her to pioneer innovations such as the Doctor of Psychology (PsyD) degree. The conceptualization of the PsyD is an

invaluable addition to the discipline of psychology as its realization allowed for the mobilization of well-trained clinicians. Ultimately, this paper seeks to bring to light and contextualize Hollingworth's immense contributions to clinical psychology.

Résumé

Leta S. Hollingworth a apporté une contribution majeure à la psychologie bien qu'elle ait vécu à une époque où les femmes étaient largement bâillonnées dans les milieux universitaires. Un domaine pertinent, mais souvent négligé, dans lequel Hollingworth a mené des travaux fondamentaux est la psychologie clinique.

Hollingworth a lancé et organisé la formation de l'American Association of Clinical Psychologists (AACP), connue aujourd'hui sous le nom de Society of Clinical Psychology (Division 12) de l'American Psychological Association (APA). Son travail à l'AACP l'a amenée à introduire des innovations, comme le doctorat en psychologie (Psy. D.). La conceptualisation du doctorat en psychologie est un ajout inestimable à la discipline de la psychologie car sa réalisation a permis la mobilisation de cliniciens bien formés. En fin de compte, le présent article veut mettre en lumière et en contexte l'immense apport de Hollingworth à la psychologie clinique.

Leta Stetter Hollingworth was born in 1886, during a time when psychology was finally beginning to emerge as its own discipline and the women's rights movement was gaining attention in the United States (Silverman, 1992). Hollingworth is well-known today for her work with gifted children, however, she also made formative contributions to clinical psychology. Namely, her involvement in the establishment and early work of the American Association of Clinical Psychologists (AACP) is of considerable significance. Hollingworth's service to this organization led her to conceptualize and lay the groundwork for the Doctor of Psychology Degree (PsyD). Despite living in a time when women struggled for influence, Hollingworth's efforts added credibility to the clinical practice of psychology and allowed more clinicians to enter the field. To properly contextualize Hollingworth's contributions and their relevant implications, I will begin by investigating Hollingworth's early-life and the cultural period in which she lived. I will then explain why the creation and function of the AACP was influential to the field of psychology and conclude with why Hollingworth's work has remained relevant.

Hollingworth's Early Life & The Zeitgeist of the Early 1900s

To fully understand the significance of Hollingworth's accomplishments, one must first have an accurate understanding of the historical context in which she was working. Hollingworth was born in Nebraska, and her mother died when she was only three years old (Silverman, 1992). Although Hollingworth was living in a remote area, a detailed journal kept by her mother indicates that even as a young child she was intellectually advanced and had acquired a passion for learning at a young age (Silverman, 1992). Not long after the death of her mother, her father remarried and Hollingworth did not connect very well with the "fiery furnace" of a stepmother she gained (Silverman, 1992, p. 20). Hollingworth saw school as an escape from her home life and decided to devote all of her vigor to learning (Silverman, 1992).

Hollingworth graduated from high school at age 15 and enrolled at the University of Nebraska to study literature (Benjamin, 1990). After receiving her Bachelor of Arts in 1906, she taught high school English for a couple of years before marrying Harry

Hollingworth, a graduate student in psychology at the time (Symonds, 1940). She then returned to Columbia University in New York to receive further education (Symonds, 1940).

Hollingworth's original plan upon moving to New York was to continue teaching while simultaneously earning her master's degree (Silverman, 1992). However, there was a law that barred married women from teaching positions at that time, so the Hollingworths did not have the financial means to each receive the education they desired (Silverman, 1992). Even with a bachelor's degree, academic distinctions, and an evident fervour for knowledge, L. Hollingworth was subjected to occupy the traditional female role of the housemaker while Harry Hollingworth continued his career in academia. This expected position was devastating for Leta Hollingworth; her "frustration mounted daily until she would burst into tears with no apparent cause" (Silverman, 1992, p. 21).

Although the ideology of that time was beginning to deviate from traditional culture regarding gender oppression, women were generally still thought of as intellectually inferior and less valuable than men (Benjamin, 1990; Minton, 2000). Claims about the inferiority of women were rampant in the works of prominent psychologists such as James Cattell, G. Stanley Hall, and Edward L. Thorndike (Benjamin, 1990). These psychologists were proponents of the variability hypothesis, which purports that all women are more or less alike but that men range tremendously in their abilities and talents (Benjamin, 1990). Hollingworth was subject to this attitude from the first moment she entered the world: in Hollingworth's mother's aforementioned journal, an entry for Hollingworth's birth date reads that her father felt disheartened upon discovery of the sex of their newborn, uttering the words, "I'd give a thousand dollars if it was a boy" (Silverman, 1992, p. 20). Despite the prejudice against women in academia, Hollingworth was determined to pursue a professional career in psychology.

The Beginning of Hollingworth's Career in Academia

It was only in 1911 upon receiving a large stipend that Harry Hollingworth earned for his infamous Coca-Cola research that Leta Hollingworth was finally able to

begin her graduate work (Silverman, 1992). Upon earning her master's degree in 1913, Hollingworth began to work as a clinical psychologist in New York City at the Post-Graduate Hospital and Bellevue Hospital (Silverman, 1992; Symonds, 2014). Hollingworth's time at Bellevue Hospital, a hospital which acted as a clinic for "mental defectives" (referring primarily to individuals with subnormal intelligence) is what truly got her started in the field of clinical psychology (H. Hollingworth, 1943, p. 101). The position she held involved the administration of "mental tests", known today as intelligence or IQ tests (H. Hollingworth, 1943, p. 102). Hollingworth focused primarily on studying the variability between sexes; between 1913-1916 she published nine articles and a book which offered evidence refuting the aforementioned variability hypothesis (Benjamin 1990; Silverman, 1992). She poked holes in the current data by suggesting that intelligence in females was not valued; it was much more likely for a male child to be brought in for mental testing due to their parents' concerns, where only the severely deficient females were brought in, and researchers were using data from this sample to draw conclusions (Benjamin, 1990). She also pointed out that women only seem to appear less variable because they are confined to housekeeping while men are free to pursue many professions. In addition, she conducted large studies with children where she showed that male infants tend to be larger anatomically, but show no differences in mental capacity (Benjamin, 1990). Her work in this area is now considered seminal in the psychology of women (Benjamin, 1990).

Upon finishing her dissertation in 1916, Hollingworth accepted a position at Columbia University as Instructor of Educational Psychology as she was becoming increasingly interested in this subfield (Symonds, 2014). In this position, Hollingworth received the opportunity to administer the Stanford-Binet Intelligence Test and is thought to have been one of the first to do so (Silverman, 1992). She was typically known to use it to assess developmentally delayed children for research (Silverman, 1992). She decided to also use the Stanford-Binet test on "bright" children as a means of comparison, and upon recording one of the highest IQs on record, became fascinated with giftedness (Silverman, 1992). Hollingworth then began to devote much of her time to studying giftedness

and writing extensively on her work with gifted children (Silverman, 1992).

The Formation of the American Association of Clinical Psychologists (AACP)

As psychology began to garner more respect and demand grew for psychological services, Hollingworth became interested in advancing and attracting more individuals to the field. In a meeting of the American Psychological Association (APA) in 1917, Hollingworth brought together a group of psychologists with the intention of forming an organization that would focus on advancing clinical psychology (MacArthur & Shields, 2014). They felt it necessary to take it upon themselves to advance this goal as the APA was focused exclusively on promoting psychology as a science and prioritized research over certifying psychologists for clinical work (Cautin, 2009; MacArthur & Shields, 2014). Thus, the American Association of Clinical Psychologists (AACP) was born. J. E. Wallace Wallin, a fellow clinical psychologist, was named chairman and Hollingworth was named only secretary, despite her taking the initiative in forming the group (MacArthur & Shields, 2014; Routh, 2014). Nevertheless, Wallin had similar interests as Hollingworth: he wanted to provide more services to children with low intelligence, and he wanted those services to be conducted by well-trained individuals who could ensure the proper interpretation of results (Gessell et al., 1919; Routh, 2014).

Hollingworth and Wallin's objective with the AACP was to raise standards specifically for the clinical practice of psychology, as it lacked accreditation (MacArthur & Shields, 2014). Accreditation was important to achieve; without it there were no concrete standards, and therefore, no credibility. A new organization, they decided, would be able to ensure that qualifications for practitioners were met (Routh, 2014). However, the APA did not want two associations to exist; it was seen as a threat to the APA as a parent organization (Cautin, 2009). They wanted to steer clear of creating a divide between practitioners and researchers to avoid "handing over control to others, most likely state legislatures, who might create rules for everybody, including APA members" (Samelson, 1992, p.124). The APA eventually agreed to take the

recommendations of the AACP as long as the AACP joined the APA (Cautin, 2009).

In 1919, the AACP joined the APA as the "Clinical Section" and what is known today as the "Society of Clinical Psychology" (Division 12 of the APA) carries on Hollingworth's original intentions: to validate, promote, advance, and integrate the developing field of clinical psychology (Routh, 2014). Today, APA members who are active in either practice or research, or both, are invited to join this section which continues to "represent the field of Clinical Psychology through encouragement and support of the integration of clinical psychological science and practice in education..." (Society of Clinical Psychology, 2016).

The Conceptualization and Relevance of the PsyD

In an article that Hollingworth wrote as part of her work with the AACP in 1918, she discusses how the field of clinical psychology was in a significant stage of development. The demand for clinical psychologists was increasing as psychology was advancing as a science and earning credibility (L. Hollingworth, 1918). However, there was still much debate over what the qualifications should be for becoming accredited as a clinician (L. Hollingworth, 1918; Gesell et al., 1919).

In order to become a clinical psychologist, one had to obtain a Doctor of Philosophy (Ph.D.) degree in psychology, meaning rigorous training in both clinical and experimental psychology was required (L. Hollingworth, 1918). Hollingworth wanted to devise a plan to accelerate the training received by psychologists in order to meet the increasing demand for clinical practice that had arisen, but she was opposed to compromising the quality of clinical service offered by a Ph.D. (L. Hollingworth, 1918). Rather than requiring all aspiring clinicians to conduct intensive research for their degree, Hollingworth suggested the integration of a program that focused primarily on preparing students for clinical practice (L. Hollingworth, 1918). She described it as a "departure" from traditional psychology in addition to an "invention" (L. Hollingworth, 1918, p. 282). Specifically, Hollingworth suggested a program involving "six years of training, including college, with an additional apprenticeship year

(instead of research)" (L. Hollingworth, 1918). This brainchild of Hollingworth's is what is known today as the Doctor of Psychology (PsyD), a degree that requires fewer research and statistics courses than a Ph.D., but still prepares individuals to practice in a wide range of clinical settings (Routh, 2014).

Hollingworth's idea for a separate degree came to be overwhelmingly successful, as today it is widespread and offered in countless universities (Routh, 2014). The PsyD is of undeniable importance; it allows those who would otherwise not pursue a career as a clinician due to the rigorous research required in a Ph.D. program, the opportunity to obtain clinical training equivalent to what is received in a clinical psychology Ph.D. program. By permitting individuals who are uninterested in research to bypass academic training, the mobilization of mental health clinicians is accelerated allowing there to be more well-trained clinicians overall. This is invaluable today given that in Canada, by age 40, roughly 50% of individuals will have or have had a mental illness (Mental Health Commission of Canada, 2013).

Conclusion

It is remarkable that Hollingworth was able to have the influence she did during a period when women were severely underappreciated in academia. Her resilience and extensive contributions to multiple areas of psychology directly contradict the variability hypothesis which had been left unchecked and was so prevalent at the time. By taking part in the formation of the American Association of Clinical Psychologists, a foundational step to the advancement of the then new-founded discipline of clinical psychology, Hollingworth became a ground-breaker as a psychologist and as a woman. This association led Hollingworth and others to rethink standards for the practice of clinical psychology, and Hollingworth specifically to develop and propose the concept for the PsyD, which is, as previously discussed, very much relevant today. Hollingworth is remembered for her work on giftedness, but her revolutionary work in clinical psychology is often overlooked. As a clinician, researcher, innovator, educator, and feminist, Leta Hollingworth merits considerable attention in every textbook on the history of psychology.

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Sexual health education: Where are we now? Understanding the state of current sexual health education (SHE) curriculum in Ontario and Québec and its effects on teachers and students

Page 4

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Page 7

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Shaping Adult Development and Ageing Through Neuroplasticity

Page 17

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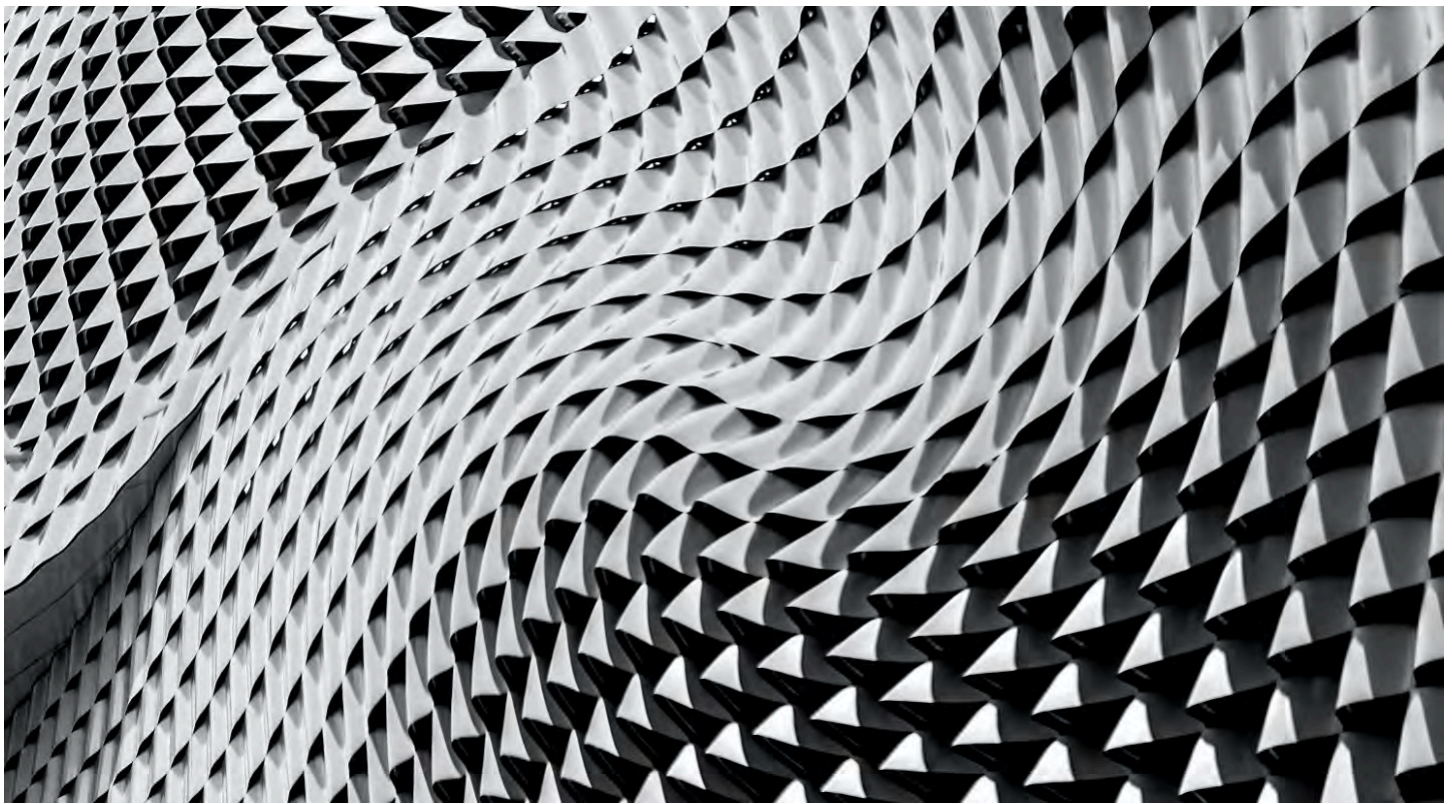


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