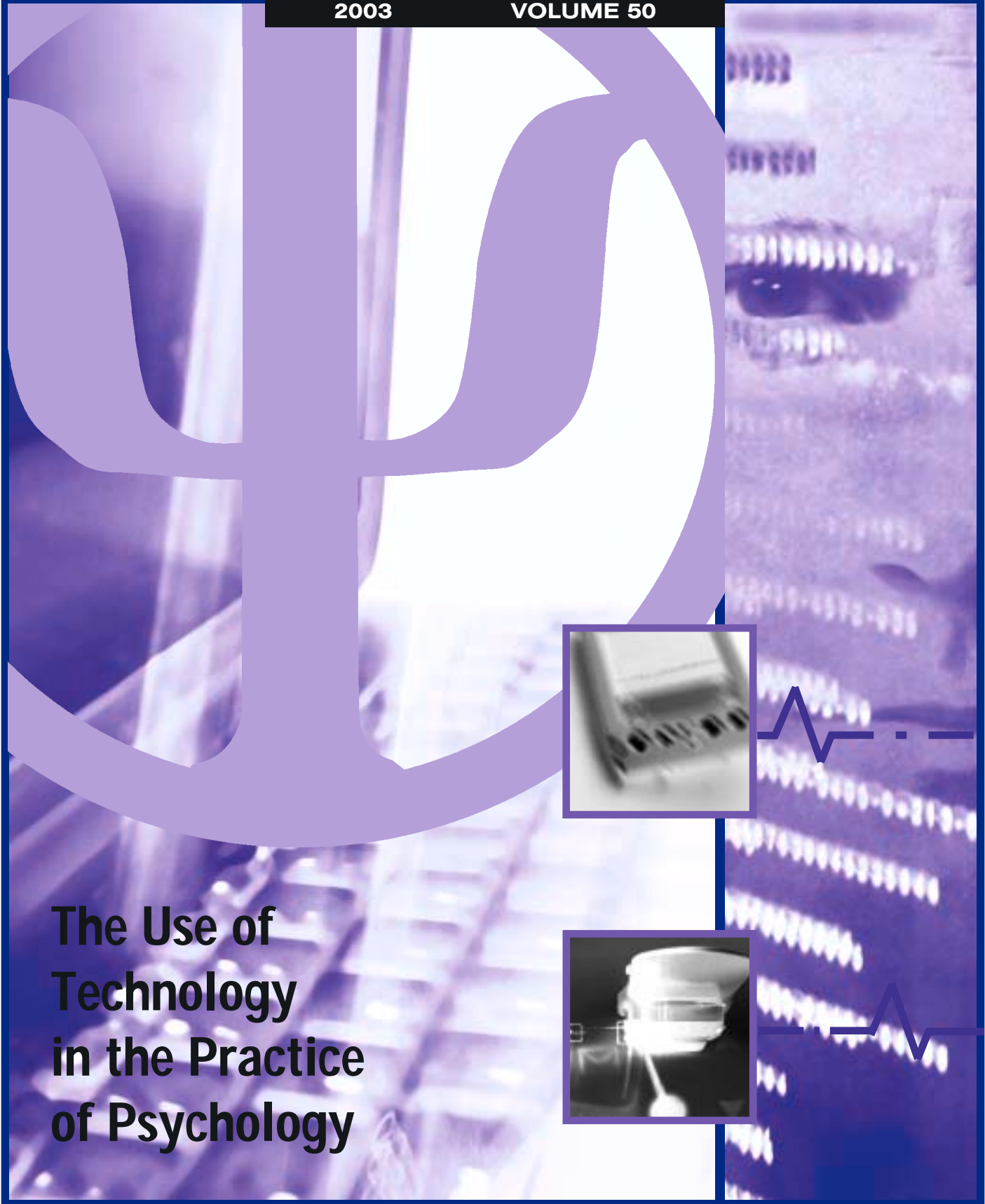


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Table of Contents

Ohio Psychological Association Membership	4
From the Editor ...	5
<i>By Kenneth P. Drude, PhD</i>	
The Wilderness of Online Therapy	6
<i>By Anthony Ragusea, BA, and Leon VandeCreek, PhD</i>	
If a Picture is Worth a Thousand Words, What is a Virtual World Worth?	9
<i>By Arthur L. Aaronson, PsyD, and Ken Graap, MEd</i>	
Applying Handheld Computers in the Practice of Psychology	13
<i>By Kenneth P. Drude, PhD</i>	
EBT... What Does it Mean?	15
Network Security	16
<i>By Ken Filbert, Practice Administrator</i>	
Web Sites for Psychologists	20
<i>By Larry Friedberg, PhD</i>	
Remembering Henry	23
<i>By Garland Y. (Gary) DeNelsky, PhD</i>	
Tributes to Henry from Around North America	25
Onward and Upward! Appreciations to Retiring OPA leaders	27
<i>By Alice H. Randolph, EdD</i>	
The Future Evolution of Professional Psychology	28
<i>By Ronald Levant, EdD</i>	
A Look at Project FAIR	29
<i>By Michael O. Ranney, MPA</i>	
Next on the HIPAA Horizon	32
<i>By Bobbie Celeste, PhD, Director of Professional Affairs</i>	
Bill Box	35
State Science Day 2003	36
<i>By Denise Sabo, BA</i>	
POSTER WINNER - 2002 ANNUAL CONVENTION	37
Measurement of Verbal Fluency in Parkinson's Disease	
<i>By Rose Mary Shaw, Laura Samson, and Jeffery Allen</i>	
POSTER WINNER - 2003 SPRING INSTITUTE	39
Prayer, Religious Appraisals, Psychosocial Functioning, and Cardiac Arrhythmia in CHF Patients	
<i>By Ethan Benore, MA, Kelly McConnell, BA, and Robert Carels, PhD</i>	
CE Credit	41
OPA CALENDAR OF EVENTS	43
APA Division Election Results	43

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From the Editor ...



This issue of *The Ohio Psychologist* is devoted to looking at some of the ways that technology can be incorporated into the practice of psychology. Electronic technology continues to rapidly change faster than the ability of most psychologists to incorporate it into their daily practices. The articles in this issue attempt to provide a hint of some of the many issues and considerable potential that exists in using electronic technology.

An article by Larry Friedberg, PhD, gives an overview of the diversity of web sites on the Internet that are relevant to psychologists. For psychologists either new to the Internet or still trying to find useful information, this is a good sampling of the numerous Internet resources that are available. Anthony Ragusea, BA, and Leon VanderCreek, PhD, outline some of the potential hazards that await psychologists as the use of computers and technology increases and changes the ways psychologists practice therapy. The innovative uses of virtual reality (VR) in mental health settings for a variety of problems are described by Arthur Aaronson, PsyD, and Ken Graap, MEd, in their discussion of a number of treatment uses of VR environments. I explore a wide range of potential practical functions of handheld computers. Psychologists are given advice by Ken Filbert about maintaining the security of practice data on computers and potential threats to computer network security.

A special tribute to Henry Saeman, former OPA Executive Director for many years, is included in this issue. Henry played a critical role in developing the Ohio Psychological Association into one of the most viable state psychological associations in the U.S. and accomplishing many of its achievements. He will be missed by the many psychologists who have known and worked with him.

Also included are updates on the latest news about the implementation of the omnipresent HIPAA rules, Project FAIR changes, articles written by the 2002 Convention and 2003 Institute Poster Session winners, and Science Day 2003 results.

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Kenneth P. Drude, PhD
Chair
OPA Communications and Technology Committee

Kenneth Drude, PhD, provides private practice clinical services in the Dayton, Ohio area and has worked in clinical and management positions in a number of primarily public settings. His long time interest in the Internet has included a passion for finding low or no cost information resources and as a result he has become familiar with the availability of psychological literature accessible online.

The Wilderness of Online Therapy

*By Anthony Ragusea, BA, and Leon VandeCreek, PhD
Wright State University School of Professional Psychology*

In a few short years, computers have worked their way into the practices of psychologists until it is virtually impossible to work without them. Computers are used to store records, to schedule clients, and (with the advent of HIPAA) are necessary to file claims with insurance companies. To some, our growing reliance on computers is viewed as an insidious and dehumanizing process; to others it is the means by which we will reach our human potential. The integration of computer technology into daily life has become the quest of so many in our modern society that it is easy to understand why some psychologists are eager to participate in this “manifest destiny.” The idea that computers can be used to not only facilitate but actually supplement the traditional practice of psychotherapy can be both exciting and frightening, and deserves an ongoing professional discussion that considers research, the law, and our ethics and values as psychologists.

To many, the idea of conducting therapy via email, chat rooms, or interactive video is no less worthy of suspicion than is emailing a friend, filing an insurance claim electronically, or buying a toaster oven on the Internet. In a few short years, our society has generally become comfortable with the goal of establishing analogies for “real life” activities in cyberspace. We shop online, we talk online, we play online, and we work online. Why can’t we do therapy online?

Answering this question depends in part on one’s definition of “therapy.” Does therapy refer to a process or an event? Can it occur anywhere? Can theoretical orientations be applied online? Some have argued that therapy possibly, and diagnosis certainly, can only occur when two people are in the same room and the client can be observed with all five sensory modalities. Grohol (1999) has argued that online therapy is not psychotherapy in the traditional sense, in part because of these perceived distinctions.

One of the questions that must be raised about online therapy is whether it works. Research on online therapy is still relatively limited, composed of unreplicated experiments and studies that use small sample sizes (Rabasca, 2000). There is simply too little data at this point to conclude that online therapy is generally as effective as face-to-face therapy, more or less effective in certain circumstances or with certain disorders, or if effectiveness is dependant on the training or experience of the therapist. The data collected so far suggests that online therapy is often at least as effective as face-to-face therapy, though some studies show lower rates of client satisfaction. Again, the reasons for these variations have yet to be explained.

From what other source can we glean the guidance necessary to decide whether online therapy is a modality in which psychologists should practice? For those psychologists looking

for an anchor, perhaps it is best to look at what other organizations are saying about online therapy. There are numerous organizations, composed of many different types of health professionals, that have chosen to publish ethical and professional guidelines for the conduct of various forms of online therapy. These organizations include the Health On the Net Foundation, Health Internet Ethics, the American Accreditation HealthCare Commission, the American Medical Association, the Internet Healthcare Coalition, the National Board for Certified Counselors, the American Medical Informatics Association, the International Society for Mental Health Online, and the American Counseling Association. The attitude these organizations take toward online therapy is generally consistent with the view that online therapy can and should be done, but that there are many unique challenges to working online that deserve special attention above and beyond the ethics codes that health professions currently have. The only organization yet to take an opposing view is the Clinical Social Work Federation, which chose to take the position that online therapy is inherently unethical and forbade its members from such practice.

There is, notably, significant variation within each code in terms of the language and foci chosen. While a comprehensive analysis of these codes is beyond the scope of this article, a more thorough discussion of ethical concerns and practical suggestions for ethical practice can be found in Ragusea and VandeCreek (in press). Some of the concerns that seem to cut across the ethics codes mentioned above include concerns about confidentiality, anonymity, client safety, therapist-client miscommunication, informed consent, and advertising.

- **Confidentiality:** While it is true that online therapists must take many steps to preserve confidentiality that do not need to be taken in face-to-face therapy, and even though confidentiality can never be completely guaranteed online, the same can be said for traditional face-to-face therapy. A locked filing cabinet can be broken into just as a therapist's computer can be "hacked" into! If sufficient steps are taken by both the client and the therapist, in the authors' opinion it is possible to reduce the risk to a point comparable to the risk found in a typical psychologist's office.
- **Anonymity:** Some online clients wish to be treated anonymously, but this request can conflict with state record-keeping laws that require clients' identities being known. Minors can impersonate adults online, as can other non-clients (e.g., an abusive spouse). Some argue that these risks are worth taking if the client would not otherwise have sought therapy.
- **Client safety:** Most organizations urge that therapists know the client's location, so that local resources can be mobilized in case of emergency.
- **Miscommunication:** Online therapists using text-based therapy must be expert at text communication, which involves unique rules and limitations due to its

nonverbal and non-visual nature. Avoiding misunderstandings requires preparing the client for the potential for miscommunications and then frequently checking-in by the therapist to ensure that he/she is being understood.

- **Informed consent:** Professionals agree that online therapy requires additional information to be understood by the client (e.g., the experimental nature of online therapy; security of communications). See Maheu (2001) for a lengthy discussion of risk management and informed consent.
- **Advertising:** Many online therapists place advertising on their web sites or links to other sites, but should be mindful that links are a representation of the therapist and the therapist should be able to vouch for their quality.

Even if the ethical and logistical issues can be managed to the satisfaction of psychology's high standards, there are legal issues to consider. There have been no cases to date that have tested whether online therapy is a legal practice or if it requires particular accreditation or training. Many states, however, have written or are planning to write statutes that regulate electronic psychotherapy within state or across state lines (Koocher & Morray, 2000). Treating a client who lives in another state or country, for example, may violate licensing laws if the client resides in a state in which the psychologist is not licensed.

Psychologists are finding many unique benefits from online therapy, but cyberspace remains a wilderness that should be entered with caution. At this time, the safest practice is to use electronic communication as a supplement to face-to-face therapy, just as therapists often use telephones to communicate with clients after-hours or during emergencies. Ethical and legal concerns are more likely to come into play when clients are never seen in person.

Many pioneers must enter the wilderness before it can be conquered. Will the forest prove bountiful, or will the thorns and briars interfere? Such is the plight of all exploration. ■

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If a Picture is Worth a Thousand Words, What is a Virtual World Worth?

By Arthur L. Aaronson, PsyD,
Dayton VA Medical Center
and

Ken Graap, MEd, Virtually Better Corporation
Emory University, Department of Psychology

It has been said that the movie is never as good as the book; yet, movies of popular books seem to perform well at the box office. It seems that people do not always want to put forth the effort to utilize mental imagery during entertainment. It seems that people want to forgo mental imagery required of a book in favor of visual and auditory stimulation. While imagery might still be robust for some patients, their desire for realism and the need for the therapist and client to share the experience make virtual reality (VR) an exciting tool.

VIRTUAL REALITY IS NOT NEW

VR is an interactive computer generated simulation of a world. VR programs are designed to allow the user to interactively participate in an environment. VR has been around for many years and has been utilized in various aspects of military training and entertainment. For example, Disney World's DisneyQuest features virtual reality rides, some of which are very realistic. There is a white water raft, which can be paddled to avoid obstacles. The VR ride even squirts water when appropriate. Disney has also developed an environment in which one designs a roller coaster with the computer tools, then gets to ride on it. The "ride" simulates pitching and rolling like a real roller coaster. The 'movement' and the illusion of being g-stressed are caused by the addition of a combination of tactile and visual simulation.

The systems used at Disney World cost millions of dollars and are truly impressive. The basic technology utilized in these VR experiences is similar to therapy settings that use VR. For example, VR simulations utilized in mental health settings allow multiple sensory stimulations (e.g., tactile, visual, and auditory) that allow participants to feel like they are in a different environment. Most of the virtual reality programs allow for a "helmet" or Head Mounted Display (HMD) that may contain two small video screens, one for each eye. The HMD also incorporates headphones so that the program may be heard while external distracting sounds may be blocked out. An integrated tracking system leads

the screen images to change as one moves to look at different areas. The tactile stimulation is a transducer system that creates vibration. Unlike the systems used for entertainment, these VR systems would utilize hardware that costs approximately \$5,000 or less. While HMD's provide only one level of immersion in VR, a CAVE (Cave Automated Virtual Environment) has the potential to enhance that experience. In a CAVE, computer generated images project on the walls and floor of a room-sized cube. This environment, while not commercially available, may be the contemporary version of the "Holodeck" from Gene Rodenbury's Starship Enterprise and may represent the future for VR. Movement and manipulation of the environment in VR uses manipulanda, like a "puck," a mouse, a "wand," "data gloves" or a joystick. VR experiences can also be augmented by the addition of other input devices such as bicycles or skis in an area often referred to as augmented reality.



Jon Gershon, PhD, demonstrates a Virtually Better VR system

The advantages of using VR include allowing the therapist to precisely control what stimuli are presented to the client; tailoring the treatment environment to the individual needs of each client; and exposing them to a wider range of conditions that would be impractical, unsafe, or non-existent in the real world. (Glantz, Rizzo, & Graap, in press). Finally, as exposure is conducted in VR, in the professional's office rather than in the real world, confidentiality of the client is maintained.

As this issue of *The Ohio Psychologist* will attest, psychology as a field has been relatively slow to adopt new technology. Yet, in the past 10 years many professionals have come to rely on computers for notes, record keeping, and interactions with third party payers. While other areas of the economy have adopted technology more broadly and many of the productivity gains can be directly attributed to the application of computer technology in a wide variety of businesses settings, including many health care settings, clinical psychology has not appeared to benefit. Now, some parts of psychology are poised to benefit from the application of VR technology.

THE APPLICATION OF VIRTUAL REALITY IN MENTAL HEALTH

Applications of VR technology in mental health fall broadly into several areas: psycho-educational

applications, therapeutic applications, and research applications. For example, there is a VR program in which the user experiences both auditory and visual hallucinations. The program was developed by Janssen Pharmaceuticals (Titusville, NJ) to market Risperidal primarily to non-psychiatric physicians. In fact, the simulation was discussed on National Public Radio, and a version of this simulation can be downloaded from their web site (<http://www.npr.org/programs/atc/features/2002/aug/schizophrenia/>).

This “virtual schizophrenia” has been used by a Queensland psychiatrist, Peter Yellowless, to convince patients that their hallucinations are not real (Nowak, 2002). Dr. Yellowless has created a virtual world where common hallucinations are created by morphing photographs of familiar persons on to other photographs. Sights and sounds of hallucinations also help re-create the terror that patient’s experience. Family members of patients may use the virtual world of schizophrenics as a means of helping them to understand the patient’s sensory world and why they produce their “peculiar” behavior.

In another psycho-educational program, designed to teach patients progressive muscle relaxation, one wears a HMD and sees a variety of scenes while hearing instruction, on how to tense and relax each muscle group. This simulation follows a well-documented procedure for progressive muscle relaxation. Research is just beginning on its potential in both research and in clinical settings.

Most of the non-psycho-educational initial therapeutic applications of VR were utilized in the behavioral treatment of anxiety related disorders, such as Posttraumatic Stress Disorder (PTSD), phobias (e.g., flying, heights, storms, driving, public speaking, to name a few), and performance anxiety related to impotence. There are also programs to distract during painful medical procedures and for working with persons who have eating disorders.

POSTTRAUMATIC STRESS DISORDER (PTSD) TREATMENT

PTSD is a significant problem facing mental health professionals. PTSD occurs when after a traumatic – often life threatening – event, one develops symptoms of re-experiencing the trauma, heightened arousal, and reactivity to things that remind of the trauma. The standard behavioral treatment is exposure therapy as advocated by a consensus of therapists (Foa, Kean, & Freedman, 2000). However, there are instances in which it is difficult for both professionals and clients to utilize these techniques effectively. Theoretically, the best way to



Virtual Vietnam environments are useful in treating PTSD.

do exposure would be *in vivo*, meaning go back to the place and time the trauma occurred, have a professional along, and have a different outcome. For some traumas, such as combat in Vietnam or being in or at the World Trade Center while terrorists flew airplanes into the building *in vivo* exposure is untenable.

The power of VR facilitates the feeling, for patients, that they are back in the jungles of Vietnam, or back watching the World Trade Center (WTC) being attacked. Two simulations are for Vietnam veterans. One simulation is a helicopter (“heuy”) ride through Vietnam (Rothbaum, Hodges, Alacron, et. al. 1999 & Rothbaum, Hodges, Ready, et. al, 2001.) The patient is seated in a chair on a platform into which sound transducers have been built. The tactile stimulation from the transducers facilitates immersion and recall of memories of being in a “heuy” in Vietnam more than thirty years ago.

A second VR environment allows combat veterans to re-experience being in a landing zone (LZ). These programs allow the patient to experience or re-experience a variety of events that were common in Vietnam. The therapist controls the stimuli in both the environments including gunfire, mines, rockets, yelling, artillery or bombs rumbling in the distance, helicopters flying overhead, and other combat sounds.

Difede, Hunter, and Jaysighe (2002) developed a VR environment for persons who experienced the WTC attacks on September 11, 2001. The VR allows re-exposure to explosions, sounds, virtual people jumping



out of the WTC and other stimuli related to those events to be replayed under the control of a professional. A case report of this environment's use was published in 2003 (Difede & Hoffman, 2003)

In general, patients in all three simulations are hierarchically exposed to the traumatic events in a realistic simulation. The anxiety generated in these environments can be managed and worked with using a variety of anxiety reduction therapeutic paradigms. In all these cases, initial data suggest that VR can play an important role in the treatment of PTSD.

SIMPLE PHOBIA TREATMENT

There are commercially available virtual environments for heights (Rothbaum, Hodges, Opdyke, et al, 1995), elevators, thunderstorms, claustrophobia (Botella, Banos, Perpina, et. al., 1998), flying (Rothbaum, Hodges, Smith, Lee, & Price 2000), spiders (Hoffman, Doctor, Patterson, et al, 2000), driving (Walshe, Lewis, Kim, et al. 2003), and public speaking (Anderson, Rothbaum & Hodges, 2000). These environments are complete with programming to allow a behaviorally trained therapist to utilize them in treatment.

For example, the public speaking environment produced by Virtually Better (Decatur, GA) allows speeches to be inserted into a teleprompter and PowerPoint presentations to be imported into slide projectors. Therapists control many of the audience features including members of the audience falling asleep, distractions such as cell phones going off, or people getting up and walking out. There are options to have members of the audience get up and ask a question at an inappropriate time. Someone from the audience can even throw paper at the presenter.

As fear of flying has been estimated to affect some 25 million adults in the U.S. (Deran & Whitaker 1980), the use of VR to reduce this phobia (Rothbaum, Hodges, Smith, 1999) represents a significant improvement. The

Virtual Airplane environment immerses the user in the interior of an airplane resembling a commercial jet. The scene out the window of that aircraft varies from an animated caricature of flying to film shot during actual airline flights. While sitting in a chair atop a vibration platform, the patient experiences the sights, sounds, and vibrations of an airplane during taxiing, taking-off, flying in good and in bad weather, and landing. Since the professional controls all aspects of the flight, it is possible to repeat necessary anxiety producing aspects of the flight while a client examines their thoughts and feelings about the experience. In a well-designed, controlled study comparing VR based exposure to *in vivo* exposure (Rothbaum, Hodges, Smith, Lee, & Price, 2000), patients using the virtual environment for exposure did as well as patients being deconditioned in an *in vivo* exposure group. There were no significant differences found between the groups at follow up and both reported significantly less anxiety when flying. Both groups also maintained gains at one-year post treatment (Rothbaum, Hodges, Anderson, Price & Smith 2002).

A VR environment designed to facilitate behavioral exposure for spider phobia (Carlin, Hoffman, & Weghorst, 1997) was developed at the University of Washington. The patients are encouraged to pick up the spider with a "cyberhand," while the therapist controls the spiders movement and position. Spiders can be placed in cupboards with webs, made to jump unpredictably when touched or can be dropped suddenly in front of the patient.

FROM SPIDERS TO BURN VICTIMS

The same spider simulation (www.hitl.washington.edu) has been used with burn victims as a means of distraction from pain. Hoffman and colleagues (2000) also used a VR simulation called Snow World with burn victims. Pain reduction is by virtue of being "drawn" into another world consisting of snow beings flying along and throwing snowballs at frozen targets. Playing the game appears to drain a lot of attentional resources, leaving less attention to "feel" the pain. In this case, the virtual environment becomes a distraction from the real world of pain. After the virtual experience, patients report that the pain from the burn is easier to manage.

VIRTUAL REALITY AND SEXUAL DYSFUNCTION

Virtual reality has also been used as treatment for impotence and premature ejaculation (Optale, Munari, Nasta, et al. 1998). The study authors used 12, one-hour long sessions over 25 weeks in which the patient was immersed in a virtual environment where openings in a forest were available. The pathways when opened up would take them back to their childhood and

adolescence when they started to get interested in the opposite sex. Also, 30-second non-erotic film clips were presented. Each film-clip related to genesis of the male sexual identity. Virtual environments that might directly evoke sexual reactions were not used. In patients where the impotence was due to psychological factors, 82% enjoyed partial or complete positive results.

EATING DISORDERS

Riva and Melis (1997) report the use of virtual reality in treating eating disorders. They utilize a virtual environment for guided imagery. They have clients associate to a selected image and then move the image through a variety of environments including small rooms and openings that are difficult for the body type to pass through. Patients who perceive themselves to be grossly obese, pick large virtual representations of themselves and when they are able to get their image to pass through small doors and rooms, they begin to perceive their body type in a much more realistic manner.

CONCLUSIONS

This article presents an overview of current uses of VR environments in mental health settings. The VR programs discussed in this article are currently running and many are commercially available. At this time, Virtually Better, Inc. (Decatur, GA) is the only commercial producer of VR systems in the U.S. and it has installed VR systems in approximately 50 locations in six countries. Professionals should be aware that as computer costs continue to decline, and computer performance continues to increase, the number and utility of available VR environments will continue to grow. In fact, Norcross, Hedges, & Prochaska (2002) reported that computerized therapies including virtual reality rank third and fifth out of 38 different interventions that are predicted to increase within the next ten years.

The simulations and equipment discussed in this article are currently available and are affordable to most clinicians. The cost of a setting up a practice with virtual reality is less than the cost of an average used automobile. The skills to operate the equipment are almost as simple as reading email. The time to start thinking about VR in psychology is now. ■

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Applying Handheld Computers in the Practice of Psychology

By Kenneth P. Drude, PhD

Handheld computers or personal digital assistants (PDAs) are convenient, pocket-sized, portable computers that offer many opportunities for psychologists to use mobile technology to perform a wide variety of functions in daily practice. Since the mid-1990's PDAs have evolved from basic electronic organizers to keep track of addresses and appointments with simple monochrome displays to highly sophisticated devices with color screens, increased storage capacity and a wider range of capabilities. An advantage of using a PDA is that it provides considerable portability, ability to store considerable data, and is easy to access wherever you happen to be. Medical professionals have readily seen the significant potential for PDAs in learning and clinical practice. Increasingly, medical schools actively encourage their use during medical training. Many medically related PDA programs and documents are now available as shareware, freeware or commercial software. Unfortunately there are far fewer psychological or mental health related programs and documents on the market at this time. The purpose of this article is to highlight some of the ways that PDAs can be used by psychologists.

PDAs come in a variety of forms with the most common being those based upon the Palm operating system (Palm OS) and those using the Microsoft CE operating system (Pocket PC). These different PDAs have much in common although there can be significant differences in hardware features as well as software operating systems. For more information about PDA hardware brands, options, costs, features, etc., check with a buying guide such as the online ones at www.pdabuyersguide.com or www.himss.org/webguides/handheld/buying_guides.asp.

Basic PDA Uses

The next step after choosing and buying a PDA is to decide what software to use on it besides what comes installed. PDAs began as electronic versions of address and calendar or appointment books and featured the ability to make to-do-lists and short memos or notes to yourself. A major feature of PDAs is that they "hot sync" or synchronize with a desktop or laptop computer so that whatever data is on the PDA is also



electronically backed up on the other machine.

A PDA can be used not only to schedule individual appointments but also to automatically reschedule reoccurring ones. I have found the address book to be very helpful in keeping information about clients and to be able to quickly find an address or telephone number when not at my office. In fact, I have used the address

book as a very basic database for clients, which gives me an opportunity to customize some of the fields and to transfer the data to a spreadsheet for analyzing client information such as insurance companies, home ZIP codes, admission dates, etc.

Although one can write brief notes using the PDA, the process can be very tedious if you are not using a portable keyboard attachment, even if the PDA has a built-in miniature keyboard. You will need to buy word processing software for more extensive writing needs. I use iGo[®] Quickoffice[™] software by Cutting Edge Software (www.quickoffice.com), a subsidiary of Mobility Electronics, that includes Quickword and Quicksheet that are compatible with the Microsoft Word and Excel programs that I use on my desktop. It is an inexpensive software add-on, costing only \$30. With a full-size, foldable keyboard (www.thinkoutside.com), I can easily write letters, reports and notes that I later download into Word on my desktop, edit and print.

I use the Quicksheet spreadsheet program on my PDA to keep track of some basic daily and weekly statistics that I can then monitor and compare with previous weeks. Statistics can be displayed in either graphic or table format on the PDA.

There are relatively few mental health or psychology programs or documents for use on PDAs. I suggest going to the following sites if you are interested in finding such software:

- The University of Pittsburgh Health Science Library System lists about a dozen commercial products: www.hsls.pitt.edu/guides/pda/topics/psychiatry
- PocketPsych has one of the best lists for mental health Palm OS PDA freeware, shareware, and commercial applications:

- www.pocketpsych.com/Resources/downloads.htm
- The web site for Victoria Point Consulting includes some free mental health software and documents: www.victoriapoint.com/PalmPilot.htm
- Psychpage and the Colorado University Psychology Department web sites both have a few DSM-IV and other mental health related documents: www.psychpage.com/learning/library/palm/index.html and psych.colorado.edu/~brez/pilot/pilotpsy.htm
- PDA Consults has freeware and commercial PDA mental health software information: www.pdaconsults.com/modules.php?name=Downloads&d_op=viewdownload&cid=11

Other Things You Can Do on Your PDA

One of the applications that I use on my PDA several times a week is ePocrates Rx (www.epocrates.com/catalog.do). It is a free drug database that is updated each time you hot sync your PDA when your desktop is connected to the Internet. This resource is an amazing and highly useful program that provides medication information like typical dosages, contraindications, side effects, and drug interactions. It is much easier to use than a standard hard copy *Physicians Desk Reference* (PDR) and is updated daily! There are other commercial databases available, such as the PDR (www.pdr.net/index.jsp).

A major use of PDAs is accessing reference material. Electronic commercial versions of the *DSM-IV TR* manual and the *Merck Manual* that are published by HandheldMed (www.handheldmed.com) are available. Simpler and free versions of the DSM-IV TR can be found at some of the mental health resource web sites listed above.

I have found that it is extremely difficult to proactively remain knowledgeable about what is professionally published in my areas of interest. Again, this area is another where medicine and psychiatry has gotten a jump on psychology. There are Internet sites where you can automatically download abstracts for mental health journals into your PDA each time you hot sync to your desktop. Some psychiatric and health journals are available in this manner. Regrettably psychological journal abstracts are seldom available in this format.

Below is a list of Internet sites that offer free health or mental health journal abstracts that can be downloaded to your PDA whenever it is hot sync'd. Registration at each site and installation of the software to automatically update the most recent abstracts are quick and easy.

- HighWire (highwire.stanford.edu/pda/). The Library of Sciences and Medicine at Stanford University provides abstracts in PDA format for five psychiatric journals.
- JournalToGo (www.journaltogo.com/about.asp) has twenty-four "channels" of American and British health journals grouped by topic with one of them a mental health "channel" with fourteen journals for which it provides abstracts.
- AvantGo (avantgo.com/frontdoor/index.html) is a vast portal to accessing hundreds of Internet sites that offer PDA downloads, including health journal articles. It has hundreds of channels to choose from such as news, finance, entertainment, business, weather, and travel. (I set my preferences to get the daily front page of *The New York Times* articles, weather forecast and the times and locations of movies in my area). A site for receiving PDA-formatted information about psychology is the American Psychological Association's PsycPORT (www.psycport.com/) which is available via AvantGo. PsycPort provides psychology news for the general public but does not provide journal abstracts.

If you are eager to read your e-mail on the go, it is possible to do so via your PDA by either downloading it from your desktop e-mail program or connecting directly to the Internet via a wireless connection (this option is becoming more common).

More adventurous PDA users may find it useful to install clinical recordkeeping programs, including both standalone PDA versions and the ones that are integrated desktop versions. Virtual Briefcase Psych (www.thevirtualbriefcase.com) includes client assessment, history, demographics, and the ability to keep ongoing client progress notes. SoapMH (www.ytechnology.com) uses the SOAP note taking format for client treatment documentation and tracking client contacts.

A favorite past time when I am between appointments is to read books on my PDA. Reading on a PDA takes some getting used to due to the small size of the display screen. Nonetheless, it is easy to carry around several books in a PDA and to quickly read a few pages. Electronic books or e-books are commercially available from a variety of publishers such as Peanut Press (www.peanutpress.com), as well as free books that are no longer under copyright from Internet sites such as Free eLiterature (www.freeeliterature.com). E-books and documents can be in different file formats and require that you have document reader software installed on your PDA.

No PDA is complete without at least a few games to play. In addition to numerous commercial games, many freeware or shareware games are available from such sites as: PDA Street (www.pdastreet.com) and Palm Pilot Archives (www.palmpilotarchives.com). I like to play a freeware game called Pocket Chess (pda.tucows.nyi.net/epoc/preview/11199.html).

My PDA does not play audio or video files, does not have a built-in digital camera and is not integrated with a cell phone like some of the more advanced models. I can, however, load graphic files and digital photographs into it from my desktop using free software such as AlbumToGo (www.clubphoto.com/tools/atg.php).

PDAs have considerable potential for enhancing the capabilities of accessing and using information technology in the practice of psychology. They are not likely to completely replace desktop or laptop computers but will significantly expand how we can use and adapt technology to our needs. ■

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EBT... What Does it Mean?

By Michael O. Ranney, MPA

OPA plans to provide detailed coverage of the concept of "evidence based treatment" that is gaining more and more acceptance in various circles. It is a phrase that you are likely to hear more frequently on talk shows and in publications. It is showing up in healthcare policy and economic discussions. Consumers are beginning to use it.

The problem with the evidence based treatment (EBT) concept is that there is no consistent definition of it. Psychology needs to be at the table to be sure that it is defined clearly and appropriately. There is reason for concern since the discussion often emphasizes the importance of teaching practitioners to use evidence based treatments as if what they are currently doing has no evidence to support it. One potential outcome is that treatment reimbursement sources will only reimburse for evidence based treatment. A narrow definition will be detrimental to psychologists as fewer treatments will qualify.

One definition of evidence based practice comes from the Institute of Medicine (www.iom.edu):

Evidence-based practice is the integration of best research evidence with clinical expertise and patient values. Best research evidence refers to clinically relevant research, often from the basic health and medical sciences, but especially from patient centered clinical research into the accuracy and precision of diagnostic tests (including the clinical examination); the power of prognostic markers; and the efficacy and safety of therapeutic, rehabilitative, and preventive regimens. Clinical expertise means the ability to use clinical skills and past experience to rapidly identify each patient's unique health state and diagnosis, individual risks and benefits of potential interventions, and personal values and expectations. Patient values refers to the unique preferences, concerns and expectations that each patient brings to the clinical encounter and that must be integrated into clinical decisions if they are to serve the patient.

Watch for more information about EBT in future OPA publications. ■

Network Security

By Ken Filbert, Practice Administrator



Ken Filbert

HIPAA concerns have prompted many of my clients to call regarding “security” issues. Almost all of the practices that I have talked to, both medical and psychological, have had few or no safeguards in place to protect their practices in the past. This is a shame since threats to practice data have been around for years and only now with legislation being enacted are many practices taking steps to protect themselves.

Every practice should have a data security plan in place to address the issues in this article. Failure to do so will compromise your data in the months ahead.

Security of your practice data is not just for the purpose of preventing disclosure. It is a matter of protecting it from accidental damage, loss and purposeful attack. Threats to your data can come both from **within** (inside your office or network) and **without** (outside of your office or network).

Threats to your data originating from within your office can consist of many things, but the most common are:

1. Theft of electronic files, information, and hardware
2. Malicious or accidental deletion of electronic files
3. Abuse of email and internet access
4. Power failure and surge damage to data
5. Hardware failures
6. Viruses from disks

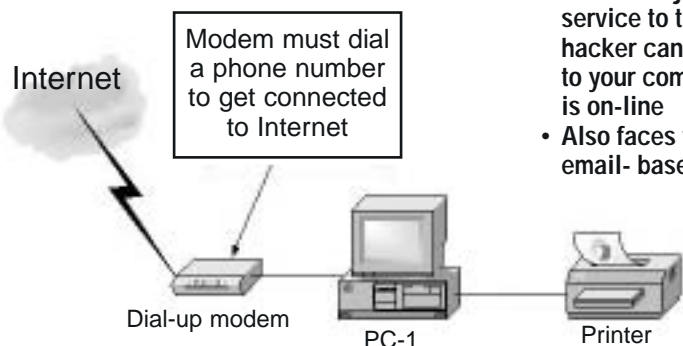
Each of the above possibilities needs to be addressed in your security plan. The most basic procedure is a common backup of all data files. However, putting together a comprehensive data security plan would help assure better protection. In this article, I will focus mainly on the outside attacks that are of interest these days.

In order to consider threats from outside your office you need to break them down into the most common categories. These can include:

1. **Viruses sent via email** – Examples include, but are by no means limited to, erasing files, or copying your personal files and then emailing them out to people listed in your address book at random or directly to other third parties unknown to you.
2. **Identity theft** – Stealing personal information such as your social security number, credit card or banking information, address, or phone for use by an unauthorized party.
3. **Use of your computer in a Denial of Service (DoS) attack** – Dropping small programs on your system with instructions to attack another person’s system or website from your location.
4. **Accessing information** – Obtaining transmitted data by unauthorized persons.
5. **Email forgeries** - Using your computer to forge emails to other people known or unknown to you.
6. **File damage** - Maliciously deleting files or changing data in your files.
7. **Tracking** - Monitoring your activity on the internet.
8. **General break-ins** - Accessing “back doors” and remote administration to get into your computer by use of “Trojan Horse” and other programs located on your system.

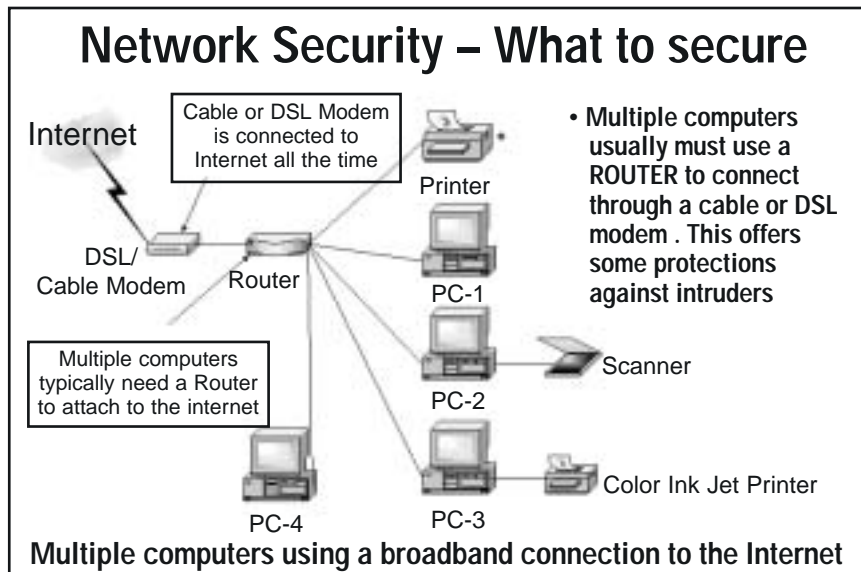
While the Internet is extremely valuable for claim look-up, email and other practice activities, threats exist if you do not take measures to protect your data and personal computers (PCs). Any time a computer is connected to the Internet, it becomes a target and is vulnerable to outside attacks. Even if your office computer(s) does NOT connect to the Internet, it is still

Network Security – What to secure



- Even with just dial-up service to the Internet, a hacker can gain access to your computer while it is on-line
- Also faces threats from email-based viruses

Single computer using a dial-up modem connection to the Internet



exposed to getting a virus or Trojan Horse from a floppy disk that came from another computer that DOES connect.

There are many products available that help to secure an individual computer or a network of PCs. There are also some common sense things you can do to help keep intruders out and your data safe from viruses, as well as unauthorized access and attack.

To protect against viruses:

Use a good Anti-Virus software package on all of your computers! (I use Norton Anti-virus on my computers.) You MUST keep it updated with the latest virus definitions and this requires Internet access. Remember that the virus protection is only as good as the virus definitions you are using. If you are using old definitions, they will not protect you from viruses written more recently. Once an infection occurs on a network PC, a virus will seek out other computers in the network, disks in them, and even loaded backup devices to replicate itself where ever it can.

Remember to take some basic steps to minimize virus dangers.

1. Don't open file attachments without scanning them for viruses first.
2. Don't open file attachments that are programs. (file ends in .exe)
3. Don't open file attachments from questionable sources. (Questionable is hard to define, as I had one practice that got a virus from updating their billing software from the billing software site!)
4. Don't forward email attachments or hoaxes before checking them out. This will spread panic to your friends. Go to

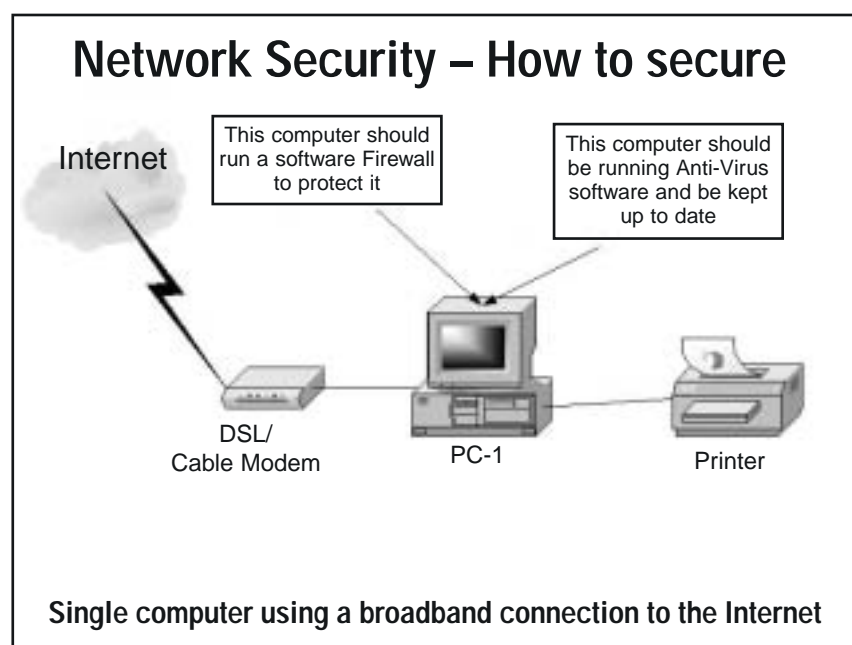
www.symantec.com and search for the "virus" the person is warning you about. The site will give you any information they have on the virus, including if it is a hoax.

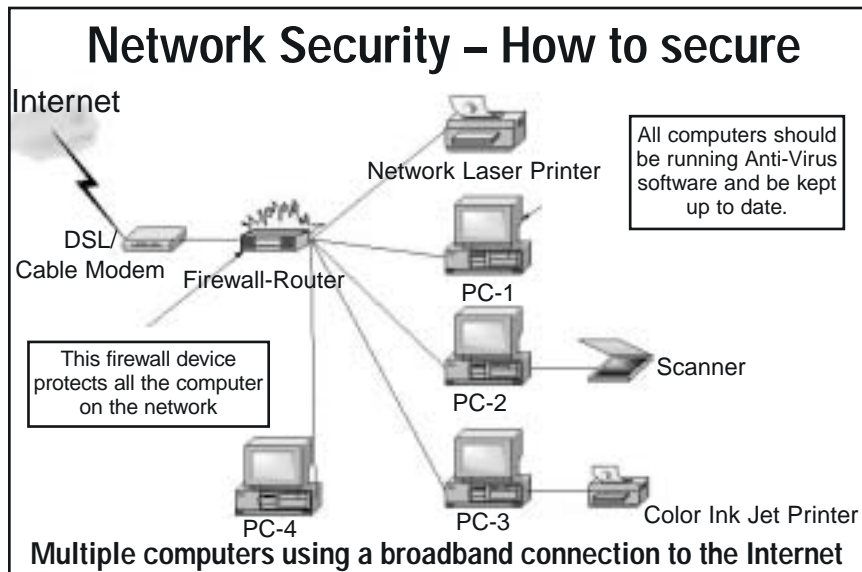
5. Scan floppies or homemade CDs before using them in your network or stand alone PCs. They may have virus files on them.

Next, be aware that both single PCs and multiple computers on a network, with broadband access (such as DSL, cable and T-1) to the Internet are continually vulnerable to attack if you do not have a router or protective software in place. Even dial-up PCs are open to the same threats while they are dialed into their Internet Service Provider (ISP). You can

choose either hardware or software to protect your computers.

1. **Software** - Purchase or download a software firewall. This device will keep unauthorized people out and secure your data. It also protects the computer while it is connected to the Internet and blocks attackers from accessing your computer. (Zone Alarm, Check Point, and BlackICE are common programs used for this purpose.) Note that software solutions can SOMETIMES interfere with your billing and other software. Consult your billing software company BEFORE using a software solution.
2. **Hardware** - Purchase a hardware firewall router. I urge all practices to at least get a router installed on your network. I recommend one with firewall





effectively block unauthorized entry into your system. It will monitor incoming transmissions and block any that are coming from an attacker. Hardware firewalls rarely interfere with other software such as billing software. (Linksys, Netgear, D-Link, Cisco and WatchGuard are common firewall router vendors.)

With limited space in this article to detail solutions to all these dangers, I hope you find this overview helpful. I would be happy to consult directly with any OPA member practice on network and data security issues. Please contact me for more information on how to build an overall security plan for your practice. You can reach me either by my voicemail pager at (330) 250-1492, email me at kenfilbert@hotmail.com or fax me at (928) 396-7304. Additional information can be found on my web site: kenfilbert.com. ■

software and possible virtual private networking (VPN) ability. This hardware will allow you to access your own network remotely over the Internet via a type of “tunnel” that is hard for hackers to break into. This is in addition to the firewall protection it offers your practice. This type of router will

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Web Sites for Psychologists

By Larry Friedberg, PhD



Larry Friedberg,
PhD

The following article is a section of a longer article "The Best Electronic Technology for Psychologists" previously published on the Michigan Psychological Association web site (www.michpsych.org/index.cfm?location=100&subsectionid=89).

The following web sites are the ones I have found to be most obviously useful for psychologists. I tried to factor in depth and breadth of coverage, as well as ease of use.

One site deserves special mention as the "Best Web Site for Psychologists," in my opinion. If you are new to the Internet, or looking for web knowledge or skills, or looking for great web sites, go to The Psychologist's Internet Guide (www.drwallen.com/internetguide.com), a site edited by Pauline Wallin, PhD. This site has sections explaining Internet connections, explaining and linking to the best search engines (with tips how to best use them), introducing mental health web sites and linking to many useful sites.

Following are overviews of other sites with I recommend:

1. **APAOnline** (the American Psychological Association's web site). APA members can access this site at <http://members.apa.org>. This site has evolved substantially over the last few years and offers many useful features, including:
 - PsychPORT: news from the world of psychology and health care.
 - PsychINFO: the online version of Psychological Abstracts.
 - PscARTICLES: APA's online database containing more than 26,000 searchable full-text articles from 49 peer reviewed journals published by APA and allied organizations from 1988 to the present, with earlier years in production. Articles are available in HTML and PDF (Adobe Acrobat Reader) formats. PscARTICLES is also available on an article-by-article basis through PscARTICLES Direct. Users can search PscARTICLES for no charge and pay \$9.95 for each article they would like to access.
 - APA Books
 - An online version of the APA Monitor

- A web site devoted to the APA Practice Directorate
- Links to Divisions
- Annual Convention information
- A web site on which you can apply to, or renew with the APA Insurance Trust

2. Other Internet-based research sites:
 - **Medline** (www.medportal.com.medlinks.html): the world's largest database of medical literature
 - **Article Finder** (www4.infotrieve.com/search/databases/newsearch.asp): a document retrieval service, which searches 25,000 journals, leaning towards the medical and natural sciences. Articles can be retrieved (mostly hard copy, some electronic) for a fee (which can be rather high, \$25 to \$35 per article).
 - **Find Articles.com** (www.findarticles.com/PI/index.jhtml): a free source for articles from a more limited set of journals. It includes full-text access to that very useful journal, *The Journal of the American Academy of Child and Adolescent Psychiatry*.
3. **The National Psychologist** (nationalpsychologist.com): the web site of the very informative newspaper for psychologists of the same name (by the way, subscribe so this valuable resource doesn't go away). The archive of past articles is what makes this site worthwhile (you still have to subscribe to get the most recent articles).
4. **National Institutes of Mental Health** (www.nimh.nih.gov/home.cfm): resources for practitioners, patients (including well-balanced printable information for patients).
5. **PsychCentral** (<http://psycentral.com/>): John Grohol is a pioneer in creating an online mental health web site. This is his site, which has been around since 1992. This is also a good place to find other sites for professionals. PsychCentral includes:
 - A nice description of disorders, including description of treatment options.
 - Links to other sites, including reviews and ratings (by people who visit his site).
 - His top rated sites (examples):
 - "Web of Addictions": www.well.com/user/woa/
 - "Pendulum Resources" (about Bipolar disorders): www.pendulum.org
 - "Crisis, Grief and Healing": www.webhealing.com
 - "Go Ask Alice" (Columbia University's Health Education Program)

6. **Internet Mental Health** (www.mentalhealth.com): a free encyclopedia of mental health information created by a Canadian psychiatrist, Dr. Phillip Long. *Yahoo! Internet Life* named this site “Best Mental Health Resource” for 2002. The site includes:
- Articles from professional and national magazines, newsletters, newspapers
 - Booklets from professional organizations, support groups
 - Full text of printed books and online books
 - News from other Internet newspapers and magazines
 - Newsletters from professional organizations
 - Stories of Recovery & Personal Experiences: telling how individuals have coped with their illness
 - Editorials
 - Letters
 - Links to other popular mental health sites
 - Information on each of the most common mental disorders. There are good links by disorder to basic diagnostic criteria, research references, brochures, articles, as well as some treatment guidelines (with which you may strongly disagree, as I did).
7. **Behavior OnLine** (www.behavior.net): A self-described “...gathering place for Mental Health and Applied Behavioral Science Professionals.” This site offers links to others sites, editorials, Dr. Katz comics, the Journal of Online Behavior. The best feature is threaded discussion of clinical issues. A Behavior OnLine consulting Editor visits each discussion area regularly and participates actively in the discussion there. Ongoing Discussions include:
- Shame and Affect Theory (Donald Nathanson)
 - Classical Adlerian Psychotherapy (Henry Stein)
 - Outcome Assessment (Steven Locke and Ellen Dornelas)
 - Cognitive Therapy (James Pretzer)
 - EMDR (Francine Shapiro)
 - Online Clinical Work (Leonard Holmes)
 - Law, Ethics, and Psychotherapy (William Reid)
 - Clinical Case Conference (Jessica Broitman, Vick Kelly, Donald Nathanson, James Pretzer, Johanna Tabin, Ernest Wolf)
8. **About.com's Mental Health Resources** (mentalhealth.about.com): updated weekly highlighting “The Best of Mental Health Online.” Recent contents/links: The Science of Mental Health; U.S. Government healthfinder®; State Mental Health Directory; Mental Health Books; Glossary of Mental Health Terms; Eating Disorders; Personality Disorders; Psych Medications; Schizophrenia; Anxiety & Panic; Cyber Addictions; E-Therapy; Social Work; Dying and Grief; Seniors & Aging; Health Psychology; Abuse; Depression;

Trauma & PTSD; Crisis; Continuing Ed.; Local and Regional; Women's Mental Health; MPD, Dissociation; Sexuality; OCD; Professional Stuff; Budget Mental Health; Managed Care; Stress Management; Self-Help; Family Resources; Academic Psychology; Online Journals; Chemical Dependency; Subject Library; Abuse/Incest Support; Alcoholism; Attention Deficit Disorder; Bipolar Disorder; Celexa; Death and Dying; Depression; Panic/Anxiety Disorders; Psychology; Stress Management.

9. **Bartelby.com** (www.bartelby.com): Most psychologists are writers. This is the best site on the Internet for writers. The editors of *Yahoo! Internet Life* voted the 2002 “Best Literary Resource” on the web award to Bartelby.com. It includes great references, e-books (the Harvard Classics, all kinds of classical fiction and poetry). Reference works include:

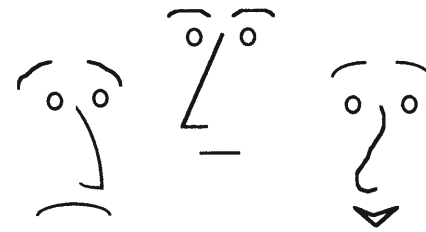
Columbia Encyclopedia, World History Encyclopedia, World Factbook, Columbia Gazetteer, American Heritage Dictionary, Roget's Thesaurus (I and II), Bartlett's Quotations, Columbia Quotations, Simpson's Quotations, English Usage, Modern Usage, Fowler's King's English, Strunk's Style, Cambridge History, Oxford Shakespeare, Gray's Anatomy, Brewer's Phrase & Fable, Bulfinch's Mythology, Frazer's Golden Bough, various anthologies of verse, the Harvard Classics, Modern Essays, American Essays, Presidential Inaugurals, Short Stories. ►

10. **Medbioworld** (www.medbioworld.com): With 25,000 links, Medbioworld says it is “the largest medical reference site,” including medical journals and medical associations, and similar resources in the biological sciences. Links include 6,000 medical journals in 80 subspecialties, and the home pages of 4,000 medical associations. Other research tools include medical glossaries, disease databases, clinical trials and guidelines, and medical journals offering full-text articles.
11. **Psychology Virtual Library** (www.clas.ufl.edu/users/gthursby/psi/): keeps track of online information as part of The World Wide Web Virtual Library. Sites are inspected and evaluated for their adequacy as information sources before they are linked from here. The Journals section indicates which journals show “Current contents, abstracts, subscription information” or “Selected articles and information” or “Articles are available in PDF file.”
12. **The Test Locator** (<http://ericae.net/testcol.htm>): a joint effort of the ERIC Clearinghouse on Assessment and Evaluation at the Catholic University of America, the Library and Reference Services Division of ETS, the Buros Institute of Mental Measurements at the University of Nebraska, and Pro-Ed, a publisher of test reviews.
- The *Test Review Locator* will allow an individual to enter the name of a test and references of reviews of the test entered will be listed.
 - The *Test Publisher Locator* allows individuals to type in the name of a publisher and the contact information on that publisher will be available.
 - The *Test Locator* also provides access to the ETS test file, which is a database of over 10,000 published and unpublished tests.
13. **Test Reviews Online** (www.unl.edu/buros): a service of the Buros Institute of Mental Measurements. Reviews come from 9th through 14th Mental Measurements Yearbooks, plus regular updates to their database. For a fee, users may download information, including critiques, for any of approximately 2,000 tests.
14. **Want to find a book?**
- **Amazon.com** (www.amazon.com): With advanced searching and an incredible catalog of professional books, reviews, sample pages (often including the Table of Contents), Amazon blows away the competition. A new feature is Amazon Marketplace Sellers, which is a listing of discounted prices for new or used books from bookstores which are

associates of Amazon. Amazon handles the credit card transaction for you, and the condition of the item you buy and its timely delivery are guaranteed by Amazon.

- **Barnes and Noble** (www.bn.com): also provides an excellent selection of books, with reviews and an excellent search engine.

For more web sites of interest to psychologists, go to The Psychologist's Internet Guide (www.drwallin.com/internetguide.html), to any of the web sites listed above, to APA's search engine PsychCrawler (www.psychcrawler.com), or search under “psychology” or a specific topic with a search engine such as Yahoo, Google, Dogpile, MetaCrawler, Lycos or Altavista. ■



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Remembering Henry

By Garland Y. (Gary) DeNelsky, PhD

Henry Saeman passed away May 12, 2003 in Columbus, Ohio, less than two weeks after his 76th birthday. He was OPA's first Executive Director, a post he held until his retirement in 1991. After he left OPA he founded *The National Psychologist*, a national psychology newspaper designed primarily for practitioners.



recognized by OPA when he became the first non-psychologist to receive OPA's Distinguished Service Award. Last year he was again recognized nationally when he was inducted into the Psychology Academy of the National Academies of

Practice, the first non-psychologist ever elected to this select group. This honor was bestowed upon him for all that he had given to the field of psychology and to psychologists.

For the last half-dozen years, Henry suffered from myelofibrosis, a rare blood disease. He was doing relatively well until approximately two weeks before his death when he developed severe pain in both legs, reportedly caused by a neuropathy (believed to be related to his blood disease). He was hospitalized to help treat the pain; while there he developed pneumonia which was reportedly the actual cause of his death.

Henry joined OPA in 1973 and remained there for 18 years. He began as its (part-time) lobbyist and eventually became its full-time Executive Director – the first ever for a state or provincial psychological association in the United States or Canada. He helped OPA become one of the most recognized and lauded of all state psychological associations. He was recognized as one of the premier lobbyists in Ohio by a Columbus magazine. Among his many varied duties, he took over the editorship of *The Ohio Psychologist*, turning it into one of the most recognized newsletter of any state psychological association newsletters.

Saeman was honored by the American Psychological Association when he received Division 31's first-ever award as Outstanding Executive Director of a state psychological association. He was

After outlasting virtually all of his Executive Director colleagues in other associations, he retired from OPA in 1991 at the age of 63. At a time when most people this age are planning retirement, he began to plan what was to become the most ambitious project of his life – founding and managing an independent national psychology newspaper, *The National Psychologist*. His family not only supported him, they joined him in this effort. His wife, Mitzi became Office Manager, and his son, Marty, Business Manager. *The National Psychologist* developed a circulation of more than 35,000. In 1996, it was a first-place winner in a national editorial competition of the American



Henry and wife Mitzi made a great team.
(Photo courtesy Wittenberg University)



Gary DeNelsky, PhD, and Henry (right) were long-time friends.

Society of Business Press Editors. The award was presented to Henry for the article he wrote, "Behavioral Health and the Managed Care Dilemma."

Not long after he left OPA, a terrible personal tragedy occurred when he and Mitzi lost their 31 year-old son, Joe, following complications of an asthma attack.

Henry overcame significant hurdles in his life. At the age of 14, just days before the doors slammed shut forever for millions, Henry was able to escape Nazi Germany. He came alone to the United States and soon found himself an orphan as his mother perished in a concentration camp (his father had died several years earlier). He moved about among several different foster homes, not mistreated but not fully welcomed, either. One of his foster parents suggested that he should learn a trade as a means of supporting himself; he chose the printing trades, studying and working for two years in a printing cooperative during high school. At this point, he realized that he wanted something different from life, so he began taking night courses that might eventually pave the way for admission to college. A social work agency sponsored him for these courses (a kindness he never forgot, and which he claimed contributed to his lifelong philanthropy). One of the courses he took was from a noted journalist, a class that was to leave a lasting impression on Henry.

Lack of funds initially made college unattainable for him. At the age of 18, before actually gaining his U.S. citizenship, he volunteered for the draft and entered the Army just after the war had ended. He was

selected for radio repair school, which he completed. But he felt totally out of his element in this field, he pleaded for an occupational transfer, and he wound up a teletype operator in Goose Bay, Labrador. Here is where he developed his prodigious typing skills that later became an important element of his journalistic tools.

After discharge from the Army, he was eligible for the famous "GI Bill" which financed much of his college education. He opted for a small school and chose Wittenberg in Springfield, Ohio. He did quite well at Wittenberg, majoring in social science. He also became a long distance runner, captain of the track team, and sports editor of his college newspaper. Although in his native Germany he had known only soccer, he quickly immersed himself in American athletics and became an avid baseball fan. After graduation, he worked for the *Springfield News and Sun* for 15 years and the *Dayton Daily News* for three. It was during his time in Springfield that he met Mitzi, who was to become his wife of 49 years.

Henry was involved in a variety of philanthropic efforts. He tutored inner city youth in reading, he set up special scholarship funds in his Temple, and he helped resettle immigrants from other countries. He was also well-known for his helping psychologists find employment, deal with bereavement, and cope with loneliness during their later years.

Saeman is survived by his wife Mitzi, and their son, Marty. Donations may be made in Henry's memory to the Henry & Joseph Saeman Youth Scholarship Program at Temple Israel, 5419 East Broad Street, Columbus, OH 43213 or to the Foundation for Psychology in Ohio, 400 E. Town Street, Suite G20, Columbus, OH 43215. OPA will notify the family of all gifts received by the Foundation. ■

Note: Dr. DeNelsky is a Past-President of OPA and served on its Board of Trustees for over 25 years. He and Mr. Saeman were very close friends.



Henry had a great working relationship with legislators. Here is he pictured with Senator Lancione, who was instrumental in establishing Wright State University's School of Professional Psychology.

Tributes to Henry from Around North America

When Henry Saeman died in May, 2003, the world lost a very special man.

I knew Henry for more than 30 years, and was continually amazed at him as a person and a professional. He was one of the most honest, caring, dedicated, energetic, and hard-working men I ever met, and yet he had many reasons in his life's background that should have made it easy for him to be otherwise.

In 1972, the Ohio Psychological Association agonizingly decided to find and hire an Executive Director. Many on the OPA Board strongly believed that we needed to hire a psychologist, but finally it was decided that the OPA Board itself provided enough psychologists. What we needed was someone who could help us in dealing with the legislature (particularly concerning licensing and freedom of choice legislation), who could run a central office, network with psychologists throughout the state, and who could improve *The Ohio Psychologist*.

As chair of the OPA committee, I interviewed Henry who, at the time, had been a newspaper reporter in Springfield and Dayton, Ohio and a "stringer" for the *New York Times*. More recently, he had started his own public relations business, which included dealings with the legislature. Immediately, I was struck by his energy, his straightforwardness, and his mental quickness in grasping new ideas and situations. OPA subsequently hired Henry, and soon discovered what a jewel they had acquired.

Henry's energy and skills quickly became legendary. With newspaperman's aplomb, he could handle two telephones simultaneously, while also typing a story and carrying on a herky-jerky conversation with an employee or visitor. Henry did not know the words "stranger" or "pretentiousness." He was friendly and straightforward, and he soon became known throughout the legislature as someone who persistently sought to achieve goals in an open and ethical manner.

The partnership between Henry and psychology was a good one, and both profited enormously. Henry was an idealist, and he found himself in the company of many other idealists. But Henry also offered practical skills that many psychologists lacked.

Together they worked to make the world a better place. Very active in his Synagogue, Henry's quiet and unassuming manner achieved much that helped—and continues to help—many people.

Henry was an inspiration to many of us. He will be sorely missed.

— James T. Webb, PhD
President - Great Potential Press, Inc.
Scottsdale, Arizona

I would like to echo the sentiments expressed by Gary DeNelsky. While I am not nearly as eloquent as Gary, I would say that Henry was a unique human being who truly touched all those he interacted with. Psychology, Ohio and the nation have lost a valuable asset. However, the degree to which he has influenced all of us is evidence that he lives on.

— David Aronson, PhD, FAACP
Director of Psychology, Heartland
Behavioral Healthcare
Massillon, OH

Henry was a lovely man, and I too will miss him. I knew him over the years, when I was on the Council of Representatives, and thereafter just to chat, to catch up, to see what piqued his interest (more or less everything).

Henry was utterly knowledgeable about the practice of psychology, yet it always seemed to me that he didn't have an "agenda" and that he maintained the reporter's skill in working to understand and convey whatever the reality was in our complex field and its organizations.

— Kate F. Hays, PhD
The Performing Edge
Toronto

I am saddened to hear of the loss of Henry. His contributions to the vitality of psychology in Ohio and throughout the country are undeniable.

— Sandra McPherson, PhD
Cleveland Heights, Ohio

When Division 42 was struggling to raise the alarm that practitioners faced draconian methods under certain state licensing boards, Henry printed article after article on that subject. He knew the importance of protecting the public, but he was one of the first to see that the pendulum had swung too far and that practitioners were getting railroaded in some states. Henry was fearless. When he decided an issue needed to be addressed, he addressed it. Nothing swung me into action as swiftly as a telephone call from Henry, an inspiration of his that an article was needed, and his determination to have me meet his deadline. He was a great journalist and crusader. He was a man of principle, unfettered by business concerns, even though he was running a business.

— *Martin H. Williams, PhD*
Clinical and Forensic Psychology
Sunnyvale, California

For many years Henry WAS Ohio Psychology in the minds of many psychologists across the country. Everybody knew Henry and everybody knew that he was a key player in making OPA the envy of other state associations. I worked with Henry on countless major and minor tasks and learned a great deal from him in the process.

Most readers may not know how critical he was to the founding of the School of Professional Psychology at Wright State. We psychologists had the concepts and the rationale for the School, but it was Henry who knew how to make it happen legislatively. He did so with only partial compensation for his time because he believed in what we were doing. It was Henry who pointed out the key role that would be played by Senator Harry Meshel and arranged for the Senate majority leader to attend a Spring OPA Conference at Salt Fork State Park. At that meeting Meshel met with the proposed school planning group and outlined a blueprint for what was needed to get it approved, which we then followed to the letter. It was Henry who introduced me to Representative C.J. McLin from Dayton, arguably the most influential African-American politician in the state and the founder of Black Elected Democrats of Ohio (BEDO). When C.J. agreed to be our sponsor in the House, and to get BEDO to endorse us, our success was virtually guaranteed. It was Henry who argued for and then arranged a series of luncheon meetings in Columbus with key state legislators so that I could provide information, get their input and solicit their support. It was Henry who helped me find a way to talk directly with the Governor's office and gain assurances that if the bill was passed, the Governor would not veto it. During the initial phase of the School's operation, Henry even wrote and published its newsletter. The rest of us had ideas, but Henry, more than anyone else, made them happen. During that busy, happy and challenging time, he and I were in almost daily contact.

I could never repay Henry for what he taught me and for what he did for my career. I know that he was a rare and good man. I know that he was an energetic dynamo and a work freak. I know that my own success would have been infinitely harder without him. And, I know that I will never forget him. Peace be to you Henry. Your spirit will always dwell in the hearts and minds of those who were lucky enough to really know you. You will be sorely missed.

— *Ronald E. Fox, PhD*
Executive Director, The Consulting Group of HRC
Chapel Hill, North Carolina

Psychology lost a great advocate and psychologists lost a gifted friend with the passing of Henry Saeman, Managing Editor of *The National Psychologist*. We bonded over thirty years ago by successfully advocating for insurance reimbursement through "freedom of choice" legislation, inclusion of psychologists in Ohio Worker Compensation and Ohio Medicaid. He was OPA's first hired Executive Director and became the Dean of State Executive Officers in psychology.

He was as doggedly determined as he was skillful in achieving these objectives. When I filed a complaint with the Ohio Attorney General about the discrimination against psychologists being denied hospital staff privileges, it was Henry that became the instrument of OPA to file the formal complaint resulting in the AG suing (formerly) JCAHO using antitrust statutes in federal court. The successful conclusion of this suit required three years and Henry was there every step of the way. This outcome for JCAHO to abide by state laws opened up hospital practice to psychology. This outcome was tested in California with the CAPP v Rank when the AG of California, Rank, refused to uphold their new hospital practice law. Henry, of course, followed these developments closely. It gave him exposure to psychology at the national level that became one of his spring boards to creating the National Psychologist.

Our last legislative soiree together was one of the first state mandatory mental health insurance reimbursement laws. These pre-dated mental health parity laws by a decade. Again, Henry was equal to the task with his effective, reporter-like, in his "vest pocket style" of lobbying. We were able to get \$500 of mental health coverage in health insurance contracts in the same session it was introduced in the Ohio legislature.

Yes, I will miss Henry, just as his wife, Mitzi, his son, Marty, and others do. His efforts led to the growth of psychology in Ohio and the economic foundation of the practice of psychology nationally. We, as psychologists, owe a great deal to our friend and advocate Henry Saeman and to Mitzi and Marty who worked with him on *The National Psychologist*.

Thanks, Henry.

— *Jack Wiggins, PhD*
Fountain Hills, Arizona

Onward and Upward!

Appreciations to Retiring OPA Leaders

By Alice H. Randolph, EdD
OPA President

As President of the Ohio Psychological Association, it has been my pleasure to work with a talented team of volunteer board members and committee leaders. Without their dedication, not only this year but over many years, OPA would not be the successful and innovative professional organization that it is today. Unfortunately, there comes a time when other commitments or opportunities cause members to leave their OPA roles. Thank you to the psychologists who will not be returning to the Board of Directors.

Suzanne LeSure, PhD, Advocacy Committee Chair

Dr. LeSure has contributed more to OPA and to psychology in Ohio than can possibly be listed. As chair of the Regulatory Committee, President, and chair of the Advocacy Committee over the last eight years she has worked tirelessly. Passing of the prompt pay bill, working with Senator Spada to create fair and reasonable legislation for psychologists involved with sexual misconduct, fighting to have OPA's position heard and respected with regards to several licensure bills, and helping to develop a prescriptive authority strategy are among Dr. LeSure's most significant accomplishments. Those of you who are on the listserv and who attend OPA events can personally attest to her quick wit, ability to mobilize the troops for quick action and effective communications skills. She has worked tirelessly to connect with individual OPA members in key Ohio districts to get them involved with grassroots advocacy efforts. Perhaps the most impressive work is reflected in her persistence in the face of economic and political "challenges" that would frustrate a mere mortal.

Sandra Shullman, PhD, Finance Officer

All Ohio psychologists should be proud that one of their own, Dr. Shullman, was recently elected to the American Psychological Association Board of Directors. With this new responsibility, she has stepped down from both her Finance Officer and Public Interest Chair positions within OPA. Dr. Shullman will remain active in the Association by continuing in the very important role of Planning and Development Chair, a non-voting seat of the OPA Board of Directors. In this capacity, she will help OPA define itself and plan for its future. You will be hard pressed to find a more politically savvy, instinctive, strategic asset in any organization. Dr. Shullman is a veteran of the OPA Board of Directors, serving in a variety of capacities including President, a dedicated advocate for psychology and a Distinguished Psychologist Award recipient.

Deborah Koricke, PhD, Cleveland Psychological Association Representative

Dr. Koricke has been a regional affiliate representative to the OPA Board of Directors since 1999-2000. She represented the Cleveland area well by actively sharing in discussion and informing the Board of her region's activities, concerns, successes and challenges. In the event that she was unable to attend a Board meeting, she was conscientious to find a replacement to be in attendance. It has been a pleasure working with Dr. Koricke over the years and I look forward to many future opportunities to cross paths.

Briget Lanktree, MA, Ohio Psychological Association of Graduate Students (OPAGS) Chair

Ms. Lanktree has regularly attended and actively participated in OPA Board meetings as the OPAGS Chair. During her term, OPAGS was the first student chapter to receive the American Psychological Association of Graduate Students' State and Provincial Association of the Year Award. Ms. Lanktree represented OPAGS to accept the award as part of Ohio's delegation to APA's State Leadership Conference 2003. Her other significant contributions include helping to develop an OPAGS web site and producing a second student educational summer forum at Ohio State. Briget is now in Denver working on her internship.

Patricia James, PhD, Professional Practice Committee

Dr. James has successfully guided this committee - under a variety of names - for many years. The group has been very active, especially in its efforts to educate psychologists on operating a practice free from managed care. Over the years, this group has explored the wide range of options available to practitioners and presented at OPA events to educate psychologists. Dr. James has been instrumental in identifying current issues and emerging trends that impact the practice of psychology. After completing this term as Professional Practice Chair she will spearhead a special interest group focusing on child and family topics.

Every single OPA member has been touched by the contributions of these colleagues. Please let them know that you are thankful, maybe by writing a short note, by making an effort to talk to them at an OPA event, or by picking up the phone to acknowledge their efforts. If you would like to become involved in the leadership of the OPA, contact the Chair of a Committee in which you are interested, or call the Central Office to discover your options. ■

The Future Evolution of Professional Psychology

By Ronald F. Levant, EdD, APA Recording Secretary



At the OPA Spring Institute I enjoyed the opportunity to share some of my thoughts regarding the evolution of professional psychology. A summary of this one-hour keynote address follows.

First of all, the field needs to continue strengthening our efforts to shape the changing marketplace for professional practice, which is — without doubt — the single most important issue for professional psychology today. The industrialization of health care has turned psychotherapy into a commodity, which seriously shortchanges the consumers of mental health services and drastically reduces the numbers of psychologists-psychotherapists who can earn a living in practice. In response, organized psychology and individual psychologists have developed a broad range of initiatives to maintain and enhance the importance of mental health services in the nation's health care system. These initiatives at times seem to be "turning the tide on managed care." They include legislative and litigative actions undertaken to contain the abuses of managed care, such as the Patient's Bill of Rights legislation and the New Jersey Psychological Association's no-cause termination lawsuit against MCC Behavioral Care, Inc. and the California Psychological Association's lawsuit against Aetna U.S. Healthcare. The action of tobacco litigation attorneys filing class action suits against managed care companies is a very encouraging sign. In addition, some psychologists have moved to create leverage for psychological services in the marketplace. Capitalizing on our inherent strategic advantages in being the best trained and most research-oriented mental health profession, some psychologists are creating data-driven integrated health care delivery systems that could compete very effectively with managed care companies.

Second, there is a growing recognition of the importance of psychologists being involved in matters of public policy. Psychologists' role in public policy is expanding. We now have psychologists who serve as state and federal legislators, as public administrators, and on public commissions at the local, state and national level. We need to keep public policy issues at the forefront of professional psychology, because I believe that professional psychology's future hinges to a large extent on our ability to respond to important public health and societal needs.

Third, and no less important, is the evolving nature of professional practice. The scope of psychological practice is expanding and diversifying into new areas — areas where the distinction between applied scientist and professional practitioner begins to blur — such as health psychology (and its related aspects such as psychology in primary care, psychoneuroimmunology, and applied psychophysiology), neuropsychology, rehabilitation psychology, forensic psychology, feminist psychology, child and family psychology, multicultural psychology, geropsychology, business and industry consultation, and psychopharmacology. In addition, public sector care is very recently being seen anew, as an area rife with possibilities for an expanded scope of practice, such as in the correctional systems, and in the federal (VA) facilities, state hospitals, and community mental health centers, which serve those with long-term mental illness.

Two of the most important issues for the future of professional psychology arise from the evolving nature of professional practice: the redefinition of psychology from specialty mental health care to primary health care and the expansion of the scope of practice of psychology to include psychopharmacology. As a specialty profession of mental health care, we deal primarily with the people who self-identify as having psychological problems and who have access to a mental health specialist, which is just a fraction of those who need psychological services. As a primary health care profession we would be able to serve the much larger group of people who do not have access to mental health care or who do not identify their problem as psychological. To grasp this potential, please consider a few facts about health care: (1) Seven out of the nine leading causes of death have significant behavioral components; (2) At least 50% (and maybe as much as 75%) of all visits to primary care medical personnel are for problems

with a psychological origin (including those who present with frank mental health problems and those who somaticize) or psychological component (including those with unhealthy lifestyle habits such as smoking, those with chronic illnesses, and those with medical compliance issues); (3) The vast majority of people receiving mental health treatment are cared for by medical professionals with minimal specific training in mental health. The Cartesian world view, which separates mental health from physical health, is breaking down, and as a result psychology has a tremendous opportunity to evolve into a premier primary health care profession. At the very least this would put psychologists on the front lines of health care, working collaboratively with physicians and nurses. The more visionary — if less probable — perspective is that health care should be reorganized so that psychologists serve as primary caregivers at the gateway to the health care system, functioning to diagnose and treat the more prevalent psychological problems, and referring to medical physicians when indicated.

With regard to expanding the scope of practice to include psychopharmacology, the prescription privilege agenda has the capacity to dramatically accelerate the evolution of professional psychology, and to move us closer to fulfilling our potential of being a premier primary health care profession. The Department of Defense Psychopharmacology Demonstration Project graduates who are now prescribing have recently demonstrated through the USGAO report of 1999 that not only will properly trained prescribing psychologists NOT be a public health hazard as psychiatry has so ignominiously claimed, but also that such psychologists will do an outstanding job at psychodiagnosis and at expertly combining psychological and pharmacological treatment.

Fourth, we need to continue to identify new opportunities for practice and provide guidance on how psychologists can access these opportunities. It cannot be emphasized enough that the future evolution of professional psychology will entail the development of roles that do not now exist - in health care, schools, the courts, the correctional system, businesses - in the numbers that psychologists entered the role of outpatient therapists in the 1970s and 80s.

Fifth, in regard to training, I think the education and training community needs to respond not only to present-day marketplace concerns resulting from the industrialization of health care, but even more importantly to future concerns such as the evolution from specialist to primary care and psychopharmacology. We have not even begun to grapple with the training issues involved in the evolution to primary care, which, if taken seriously, might involve the revamping of the curriculum such that the generalist predoctoral training would be in health psychology, and mental health (perhaps in some specialized form such as the psychology of long-term mental illness) would be one of the postdoctoral specialties available.

Last but certainly not least, we need to enhance science-practice collaboration. For one thing, the APA Science-Practice Task Force wrote of the need for practitioners to identify clinically-immediate problems for scientists to investigate. Secondly, with the increased emphasis in NIMH on "effectiveness" research, which studies psychological interventions as they are actually implemented, opportunities for practitioners and scientists to create practice-research networks are greater than they have been in a long time. ■

Biographical Sketch

Ronald F. Levant, Ed.D., A.B.P.P., is a candidate for APA President. He is in his second term as Recording Secretary of the American Psychological Association. He was the Chair of the APA Committee for the Advancement of Professional Practice (CAPP) from 1993-95, a member at large of the APA Board of Directors (1995-97), and APA Recording Secretary (1998-2000). He is Dean, Center for Psychological Studies, Nova Southeastern University, Fort Lauderdale, FL.

This is a short version of the keynote speech that Dr. Levant presented at the Ohio Psychological Association Spring Institute. If you would like a copy of the longer talk, please write to him at rlevant@aol.com

From the Shallow End of the Pool A Look at Project FAIR

By Michael O. Ranney, MPA



Michael O. Ranney, MPA,
Executive Director

It may be useful to give some historical background to members who have begun to view Project FAIR as one of the cornerstones of OPA services. The original idea for Project FAIR was developed by attorney Glenn Karr as a resource for psychologists who were victims of errors by insurance companies. Initially, Mr. Karr volunteered his time until grant support from APA's Committee for the Advancement of Professional Practice enabled OPA to fully implement the program in 1997, at which time he became a consultant to the project.

When Project FAIR began, Mr. Karr's commitment was to work on it for two years. Now almost seven years later, Glenn, OPA, and Project FAIR have continued to be a "force to be reckoned with" in dealing with issues OPA members have faced with insurers operating in Ohio. In the beginning, FAIR sought to identify trends and practices of insurers in Ohio that it could address on behalf of OPA members. Often the scope of these issues connected to the work of several of the OPA Board's committees, including Insurance, Managed Care, Professional Practice, Regulatory, Advocacy, and Public Interest. OPA staff became more and more involved in aspects of the Project FAIR work over the years, helping to support Glenn with OPA and APA resources. FAIR has adjusted its focus to keep pace with the issues, trends and needs of OPA members. Last February, Glenn suggested to the OPA Board of Directors that it was time for FAIR to be further refined to keep pace with what was needed.

One of the biggest problems on which FAIR focused was prompt payment issues that many OPA members brought to our attention. APA funded a study of payment problems that was run through Project FAIR and the data collected supported an aggressive advocacy effort that led to passage of prompt pay legislation. This action has had a significant impact on payment delays.

As HIPAA became a major issue, it was decided to put OPA's efforts to help its members with the intricacies of compliance under Project FAIR. Glenn Karr and Bobbie Celeste, PhD, worked jointly on responding to OPA member questions and providing training on compliance with the law and rules.

At the same time, OPA orchestrated high level contact with Anthem and Magellan out of concern about the significant number of OPA members who were

experiencing problems with them. Over time, I took on the lead responsibility for managing OPA's work with its members on these issues.

Glenn Karr has confirmed that he will end his Project FAIR work at the end of August, when he completes his analysis of the NCQA guidelines which will be a helpful resource to OPA members. This initiative is yet another significant accomplishment for him and for Project FAIR. Glenn has indicated that he intends to focus more attention on other areas of his practice, including representation of psychologists before the Ohio State Board of Psychology, which has become more active in its enforcement role. OPA applauds his efforts on behalf of psychology and looks forward to working with him on special projects in the future. Mr. Karr has agreed to continue to be available as a presenter of workshops on legal, ethical and confidentiality issues.

Since there are still battles to be waged with insurance companies on behalf of OPA members and their clients, Project FAIR will continue. To assure that Project FAIR remains a force for psychology against the evils of the current health care system, Dr. Celeste, OPA's Director of Professional Affairs, will increase the time she works on OPA matters from one to two days a week and I will continue to increase my involvement in such issues to benefit OPA members.

Project FAIR will continue to work with Anthem/Magellan on global problems experienced by many OPA members and to insist on finding fixes for these. FAIR will continue to advocate on behalf of individual psychologists and patients who experience problems. One issue that is pending relates to credentialing frequency and OPA continues to push for a three-year credentialing period.

FAIR will attempt to duplicate the Anthem/Magellan model for action on global issues and for problem resolution with other insurers. FAIR will continue to work to get psychologists involved on insurer's advisory committees. OPA believes that it is important for the private practice psychologist's perspective to be represented on these committees.

FAIR will also give greater attention to OPA's

relationship with the Department of Insurance (DOI) this coming year. OPA's leadership believes that the DOI needs to be better informed of the problems and issues psychologists encounter. Ann Womer Benjamin, who was recently appointed to be Director of the Department, was responsive to OPA concerns when she was a State Representative.

HIPAA issues will continue to be addressed by OPA through Project FAIR and OPA committees, with new educational programs and explanations of changes. All of Project FAIR's efforts will be integrated with OPA's work on the advocacy and regulatory fronts, including Medicare and Medicaid. FAIR's focus will continue educating public policy makers.

FAIR will also monitor national trends and keep OPA members informed about them. The growing debate over "evidence based treatment" ("EBT") is one such emerging issue that has great significance for

psychologists and this topic will be addressed in greater depth over the next year (see related article on page 15 for further detail).

The direction that Project FAIR takes is driven by issues raised by OPA members. One of the most prevalent issues that has been raised in the past year and that we are tracking now is the problem of "phantom panels." When OPA works on patient access issues and legislation, insurers tout the quality of their panels as the reason to oppose "any willing provider" or similar legislation. OPA members tell us that the quality of these panels is way overstated. Panels include deceased psychologists, psychologists who are not taking new patients and psychologists who only practice in the area a few days a month. As OPA gathers data on this problem we will propose remedies through legislation, regulatory action or legal action. We urge OPA members to keep us informed of experiences they have with "phantom panels." ■

Psychologically Healthy Workplace Award

Applications are now being accepted for OPA's First Annual Psychologically Healthy Workplace Award. Companies of all sizes throughout Ohio are encouraged to apply. Materials are available on OPA's web site at www.ohpsych.org. Any organization that has programs or policies to address the following issues is eligible to apply:

- Employee involvement
- Family support
- Employee Career Development
- Health & Security

Winners will be honored at a special luncheon at OPA's Annual Convention on Thursday, November 6, 2003. Recipients will be named in each of six categories, based on type of business (for profit or not-for-profit) and number of employees.

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- WANTED -

PSYCHOLOGISTS FOR NEW ONLINE REFERRAL PROGRAM

Beginning September 1, 2003, the Ohio Psychological Association is instituting a new, ONLINE Psychologist Referral Program! In previous years, the referral program has been a telephone-only system, and with minimal advertising, OPA distributed an average of 30 referrals every day. Now the program will be available online as well, to provide a convenient and anonymous way for consumers to search for psychological assistance at any time of day.

OPA has expanded its already broad list of practice areas to enable more specific searches. The Referral Program is available statewide. All members are encouraged to participate, especially psychologists meeting any of the following criteria:

- Practice in a rural community
- Speak a foreign language(s)
- Are a member of an ethnic minority group
- Are friendly to Lesbian, Gay, Bisexual and Transgender (LGBT) clients
- Are Christian
- Accept Medicaid and/or Medicare
- Offer sliding scale fees
- Have experience with forensic issues

OPA is making every effort to make this initiative a win-win for practitioners and the general public. We need participants to give consumers more options. The more choices consumers have, the more they will use OPA's referral program. The more they use OPA's referral program the greater the benefit to psychologists. Help the program realize its fullest potential to meet the needs of ALL consumers in Ohio. SIGN-UP TODAY!

Yes! I want to join the new, online OPA referral program for the 2003-2004 membership year.

Name: _____ License Number: _____

Office Address: _____

City, State, Zip: _____

Office Phone: _____ Office County: _____

Email Address: _____

(please PRINT or TYPE legibly)

Payment Method - \$30.00 charge for one year

- Check enclosed (payable to OPA)
- Charge my (please circle one) VISA MASTERCARD

Account No.: - - - Exp Date: /

Signature: _____

Please mail your completed form to Ohio Psychological Association, 400 East Town Street, Suite G20, Columbus, OH 43215 or fax it to (614) 224-2059. Questions? Call our Central Office at 1-800-783-1983.

NOTE: Additional form will follow on which you will indicate your practice area(s) and demographic information.

YOU MUST RETURN THIS ADDITIONAL FORM to activate your participation in the online referral program.

Next on the HIPAA Horizon

By Bobbie Celeste, PhD, Director of Professional Affairs

Just when you thought it was safe to stop thinking about HIPAA, a new deadline is looming. October 17, 2003 marks the time that the Transaction Rule becomes effective. Remember last year when many of us signed an extension? Now the rubber hits the road and many psychologists will need to become compliant. The Transaction Rule deals with the electronic billing process. The purpose of the new rule is to simplify and standardize the flow of electronic information. Therefore there are (of course) new forms (similar to the HICFA 1500) which require slightly different bits of information. For example, on the new form in the section asking about the "patient's relationship to the insured", the new forms include new categories such as stepchild, foster child, or grandchild. The good news is that if you are in a practice with three or fewer practitioners and only send paper bills and do not see Medicare patients you may ignore the Transaction Rule for now.

If your office has four or more practitioners, bills Medicare, or does any electronic billing, you will want to familiarize yourself with the HIPAA Transaction Rule. To that end, OPA is working with the Ohio HIPAA Implementation Organization for Electronic Data Transfer (O.H.I.O. for EDI) to bring you the up-to-date information. You or who ever does your billing will want to attend one of the upcoming workshops to get the latest training on the ins and outs of the Transaction Rule. The same program will be held once each in Columbus, Cleveland and Cincinnati and may be available via video transmission in Toledo and/or Athens. Dates are listed below. After the workshop, you can contact me regarding compliance.

I invited Gary Pritts, Co-President of O.H.I.O. for EDI, to explain in more detail who will be affected by the HIPAA Transaction Rule. He responded with the following:

Many psychologists think that HIPAA is about privacy and that it's all over with now that they have created policies and are distributing the notice of privacy practices. The reality is that there are two major sections yet to come – HIPAA Security and HIPAA Transactions.

The deadline for the Transaction Rule is October 17, 2003 – just a few months away. If you are a solo practitioner who bills on paper, you don't need to make any changes for the HIPAA Transaction rule. However, you ARE affected if you:

- are in group practice with 10 or more full-time equivalent (FTE) employees that bills Medicare
- do electronic billing either with your own computer system or through a billing service
- are in group practice with at least four clinicians and want to improve the efficiency of your billing and administration

If you have 10 or more FTE employees and bill Medicare, a new law called ASCA requires that you bill Medicare electronically effective October 17, 2003. If you or your billing service is not doing this process electronically, you need to make a change quickly or you risk not getting paid.

If you currently bill electronically, either yourself or through a billing service, you must convert to the new electronic format (ANSI 837). As part of this, you may also need to update your new client paperwork in order to capture the necessary data elements.

If you are a group practice with four clinicians (four is an arbitrary number) you would be advised to educate yourself on new electronic capabilities – and new software – which will allow you to do more things electronically – check insurance eligibility, the status of unpaid claims, request pre-authorization for services, and receive remittance. This improved performance is what the HIPAA Transaction rule is all about – improving office efficiency.

If you are in one of the three categories above, OPA strongly encourages that your office manager attend a training session it is co-sponsoring with O.H.I.O. for EDI, a non-profit organization that provides education on electronic commerce. The session will provide a detailed description of the necessary data items for billing, education on new electronic capabilities which can eliminate the time your office person spends on the phone with payers, an update on the regulatory details, and a preview of the next HIPAA chore – the computer security regulations. Visit www.ohpsych.org/OHIOEDIWORKSHOP.PDF or call OPA (800-783-1983) for exact details.

Seminar Dates:

September 11 – Columbus
September 12 – Cleveland
September 18 – Cincinnati ■

Getting Paid Under HIPAA (and more!)

Course Objectives

1. Know the key HIPAA transaction compliance dates
2. Understand how to determine the new data items and billing codes your organization needs for electronic billing
3. Understand the new, more stringent requirements for electronic claims and how to avoid payer rejections
4. Understand how to conduct a due diligence with your billing software vendor and clearinghouse
5. Understand the new capabilities software vendors are including in their products and what the benefits are
6. Understand your legal responsibility to conduct EDI testing, the benefits, and your various options
7. Learn how to develop an action plan for complying with the HIPAA transaction rule

Faculty

Nancy Gillette, Esq. is Legal Counsel for the Ohio State Medical Association (OSMA) and an expert in various aspects of the HIPAA regulations. She is Vice President and Treasurer of O.H.I.O. for EDI.

Rick Moore is President of DME Consulting. He specializes in the implementing the ANSI transactions and consults with both providers and payers.

Gary Pritts is President of Eagle Consulting Partners, Inc. He consults for providers, software vendors, and government agencies regarding HIPAA Privacy and Transactions. He is Co-President of O.H.I.O. for EDI.

Matt Curtin, CISSP is president of Interhack, Inc. He is an expert and consultant in computer security, author of numerous publications on trustworthy computing, and a lecturer at The Ohio State University.

Ajit Kumar is President of Microsys Computing, Inc. He is a 20 year veteran of medical billing software industry and has implemented innovative software functionality based on the new ANSI transactions.

Other faculty. Over 10 others will present as representatives of the following organizations:

- **Payer Representatives** from major Ohio payers
- **Clearinghouse Representatives** from both national and regional clearinghouses
- **Billing Software Vendor representatives** from Ohio based and national firms

Registration Form

Call (800) 766-6762 or (614) 527-6762 OR

Fax form (614) 527-6763

Mail: **Ohio State Medical Association.**

3401 Mill Run Dr.

Hilliard, OH 43026

September 11 - Columbus

September 12 - Cleveland

September 18 - Cincinnati

Name _____

Title/Role _____

Organization _____

Type of Organization _____

Address _____

City _____

ST _____ Zip _____

Telephone (____) _____-_____

Fax (____) _____-_____

E-mail _____

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Member Rate (\$159)

(Association: _____)

Member Name: _____)

Member Number: _____)

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Registration

Cost is

- ➔ Non-member Rate \$199/person
- ➔ Member Rate \$159/person (for members of any sponsoring organization)
- ➔ \$20 Fee for Registration within 72 hours of event
- Register early, space is limited. Registration is not guaranteed until you receive a written confirmation.
- Lunch is provided
- Payment accepted by Mastercard, VISA, AMEX or check payable to **O.H.I.O. for EDI** (Note: Credit Card charges will appear as "Ohio State Medical Association")
- Cancellations, with full refund, will be accepted up until seven days prior to Seminar; no refunds are made after this date
- O.H.I.O. for EDI, if necessary, will substitute faculty with others of similar qualifications. In the event of circumstances beyond our control, the seminar will be cancelled. A full refund will be provided in the event of cancellation.

BILL BOX

BILL # & SPONSOR	DESCRIPTION	OPA ACTION STEPS	HOUSE/SENATE ACTION	ADDITIONAL INFORMATION
Comprehensive Mental Health Parity HB 33 (Olman, R - Maumee) <u>OPA strongly supports this bill</u>	Health insurance - no discrimination in coverage for mental illness & substance abuse	Ask your State Representative to work for the passage of HB 33. This comprehensive bill makes mental health care a basic health care service.	Assigned to the House Insurance Committee. Hearings underway. We still lack the votes necessary to move this out of committee.	Meets 2pm Tuesdays.
Mental Health Parity and licensure of Masters level psychologists. HB 57 (Callender, R - Willowick) <u>OPA opposes this bill</u>	Mental health parity but adds licensing "Psychology Associates" with MA degree to parity bill	Ask your State Representative to oppose this bill.	Assigned to the House Insurance Committee.	
Budget Bill HB 95 (Calvert, R - Medina)	Main operating budget for FY 2004-2005, Support funding for Ohio Department of Mental Health (ODMH) and Ohio Department of Alcohol and Drug Addiction Services (ODADAS) as recommended by Governor Taft	Help may be needed on the issue of psychological services under State Plan Medicaid as the Ohio Department of Job and Family Services (ODJFS) moves forward to amend the State Plan and to approve new rules. Write Governor Taft and your legislators to express views on the value of psychological services and to let them know you think eliminating them is bad public policy.	Passed the House and Senate without amendment to protect psychological services in State Plan Medicaid.	Conference Committee did not act on amendments to protect psychological services in State Plan Medicaid; Governor signed final bill; Elimination of psychological services is anticipated to be effective January, 2004 following State Plan and rule changes. Funding levels of ODMH and ODADAS were about as much as requested. The Board of Psychology received the additional funding it requested.
Create RX Program under ODJFS. HB 166 (D. Miller, D - Cleveland) <u>OPA is monitoring this bill</u>	This bill creates a program to support providing lower cost prescription drugs to qualified participants.	Referred to House Health Committee Committee meets Wednesday mornings.		
Mental Health Parity Bill for Severe Mental Illnesses (SMI) only HB 225 (Olman, R - Maumee) <u>OPA has not taken a position on this particular bill.</u>	This bill provides for equality in health care coverage for a short list of severe mental illnesses	This bill has not yet been referred to a committee. No action needed at this time.		
Defense of Marriage Act SB 65 (Wachtmann, R - Napoleon) <u>OPA opposes this bill.</u>	Declares that same-sex marriages are against the strong public policy of the state and that statutory benefits of marriage may not be extended to non-marital relationships.	As of 7/9/03 this bill has not been referred to a committee. No action needed at this time.		
Mental Health Parity, SMI Only. SB 88 (Shuring, R - Canton) <u>OPA opposes this bill</u>	To require insurers to provide benefits to cover severe mental illnesses diagnosed by a physician. Would not include Medicaid or Worker's Comp. It takes away some of the gains that have been made in coverage for mental illness in recent years.	OPA is opposed to bills that do not cover all mental illnesses and diagnosis by psychologists. Write your State Senator to urge opposition to this bill. In particular, Senators Teresa Fedor, Ray Miller, Dan Brady, Robert Spada, and Eric Fingerhut - co-sponsors of this bill - need to hear from OPA members about the problems with an SMI-only bill.	Referred to the Senate Insurance, Commerce and Labor Committee.	



OPA-PAC:

The Difference between Grumbling and a STRONG VOICE



As psychologists, we worry about public policies that undercut our ability to help those most in need of our services. The difference between just grumbling about what is happening and having a say in what happens lies with the legislative voice the OPA Political Action Committee (PAC) gives us. Thanks to our PAC, psychology has access to key state legislators to present our message. It also helps us keep legislative friends in office.

Here's how it works. OPA staff follows legislation under development and brings bills relevant to psychology to the attention of OPA's Advocacy Committee. The Advocacy Committee studies the issues and the OPA Board of Directors decides which issues OPA will track, support, or oppose. PAC efforts, in concert with local grassroots involvement, works to educate legislators on our issues and encourage them to shepherd our message through the legislative process.

Whether you teach, do research, work in the public sector, work as an I/O psychologist, or are in private practice you need the strong legislative voice OPA-PAC provides. Why do we need the PAC to build our legislative voice for us? Because most psychologists simply do not have the time needed to do the job on their own.

Giving to OPA-PAC is one of the best bargains a psychologist can buy. While the Advocacy Committee keeps us informed about the public policies that impact psychology, it is the OPA-PAC that covers our interests at the legislative table.

Write a check to OPA-PAC today and help preserve this terrific bargain. Remember, the stronger the PAC, the stronger our voice.

Frances Strickland, PhD
OPA-PAC Chair

OPA-PAC
Frances Strickland, PhD, Chair
400 East Town Street, #G20, Columbus, OH 43215

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I will donate: ___\$100 ___\$120 ___\$250 ___\$500 ___\$1,000 ___Other: _____

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State Science Day 2003

By Denise Sabo, BA, OPA Director of Operations and Membership Services

Aspiring behavioral scientists from grades 7 - 12 gathered at The Ohio State University Jerome Schottenstein Center on May 3, 2003 for the annual State Science Day. Columbus psychologists and Central Ohio Psychological Association members again served as judges for the event, and The Foundation for Psychology in Ohio awarded \$675 in cash prizes. Awards ranging from first place to third place were given out in grades 7 to 11, with first place winners receiving \$75, second place winners garnering \$50, and third place winners earning a \$25 prize.

Special thanks goes to Joseph Bene Jr., MA, Michael Witter, PsyD, Kay Rothman, PhD, Jeff Sherrill, PhD, John McCue, PhD, Lynda Williams, MA, Ted Williams, PhD, and Terry Imar, MA (pictured below from left to right) for volunteering their time and energy and acting as judges for this year's event.

Congratulations to all of the 2003 Science Day winners:

Grade 7

Margaret Estadt - Grove City - 1st Place
Is there a similarity between font size and reading comprehension in the third grade?

Alexandra Always - Cincinnati - 2nd Place
Does sign language enhance speech development?

Zachary Mason - Westerville - 3rd Place
To tell the truth

Grade 8

Mary Brislen - Cambridge - 1st Place
Do Mnemonics affect the learning ability of students?

Mackenzie Procoffie - Wilmington - 2nd Place
See it... hear it... remember it?

Ingrid Baumann - Gates Mills - 3rd Place
The effect of chewing gum on memory

Grade 9

Benjamin Christoff - Beavercreek - 1st Place
The effect of aircraft noise pollution on the ability of mice to complete a maze

Jill Kellett - Lancaster - 2nd Place
Does practice make perfect?

Grade 10

Neha Bhoomreddy - Mason - 1st Place
Are pediatric guidelines addressing the issue of cost?

Matthew Jennings - Toledo - 2nd Place
The effect of relaxation techniques and imagery sessions on times and cortisol levels of swimmers

Grade 11

Ashley Verhoff - Ottawa - 1st Place
Subliminal messages: do they work?

Ashley Wheeler - Tiffin - 2nd Place
Androgyny and partial brain dominance ■

State Science Day 2003 Judges



POSTER WINNER

2002 ANNUAL CONVENTION

Measurement of Verbal Fluency in Parkinson's Disease

By Rose Mary Shaw, Laura Samson, and Jeffery Allen
Wright State University: School of Professional Psychology

Introduction

Semantic fluency (SF) and letter fluency (LF) are typically considered when assessing neurodegenerative disorders. Evidence indicates that LF tasks are sensitive to frontostriatal deficits, such as Parkinson's disease (PD), while SF is associated with temporal lobe dysfunction, such as Alzheimer's disease (AD; Hoa, Sahakian, Robbins, Barker, Rosser, & Hodges, 2002). Consequently, tasks involving frontal functions such as verbal fluency should be sensitive to deficits produced by PD. However, one review of the literature revealed that research on the impact of PD on verbal fluency has produced conflicting results. Some research supports the notion of significant impairment on letter fluency (LF) in PD, while others demonstrate impairment in both LF and SF (Azuma, et al, 1997).

The practice of collapsing semantic and letter stimuli into one category for analysis fails to address the stimulus effect of each distinct letter. Suhr and Jones (1998) found that qualitative errors could distinguish early stages dementia of different etiologies. However, unique patterns of SF and LF based on total scores were not statistically significant as means of differentiating between cortical and subcortical dementias.

Major aims of the study were: to assess the degree of verbal fluency impairment in mildly impaired PD individuals as compared to normal elderly individuals, to address inconsistencies in the literature noted by Azuma et al. (1997), in particular patterns of fluency performance, and to explore the relationship between deficits in SF and LF with deficits in working memory.

Method

Participants

Fifty-four participants (26 PD, 28 Control) were recruited from senior centers in central and southwest Ohio. The PD patients, ages 50 - 75 years, diagnosed with mild to moderate idiopathic PD (Hoehn and Yahr, 1967) and on stable medication, were randomly selected from Parkinson support group volunteers. The Controls were randomly selected from the same senior centers and were matched for age and education. Participants with a history of head injury, stroke or neurosurgical operation, chemical dependence history or psychiatric history were

excluded in order to control for memory and cognitive deficits related to PD. Informed consent was obtained from all subjects.

Measures

All participants were administered the Mini Mental State Examination (MMSE) and the Beck Geriatric Depression Inventory (GDI). The Controlled Oral Word Association Test (COWA) was used as a measure of word fluency; the category "Animals" was used as a measure of semantic fluency. Working Memory (WM) was assessed utilizing the following subtest from the Wechsler Memory Scale-III: Digit Span-forward and backward (DS-f, DS-b); Spatial Span (SS); and Letter-Number Sequencing (LNS). Logical Memory I (LMI) measured immediate verbal memory, and Logical Memory II (LM II) served as a measure of delayed memory.

Results

While PD patients were generally similar to Controls on overall cognitive abilities, PD patients demonstrated significantly worse performance than Controls on semantic fluency tasks [$t(31.79) = -2.54, p < .05$].

Measures of WM and verbal fluency were correlated. In the PD group, DS-f was correlated with "AA" ($r = .76, p < .01$), "F" ($r = .59, p < .01$), "A" ($r = .67, p < .01$), and "S" ($r = .54, p < .01$). DS-b was correlated with "AA" ($r = .64, p < .01$); "F" ($r = .47, p < .05$), and "A" ($r = .53, p < .01$). LNS was correlated with "AA" ($r = .571, p < .01$); "F" ($r = .53, p < .01$), "A" ($r = .549, p < .01$), "S" ($r = .475, p < .05$). In the Controls, DS-f was correlated with "A" ($r = .38, p < .05$) and "S" ($r = .40, p < .05$). Spatial Span was correlated with "A" ($r = .42, p < .05$).

Memory performance in PD individuals was compared to controls. Performance on LM II indicates that PD patients demonstrated significantly worse performance than Controls on delayed memory [$t(46.76) = -2.00, p < .05$].

Patterns of fluency performance for PD patients were examined. Individual item analysis on LF suggests that performance on semantic fluency items ($M = 14.17, SD = 5.81$) was better than letter fluency items (F: $M = 11.44,$

$SD = 5.87$; A: $M = 8.96$, $SD = 5.36$; S: $M = 11.92$, $SD = 6.34$). Analysis of letter fluency demonstrates better performance when presented a consonant stimuli and significantly poorer when presented the vowel.

Conclusions

Performance on letter fluency task may be a valid indicator of verbal WM and long and short term memory deficits for mildly impaired Parkinson's patients. Formal measures of verbal working memory were associated with semantic and letter fluency in the PD group, while only one formal measure of verbal working memory was associated with letter fluency in the Control group.

PD patients may show a potential priming advantage, which may facilitate later retrieval if they are given phonemic (letter) cues. Treatment may be aimed at assisting patients in setting up phonemic-based self-cues, which may aid their retrieval process. Significant others

can be advised to cue them when they are struggling to retrieve information. ■

Rose Mary Shaw is a fourth year clinical psychology student at the School of Professional Psychology, Wright State University. She will begin her internship this fall at the Cleveland VA with a joint research appointment at the Cleveland Clinic. Her primary research interests are cognition and memory. Specifically, she is studying the impact of Parkinson's disease on executive functioning and memory.

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Call for Posters for the OPA Annual Convention Poster Session

At
The Fawcett Center at The Ohio State University
November 7, 2003
Columbus, OH

The Ohio Psychological Association invites students conducting research on psychology-based topics to present poster summaries at its Annual Convention. This year's poster session will offer special recognition to the student who has the most exemplary poster. Judging will occur throughout Friday, November 7. The recipient of the 2003 "Poster Winner Award" will be announced during Friday's lunch at the 2003 Convention, and will be entitled to the following:

- Opportunity to highlight recipient's research in a 2004 *The Ohio Psychologist* article based on the poster
- One-year free membership to the Ohio Psychological Association
- Free attendance to the 2004 OPA Annual Convention (dates and location TBD)

The posters will be displayed from 9:00 am to 5:00 pm on Friday, November 7, 2003. It is required that you accompany your poster at breaks throughout the day. Meals are furnished by OPA.

Applicants will be informed of their entry acceptance at least two weeks prior to Convention. Submission of proposal signifies that you will present on Friday, November 7, 2003. Deadline for proposals is October 15, 2003. Visit www.ohpsych.org/Registration/PosterRegistration.htm to apply online or call the OPA office (800-783-1983) for guidelines.

POSTER WINNER

2003 SPRING INSTITUTE

Prayer, Religious Appraisals, Psychosocial Functioning, and Cardiac Arrhythmia in CHF Patients

By Ethan Benore, MA, Kelly McConnell, BA, and Robert Carels, PhD
Bowling Green State University

Introduction

In patients with congestive heart failure (CHF), cardiac arrhythmia occurs frequently and is a significant predictor of future cardiac events (Birgersdotter-Green, Rosenqvist, & Ryden, 1991; Deedwania, 1994). Research suggests that cardiac arrhythmia can be triggered by negative mood states and stressful events (Carels et al., in press; Kamarck & Jennings, 1991), suggesting that within-subject variability of arrhythmia in heart failure patients may be attributable to variations in psychological stress. Other research indicates that religious behaviors (e.g., prayer) are associated with diminished psychological stress, improved mood states, improved quality of life, and enhanced coping strategies in medical patients (Pargament, 1997). In addition, these behaviors are commonly utilized by medical patients (Koenig, McCullough, & Larson, 2001).

Religious beliefs and behaviors also predict morbidity and mortality rates in cardiac patients. Risk for myocardial infarction (MI) in an Israeli population was four to seven times greater in individuals identified as "secular" versus those identified as "religious" (Friedlander, Kark, & Stein, 1986). Rates of cardiac and all-cause mortality were lower in Coronary Artery Disease patients who reported prior attendance at religious schools, greater frequency of attendance at synagogues, and self-identification as "orthodox" believers (Goldbourt, Yaari, & Medalie, 1993). However, to our knowledge, no studies have examined the relationship between specific religious behaviors and cardiac arrhythmia.

Based on previous research on the relationship between religious behaviors and cardiac health, we hypothesized that frequent engagement in religious behaviors, including more positive religious appraisals and less negative religious appraisals, would be associated with enhanced psychosocial and cardiac functioning. In addition, we explored whether disease severity, measured by resting left ventricular ejection fraction (LVEF) moderated the relationship between religious behaviors and cardiac arrhythmia.

Method

Patients

Forty-six patients (28 men, 18 women) aged 35 to 85 ($M = 66.1$, $SD = 11.7$ years) with documented heart failure were recruited from the Heart Failure Clinic at a tertiary-care hospital in Northwest Ohio. Patients were

included in the study if they were 18 years or older and had a Left Ventricular Ejection Fraction (LVEF) of less than 50%.

Assessment of Religious Behaviors and Quality of Life

Data was collected at three time points. First, participants completed a survey assessing religious behaviors and psychosocial functioning (e.g., anxiety, depression, perceived social support, and CHF well-being). Second, participants completed a two-week daily diary in which they rated the degree to which they used positive religious appraisals (e.g., "worked together with God as partners") and negative religious appraisals (e.g., "wondered whether God had abandoned me") to cope with their heart failure. Participants also rated their psychosocial functioning (positive and negative emotions, depression, positive and negative perceived social support, somatic complaints) and use of restorative behaviors (distraction coping, following doctors' advice, coping with symptoms, and acceptance coping) in the two-week diary. Third, participants were placed on a 24-hour ECG monitoring device, which measured premature ventricular contractions (PVCs), repetitive PVCs (greater than 2 consecutive PVCs), and ventricular tachycardia. Ventricular tachycardia was defined as \geq three consecutive ventricular beats at a rate of \geq 100 beats per minute.

Results

To explore the association between religious behaviors and cardiac health, religious variables were correlated with psychosocial variables and cardiac arrhythmia. Consistent with our hypothesis, religious behaviors were significantly correlated with greater positive emotions, perceived social support, and restorative behaviors, and with less anxiety, depression, and negative emotions (all $ps < .05$). No significant relationship was identified between religious behaviors and CHF well-being. Also, a positive relationship was identified between some religious behaviors and somatic complaints. In regards to cardiac arrhythmia, religious behaviors were significantly associated with lower rates of PVCs, repetitive PVCs, and tachycardia (all $ps < .05$).

Further analyses examined the association between religious behaviors and cardiac arrhythmia, using separate linear regression models that controlled for age, gender, use of antiarrhythmic medications, and LVEF. Results demonstrated that greater frequency of prayer significantly predicted fewer total PVCs ($R^2 = .216$, $B =$

-.361, $p < .05$) and repetitive PVCs ($R^2 = .238$, $B = -.411$, $p < .01$).

In addition, we wanted to explore whether the relationship between religious behaviors and cardiac arrhythmia was moderated by disease severity (i.e., LVEF). In separate linear regression models, the association between cardiac arrhythmia and each religious behavior was examined, controlling for age, gender, use of antiarrhythmic medications, and LVEF. In this model, the interaction of positive religious coping and ejection fraction was significantly associated with tachycardia ($R^2 = .455$, $B = 1.087$, $p \leq .05$).

For individuals with lower ejection fraction (i.e., greater cardiac dysfunction), positive religious coping was more strongly associated with less tachycardia (see Figure 1).

Discussion

While a vague association between religion and cardiac health has been demonstrated in the literature, there has been little effort to identify a functional relationship between religious and cardiac health variables. This study examined the hypothesis that religious behaviors were associated with psychosocial functioning and cardiac arrhythmia in CHF patients. Results demonstrated that religious behaviors were significantly associated with a number of important psychosocial health variables and that religious behaviors predicted rates of cardiac arrhythmia in 24-hr ECG monitoring. Specifically, more religiously active individuals reported greater psychosocial functioning and experienced less cardiac arrhythmia. Further, the relationship between religious behaviors (e.g., positive religious appraisals) and arrhythmia was moderated by disease severity (LVEF). Specifically, as cardiac dysfunction increased, positive religious appraisals were more strongly associated with lower tachycardia.

These results support a growing body of research on the association between religion and health (Koenig, McCullough, & Larson, 2001). It is plausible that religious behaviors serve a stress-buffering role in patients, and this functional relationship may influence cardiac arrhythmia via adrenergic pathways (see Kamarck & Jennings, 1991). The strength of this study was its proximal measurement of religious behaviors and cardiac functioning. However, this study was limited by a modest sample size and by the non-concurrent assessment of religious behaviors and cardiac functioning. Replication is clearly warranted. Future

research should examine concurrent religious behaviors and acute cardiac functioning using ecological momentary assessment (EMA) techniques. In addition prospective research could determine whether cardiac arrhythmia mediates the reported relationship between religion and cardiac morbidity and mortality. ■

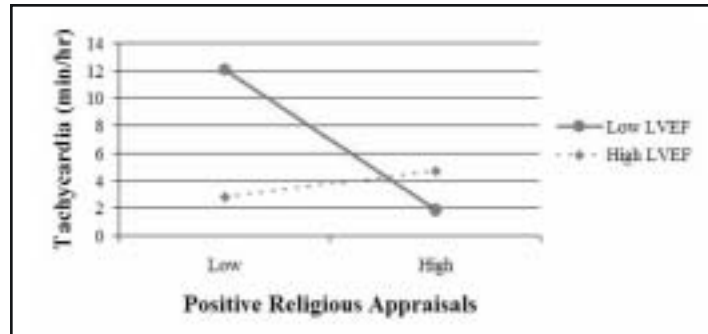


Figure 1. The association between tachycardia and positive religious appraisals for high and low LVEF groups.

About the Authors

Ethan Benore is a doctoral candidate at Bowling Green State University. He is currently completing his internship assignment in pediatric psychology at The Kennedy Krieger Institute, Johns Hopkins School of Medicine. His primary research interest is spirituality and children's health.

Kelly McConnell is a first-year clinical psychology student at Bowling Green State University in Bowling Green, Ohio. Her primary research interest is the psychology of religion. Specifically, she is studying the impact of confession and forgiveness on psychological well-being.

Dr. Robert Carels received his PhD in Clinical Psychology from the University of North Carolina at Chapel Hill and completed a post-doctoral fellowship at Duke University Medical Center in Cardiovascular Behavioral Medicine. He is currently an Assistant Professor in the Psychology Department at Bowling Green State University. His research interests are heart disease, weight loss and physical activity.

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Continuing Education Credit

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QUESTIONS

The Wilderness of Online Therapy

- The American Psychological Association has developed ethical and professional guidelines for conducting online therapy.

True
False
- Research about online therapy has shown it to be less effective than face-to-face therapy.

True
False
- Which two of the following are not identified by the authors as common concerns raised by different ethical guidelines or codes regarding online therapy?

a. confidentiality
b. therapist-client communication
c. advertising
d. fees

- Ragusa and VanderCreek use the term "wilderness" to convey the image of online therapy being a new and uncharted form of practice.

True
False
- Which of the issues about online therapy listed below is not mentioned by the authors?

a. does it work
b. how much training should practitioners have
c. what are the research findings
d. therapists should know the client's location

If A Picture Is Worth A Thousand Words, What Is A Virtual World Worth?

- Virtual reality technology used in therapy settings is NOT similar to that used in military training and the entertainment industry.

True
False
- A HMD is a

a. handheld minimal display
b. head mounted display
c. health management document
d. helmet monitoring display
- Which is an advantage to using virtual reality identified by the authors?

a. it is less expensive than other forms of therapy over time
b. it does not require the client insight
c. it allows the tailoring of the treatment environment to the client
d. more than one client can be treated at the same time
- Which of the following is NOT one of the application areas of virtual reality technology in mental health?

a. therapeutic applications
b. research applications
c. psycho-educational applications
d. training therapists applications
- In using virtual reality simulations with clients for treatment, clients are generally exposed to traumatic events in a realistic simulation.

True
False

Continuing Education Credit

Applying Handheld Computers to the Practice of Psychology

- A major use of PDAs is to access reference information
True
False
- Which of the following is not a common PDA function?
 - schedule appointments
 - read books
 - wordprocessing
 - fax messages to other PDAs
 - play games
- A PDA can be connected to the Internet and automatically download information into the PDA from designated Internet sites
True
False
- There are many mental health or psychological software applications available for use on handheld computers
True
False
- Which is an example of an Internet site that provides access to journal abstracts for downloading to a PDA?
 - Abstracts.com
 - JournalAbstracts
 - JournalToGo
 - HighTop

Network Security

- Network security of practice data is important in order to protect it from
 - accidental damage or loss
 - purposeful attack
 - unauthorized disclosure
 - a and b
 - a, b, and c
- Which of the following does the author advise readers to use for computer security?
 - an anti-virus software program
 - a software firewall
 - a hardware firewall router
 - a, b, and c
 - a and c

- Hardware firewalls often cause serious problems with the use of billing software
True
False
- Computer viruses usually are not easily transmitted to other computers in the same network
True
False
- What is the most basic procedure in a security plan?
 - making sure that everyone knows what the plan is
 - backing up all data files
 - having a power backup for power outages
 - limiting who uses all computers

Web Sites for Psychologists

- Which web site does the author rate as the Best Web Site for Psychologists?
 - Drwallen.com
 - Psychologist.com
 - APAOnline
 - Psychology Virtual Library
 - Drshrink.com
- The best feature of Behavior Online is it's
 - well organized table of contents
 - threaded discussions of clinical issues
 - numerous online full-text articles
 - analyses of innovative techniques
- Bartleby.com is considered by the author the best site on the Internet for writers
True
False
- Which Internet site says that it is "the largest medical reference site"?
 - MedWeb.com
 - PsyCentral.com
 - Healthgate.com
 - MedicalMatrix.org
 - Medbioworld.com
- The National Psychologist does not have an archive of past articles
True
False

OPA CALENDAR OF EVENTS 2003-2004

AUGUST - 2003

OPA Fiscal Year ends August 31

SEPTEMBER - 2003

OPAGS/Student Summit: September 13 - 1:30pm

Executive Committee Meeting: September 5

Board Retreat: September 5 - 6

State Board of Psychology Meeting: September 12

OCTOBER - 2003

Executive Committee Meeting: October 3

Board of Directors Meeting: October 4

NOVEMBER - 2003

Annual Convention: November 5, 6, and 7 at The Fawcett Center, The Ohio State University

Foundation for Psychology in Ohio Annual Meeting: November 4

Executive Committee Meeting: November 14

DECEMBER - 2003

Executive Committee Meeting: December 12

JANUARY - 2004

Executive Committee Meeting: January 9

Board of Directors Meeting: January 10

FEBRUARY - 2004

Nominations for officers received by February 15

Executive Committee Meeting: February 6

Advocacy Day: February 24

MARCH - 2004

APA/State Leadership Conference: March 13-16, 2004, Washington, DC

APRIL - 2004

Finance Committee Budget Meeting

Executive Committee Meeting: April 2

Board of Directors Meeting: April 3

MAY - 2004

Executive Committee Budget Retreat: May 7

JUNE - 2004

Executive Committee Meeting: June 4

Board of Directors Meeting: June 5

JULY - 2004

Executive Committee Meeting: July 16 (if needed)

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2003 APA Division Election Results

The Ohio Psychological Association is proud of the outstanding psychologists licensed in Ohio who were elected to serve as APA Division leaders. Congratulations to all!

Division 18 - Psychologists in Public Service
President-elect: Robert W. Goldberg, PhD *

Division 29 - Psychotherapy
President-elect: Leon D. VandeCreek, PhD *

Division 33 - Mental Retardation and Developmental Disabilities
Council Representative: James A. Mulick, PhD

Division 40 - Clinical Neuropsychology
Secretary: Paula K. Shear, PhD
Treasurer: Jill S. Fischer, PhD

Division 43 - Family Psychology
V. P. for Practice: James E. Dobbins, PhD

Division 49 - Group Psychology and Group Psychotherapy
Member-at-Large: Lynn S. Rapin, PhD **

Division 54 - Society of Pediatric Psychology
President-elect: Dennis D. Drotar, PhD

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** OPA Board of Directors

SAVE THE DATES!

OPA Annual Convention

**“Health Psychology:
The Integration
of the Mind and the Body”**

**Keynote Address from
APA Chief Executive Officer
Norman Anderson, PhD
Thursday, November 6 - 9:00 a.m.**

November 5 - 7, 2003

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