Expanding Psychology:
Current Challenges – Future Opportunities
Eleven of the best minds in America work for you!

No one knows you better than our trustees. Protection for psychologists, by psychologists.

Professional Liability
Student Liability
Researcher/Academician
Professional Liability
Life
Income Protection
Office Overhead
Hospital Indemnity
Auto and Homeowner’s
Retirement Plan Services
Long Term Care Insurance

1-800-477-1200 • www.apait.org
# Table of Contents

**Ohio Psychological Association Membership**  
4

**From the Editor …**  
By Kenneth P. Drude, PhD  
5

**Psychoanalysis: Does Old Wine Taste Better in a New Bottle?**  
By Karl W. Stukenberg, PhD  
6

**Expanding Psychology Using a Wellness Approach**  
By Julie Brennan MA, RD, LD  
8

**Opportunities for Psychology in the Ohio Department of Rehabilitation and Correction**  
By Andrew Lee Hinkle, PhD  
11

**OPA Homestydy Offerings**  
13

**Issues in the Treatment of Diverse Client Population**  
By Mia Weinberger Biran, PhD  
14

**Global Psychology in the 21st Century:**  
Sharing Data on Early Behavioral Development via the World Wide Web  
By Jeanette Reuter, PhD, Joneen Schuster, MA, Jessica Burke, BA, and Timothy Gallagher, PhD  
17

**Call for Posters for the OPA Convention Poster Session**  
20

**Predictors of Nonadherence to Antiretroviral Therapies in HIV-Infected Older Adults**  
By Andrea H. Waltje, MS, Timothy G. Heckman, PhD, Julie A. Suhr, PhD  
21

**OPA Calendar of Events**  
25

**State Science Day 2004 and Beyond**  
By Jeff Sherrill, PhD, and Denise Brenner, BA  
26

**Obituaries**  
27

**Classified Ads**  
30

**Ohio Psychologists Elected to APA Division Leadership**  
31

**Benefits and Services of OPA Membership**  
31

---

**Ohio Psychological Association**  
400 East Town Street, Suite G20  
Columbus, OH 43215  
614-224-0034  
800-783-1983  
614-224-2059 fax

---

Michael O. Ranney, MPA, Executive Director  
Ellen Mrukowski, BA, Managing Editor  
Kenneth Drude, PhD, Editor

Articles in *The Ohio Psychologist* represent the opinions of the writers and do not necessarily represent the opinion of governance, members or the staff of OPA. Acceptance of advertising does not imply endorsement by OPA.
Ohio Psychological Association

Board of Directors

Executive Committee
President - James J. Brush, PhD
Past President -
Alice H. Randolph, EdD
President-Elect -
Gerald J. Strauss, PhD
Finance Officer -
Vanessa K. Jensen, PsyD
APA Representative -
David L. Hayes, PhD, ABPP

Standing Committee Directors & Regional Representatives
Beth Doherty
Kenneth P. Drude, PhD
Lani J. Eberlein, PsyD
Jane L. Eckert, PhD
Kathleen D. Glaus, PhD
Carol L. Johnson, PhD
Dorothy S. Konick, PhD
Daniel J. Kuna, PhD
Kathleen A. Mack, PsyD
Beth T. McCready, PhD
Cathy L. McDaniels Wilson, PhD
Richard E. Beckman, PhD
Richard C. Rynearson, PhD
Randall J. Snyder, PhD
Craig S. Travis, PhD

Functional Committee Directors/Ad Hoc/Task Forces/Liaisons/Affiliates
Jim R. Broyles, PhD
Howard R. Fradkin, PhD
Terry R. Imar, MA
Patricia James, PhD
Kurt W. Jensen, PsyD
Harvey Kayne, PhD
Frank H. Kobe, PhD
Lynn S. Rapin, PhD
Helen D. Rodebaugh, PhD
Michelle Rone-DePolo, PsyD
Sandra L. Shullman, PhD
Frances Strickland, PhD
Mary Ann Teitelbaum, PhD

President’s Club Members
2003-2004
Howard R. Fradkin, PhD
David L. Hayes, PhD, ABPP
Vanessa K. Jensen, PsyD
Alice H. Randolph, EdD
Helen D. Rodebaugh, PhD
Richard C. Rynearson, PhD
Sandra L. Shullman, PhD
Leon D. Vandecreek, PhD
Jane Z. Woodrow, PhD

Sustaining Members
2003-2004
Anthony M. Alfano, PhD
Kevin D. Arnold, PhD, ABPP
Cheryl M. Beach, PhD
Kathryn L. Boniface, EdD
James J. Brush, PhD
Robert F. Dallara, Jr., PhD
Richard C. Davis, PhD
Fatma G. DeEsKinazi, PhD
Kathleen A. DeLuca, PhD
David S. Duane, PhD
Kenneth P. Drude, PhD
Nicolaas P. Dubbeling, PhD
Erhard O. Eimer, PhD
Barbara L. Fordyce, PhD
Sandra W. Foster, PhD
Carol S. Gee, PhD
Charles E. Gerlach, PhD
Wayne J. Graves, PhD
Roger A. Hall, PhD
David T. Hellkamp, PhD
Terry R. Imar, MA
Patricia B. James, PhD
Thomas C. Kalin, PhD
Harvey Kayne, PhD
Larry R. Kilian, PhD
Dennis W. Kogut, PhD
Phyllis R. Kuehn-Walters, PhD
Carolyn Sue Morgan, EdD

The Foundation for Psychology in Ohio Donors
(Semester 1, 2003 – present)
Henry Saeman Memorial Fund
Betty Kjellberg

2004 Political Action Committee Donors

Sustaining Members
2003-2004
Gary Kelley, PhD
Gerald Strauss, PhD
Kathy Myszak Scholarship Fund
Ohio Women in Psychology
Science Day Contributions
Akon Area Professional Psychologists
Central Ohio Psychological Association
Toledo Area Assn of Prof. Psych

2004 Political Action Committee Donors
(January 2004 – present)
Paul Becker, PhD
Alon Boerger, PhD
Gregory Briggs, PhD
Danette Conklin, MEd
Geriann Dillender, PsyD
Kenneth Drude, PhD
Michael Dwyer, PhD
Griffith Dye, PhD
Omar Dye, PhD
Howard Fradkin, PhD
Jerome Gabis, PsyD
Carol Gee, PhD
Irene B. Giessl, EdD
Richard Grant, PhD
Nathan Griffith, MA
David Hayes, PhD
Jane Hellwig, PhD
Irma Johnston, PsyD
Leslie Kern, PhD
Nancy Kiracofe, PsyD
Ann Simon Koppelman, PsyD
Ming Lai, PhD
Michael Leach, PhD
John Lowenfeld, PhD
Kenneth Manges, PhD
Donna McClure, PhD
Beth McCready, PhD
Dianna Miller, PsyD
Carolyn Sue Morgan, EdD
Stanley Palumbo, PhD
Marian Patterson, PhD
Diane Peters, PsyD
Helen Rodebaugh, PhD
Richard Sexton, PhD
Loren Shapiro, PhD
Carole P. Smith, PhD
Paule Steinchen Asch, PhD
Frances Strickland, PhD
Thomas Swales, PhD
Karen Wasserman, PsyD
Patrick White, PhD
Lynda Williams Berohan, MA
Jennifer Yarboh, PhD

Staff
Michael O. Ranney, MPA, Executive Director
Bobbie L. Celeste, PhD, Director of Professional Affairs
Ellen Mrukowsky, BA, Director of Communications and Education
Denise Bremner, BA, Director of Operations and Member Services
Beth Wherley, BA, Director of Mandatory Continuing Education

The Ohio Psychologist 2003-2004
From the Editor ...

The theme of this Ohio Psychologist, “Expanding Psychology: Current challenges – Future Opportunities,” is the same as OPA’s 2004 Annual Convention. At the beginning of a new century, it may be helpful to pause for a moment and to consider where we have been as a profession and where we seem to be going. Psychology is a very broad profession, confronted with numerous challenges and changes that some see as threats, others as opportunities. The articles in this issue highlight a small sample of the many diverse and creative responses being made to those opportunities.

Treatment issues in working with clients from different cultures are emphasized from a personal perspective in an article by Mia Weinberger Biran. Karl Stukenberg, an advocate for psychoanalysis, points out that psychoanalysis remains a valuable treatment approach and that training for psychologists is available. The benefits of using an outpatient wellness group model and outlining what is included in such groups are described by Julie Brennan. In another article, Jeanette Reuter and others articulate how psychologists are sharing valuable early child development data collected from all over the world. And, Andrew Lee Hinkle gives some background to changes in the Ohio Department of Rehabilitation and Corrections, as well as its current employment opportunities for psychologists.

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

Kenneth P. 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. Dr. Drude is currently the OPA Communications and Technology Chair, is a Past President and a Past Finance Officer.
In 1939, the American Psychoanalytic Association (APsA) created a rule that only medical analysts could be trained as psychoanalysts by member institutions (Wallerstein, 1998). Though a few psychologists received analytic training at APsA institutes in the ensuing decades, and, especially more recently, psychologists and others started non-APsA accredited institutes, psychoanalysis essentially became the exclusive purview of psychiatry. In 1989, a federal class action lawsuit brought by four psychologists against the APsA on the grounds of “restraint of trade” was settled, and APsA institutes began admitting psychologists and social workers if they met “high levels of competence.” In the meantime, independent institutes continued to offer training to psychologists and social workers as well as physicians.

The definition of psychoanalysis, and how psychoanalysis differs from psychoanalytic psychotherapy, has been controversial and continues to stir debate (e.g., Rangell, 2004). The parameters that describe the differences between analysis proper and psychoanalytic therapy include the use of the couch, frequency of meeting, and a focus in analysis on the use of interpretation to the exclusion of more supportive interventions. Within APsA accredited institutes, psychoanalytic training consists of three elements: classroom training— which consists of either four or five years of reading and discussion; supervision of psychoanalytic cases; and a personal analysis. Completing the training is a seven to ten year undertaking and is a considerable financial, temporal and emotional investment.

The rationale for this considerable additional training investment lies in the need for the practitioner to better understand him or herself and her or his functioning as he or she engages in a relationship whose goal is to help the client experience and resolve the issues that bring them into treatment within the treatment relationship—in the here and now relationship between the analyst and analysand. This creates intense demands on the practitioner to both foster and tolerate a relationship that necessarily involves the patient distorting her or his perception of the analyst, and learning to recognize and correct the distortions that have been made. Fortunately, both human nature and the rich psychoanalytic tradition provide fertile soil for engaging in intimate and prolonged work that can lead to a significant expansion in a patient’s capacity to more fully inhabit and to better make use of themselves. The rich psychoanalytic tradition also provides ample material to support an in-depth course of study that actually only begins during the training and that is likely to continue across the span of the analyst’s life, especially as the field continues to develop and mature.

It is clear that psychoanalysis needs psychologists. In an era of empirically validated treatments, psychologists bring knowledge of research design and statistical testing techniques to a field that has, with a few notable exceptions (e.g., Luborsky, 1984; Wallerstein, 1986; Weiss, Sampson, & the Mt. Zion Psychotherapy Research Group, 1986) for far too long relied almost exclusively on case reports as the empirical basis for the science. Also, as the financial luster of psychoanalysis has gone the way of traditional indemnity insurance, and as the preeminence of the psychoanalytic perspective remains only in New Yorker cartoons, excellent practitioners are much less frequently drawn to the field by those particular siren calls (McWilliams, 2004). Instead, practitioners are now drawn by a deeply held curiosity about the human condition and a desire for a certain kind of intimacy that is not offered by more time limited and theoretically circumscribed perspectives. Finally, as psychoanalysts have come from more diverse backgrounds, the emergence of new theoretical positions that emphasize the relational aspects of the healing relationship have emerged (e.g., Hoffman, 1998; Mitchell, 1988; Ogden, 1997; Stolorow & Atwood, 1997; Stolorow, Atwood, & Branch, 1987), and the continued openness of the field will (hopefully) lead to new and productive cross fertilization.

The pragmatics of practicing psychoanalysis in the current age and under the current guidelines are daunting. Psychoanalytic clients should be, even in the age of the “widening scope” of analysis (Jacobs & Rothstein, 1990; Stone, 1954), psychologically healthy enough to withstand the rigors of an intense relationship
in which they are the focus of another’s continuous and relatively silent observation. At the same time, they should have enough emotional discomfort that they are motivated to undertake an intense, intrusive and costly treatment. With increasing frequency, psychoanalysts have converted clients from a conventional therapy into analysis after the benefits of therapy are apparent to the client, and when a hunger for more intense work surfaces. Within communities, there also exist referral networks where colleagues, especially colleagues who are aware of the advantages of an analytic treatment but are unable to offer one themselves, can recognize and refer appropriate cases. Nonetheless, psychoanalysis is still a “niche” treatment with a relatively small clientele that is appropriate to and interested in psychoanalysis. On the other hand, because of the frequency of meeting (4 or 5 times per week), a clinician’s case load becomes full with far fewer clients. Also, the intensity and focus of the work with a few clients can hone our ability to listen for deeper themes among the clients with whom we work less frequently. At the same time, it can help sensitize us to just how difficult it is to take ourselves as an object, and can help therapists be more sensitive in the precious little time they have with some clients, a shift that may help those clients feel more fully heard.

However psychoanalysis is defined, it is a more intense way of engaging with our clients psychologically. McWilliams (2004) describes individuals who are drawn to psychoanalytic work as interested in the arts and theater, dance and other powerful repositories of affective expression. Although psychoanalysis is in some ways the grandfather of all the psychotherapies, it is also, in many ways, a new frontier for psychology and for psychologists. It is a field to which we have contributed a great deal over time, but also one in which, until relatively recently, full participation was not a viable option. Thus it is a “new” opportunity for us. With this, we have brought a new energy and new perspectives on the clients with whom we work. A sea change is occurring within the American Psychoanalytic Association as the membership transitions from exclusively physicians to a multidisciplinary mix of individuals with a variety of perspectives from which to inform their psychoanalytic experience. As this occurs, an exciting opportunity arises to help usher in the second century of psychoanalytic practice in the United States.

In the state of Ohio, there are two ApsA sanctioned institutes, one in Cleveland and one in Cincinnati. The institute in Cincinnati, where I am a candidate, is actively seeking candidates both in Cincinnati and within commuting distance – which has included candidates from as far away as Columbus. Commuting adds additional stress to the training, but has a long history in Cincinnati as the founders of this institute commuted to Chicago for their own training. Openness to the use of the telephone for supervision and analytic hours has helped decrease some of the stress of commuting.

About the Author

Karl Stukenberg’s graduate training was at the Ohio State University. After his internship at Baylor College of Medicine in Houston, Texas, he completed a three year post doctoral training program at the Menninger Clinic, which was then in Topeka, Kansas. He is currently an Associate Professor and the Director of the Psychological Services Center at Xavier University, as well as an advanced candidate at the Cincinnati Psychoanalytic Institute. He is a former OPA Board member who served on the Ethics Committee. He is married to Chris Mayhall, a psychologist, and they have a five year old son John.

References


Expanding Psychology Using a Wellness Approach

By Julie Brennan MA, RD, LD
Doctoral Student in Counseling Psychology
The Ohio State University

Introduction

In May 2001, the American Psychological Association (APA) formally recognized the importance of psychology in health by adding the word health to its mission statement. Since this time, psychologists have had more opportunities to integrate into various health care settings addressing issues, including the prevention of mental illness, promoting wellness issues, and teaching pain management strategies (Johnson, 2003). This article focuses on the topic of wellness and how psychologists might expand their practice and possibly work with other health professionals to promote patients’ psychological and physical health through a wellness group.

It is well known that healthy eating, moderate exercise, regular stress management, social interaction, and adequate sleep all positively influence one’s psychological and physical health. In fact, behavioral choices (e.g. unhealthy eating, lack of exercise, excess alcohol, and tobacco use) are the leading contributors of morbidity and mortality within the United States (American Dietetic Association, 2002; Kersting, 2003). Based on this statistic, psychologists have an opportunity and an obligation to help individuals begin the process of making better lifestyle choices. Though most psychologists address these issues in individual and group therapy, wellness issues are rarely the focus of therapy. The rest of this article presents a group format that allows psychologists to focus on wellness topics. The purpose of this newly created wellness group is to help patients progress in the process of developing healthier life styles while learning and practicing better coping skills.

Currently, this wellness group is being conducted in an outpatient clinic within a Veterans Administration (VA) Hospital. The group consists of males and females that range in age from 35-81 (with a median age of 56) and have diagnoses including depression, anxiety, post-traumatic stress disorder and personality disorders.

This group format, however, would fit well in a variety of settings including a college counseling center, a community mental health center, a primary care setting, a large outpatient clinic or a workplace. In each of these settings, this group could be used as an adjunct to therapy, as a stand-alone prevention or treatment program, and as a relapse prevention group.

Theoretical Underpinnings of the Group

The development of the group and its format has been guided by principles from motivational interviewing (Miller & Rollnick, 2002) and the Transtheoretical Theory (Prochaska, Norcross, & DiClemente, 1994). Five general principles of motivational interviewing that are followed in facilitating the group are expressing empathy, developing discrepancy, avoiding argumentation, rolling with resistance, and supporting self-efficacy. To promote self-efficacy (as it has been shown to be related to motivation and action-taking; Senecal, Nouwen, & White, 2000), the group is largely experiential. Individuals are encouraged to practice the skills taught so that their self-efficacy is higher and not a deterrent in the attempt to change. Additionally, group members can increase their self-efficacy by vicariously learning through other members.

Within the philosophy of the stages of change, change is seen as a process, and each individual is encouraged to move up at least one level in their current stage of change. Each group session begins with a discussion regarding the possible benefits and obstacles of the behavior change, essentially creating a decision analysis (pros vs. cons of changing a certain behavior).

Model of the Wellness Group

The Wellness Group is a psychoeducational group that focuses on teaching skills including relaxation, healthy eating, exercise (increasing activity), mindfulness, accessing community resources, time management, and sleep hygiene along with encouraging behavior change. The group meets for 75 minutes once a week. Before addressing the new topic for the group, the facilitator checks in with the members regarding their progress toward their goals (whether they are starting to think about changing, making a plan, acting on the plan, or maintaining the change).

Topics for a Wellness Group

Introduction to the group and stages of change
This session introduces the group format and topics. Each member of the group introduces him/herself to promote a more cohesive environment. The rationale for the group is explained and the idea that change is a process is emphasized. The stages of change are reviewed (Prochaska, Norcross, & DiClemente, 1994). The facilitators reinforce that individuals may be at different stages for different behaviors and that an individual's goal might be to advance to the next stage of change. Participants fill out a “stages of change” questionnaire that determines what stage of change they are in for each particular behavior set that the group will address.

Relaxation

This session begins with an introduction to the benefits of relaxation (Sultanoff, & Zalaquett, 2000). Diaphragmatic breathing is introduced, demonstrated, and practiced. The facilitator processes the experience of deep breathing with the group members and provides recommendations for practice. The facilitator then leads the group in a 20-minute relaxation exercise that includes progressive muscle relaxation, imagery, and autogenic phrases. The group ends by processing the relaxation exercise and by providing each participant with a relaxation tape.

Mindfulness

This session begins with an introduction to mindfulness and its benefits (Brown & Ryan, 2003). The facilitator leads the group in a meditation, a walking meditation, and a “mindfulness while eating” exercise. The importance of practicing mindfulness is reinforced, and each member is provided a handout describing exercises in mindfulness that can be practiced at home.

Nutrition (recommended to collaborate with a dietitian on this session)

This session begins with an introduction of the importance of nutrition in the prevention of disease (American Dietetic Association, 2002; Center for Disease Control, 2004). The facilitator covers the basics of good nutrition including the concepts of variety, moderation, and balance in one’s diet. The importance of drinking water is also covered. Each member is encouraged to make a plan to engage in one small behavioral change, if ready (e.g. cut portions by ?, adding one fruit and vegetable to each meal while decreasing portions of grain and meat; drinking more water).

Exercise

The session begins by discussing the benefits of aerobic and strength training exercise (Byrne & Byrne, 1993; Center for Disease Control, 2004; International Society of Sport Psychology, 1992; Plante, 1996). All group members are reminded that they should receive medical clearance before starting any new exercise. The facilitator leads a discussion about the obstacles to exercising. The facilitator then leads the group in different stretching exercises. Group members are encouraged to set small goals, if ready (e.g. walk around the block).

Sleep hygiene

The session begins by discussing the importance of sleep for general health and preventing exacerbation of physical and psychiatric disorders (Smith & Neubauer, 2003). The facilitator leads a discussion on general sleep hygiene facts and reviews basic treatment of insomnia (Smith & Neubauer, 2003). Additionally, a discussion of oversleeping and its relation to depression is addressed.

Accessing community resources

This session begins by discussing the importance of staying connected with people and the community. The relationship between social contact, perception of social support, depression and alcohol use is discussed (Peirce, Frone, Russell, Cooper, & Mudar, 2000). Members share their own obstacles regarding staying connecting with others. Other member share community resources where they have met people and become involved in clubs, hobbies or sports. Members are encouraged to explore one community resource that they are interested in, if they are ready.

Assertiveness

This session introduces the three ways individuals can communicate: passive, assertive, and aggressive. Examples along with the benefits and negative consequences of each pattern of communication are discussed. Members of the group share different situations in which it is difficult to be assertive. These situations are discussed, assertive ways to communicate are shared, and successful assertive conversations are role-played.

Minor Addictions

This session begins by heightening the members’ awareness regarding the risks of dependencies that they may have including caffeine (Strain, Mumford, Silverman, & Griffiths, 1994) and nicotine (American Dietetics Association, 2002). Many members may have already recovered from other addictions including gambling, alcohol, and/or other drugs. Members support and encourage each other to make goals to increase to the next stage of change.
regarding their minor addiction.

Cognitive distortions/Negative thinking
This session begins with a general discussion regarding the relationship between emotions, thoughts and behaviors. The facilitator introduces the concept of cognitive distortions and provides examples of cognitive distortions (a handout of cognitive distortions is passed out). The consequences of not disrupting cognitive distortions are discussed. Members are encouraged to share experiences in which they have experienced cognitive distortions and are encouraged to challenge their cognitive distortion(s).

For More Information
This wellness group was created by Dr. Lawrence M. Perlman, a psychologist in a Veterans Administration (VA) Hospital and two psychology graduate students, Julie Brennan and Jennifer Mainka. The effectiveness of this group within the VA population is being piloted and data was be presented at a poster presentation at the American Psychological Association Conference in Hawaii. If you would like a copy of this presentation, have any questions or comments, or would like more information about starting your own wellness group, please feel free to e-mail the at brennan.76@osu.edu.

About the Author
Julie Brennan is currently a fifth-year student at The Ohio State University in the area of Counseling Psychology. She serves as the Ohio Psychological Association of Graduate Students (OPAGS) Diversity Chair and has previously been the OPAGS Continuing Education Chair. Julie awaits her pre-doctoral internship at the Medical College of Ohio that will begin this September. She also has a Bachelor of Sciences degree in nutrition and is a licensed dietitian. Julie’s major area of research is body image and the prevention of eating disorders.

References

Opportunities for Psychology in the Ohio Department of Rehabilitation and Correction

By Andrew Lee Hinkle, PhD

Background

With the development and application of effective anti-psychotics during the 1950s, the stage was set for the Community Mental Health Act of 1962, which established the foundation for an entirely new paradigm for the delivery of mental health services in the United States. A key component of this innovative “bold new frontier” was a strong emphasis on outpatient services, along with emergency services, day care, consultation and education. A special focus of this new legislation was to reduce the prolonged — sometimes life-long — hospitalization of patients in centralized, old, outdated, oppressive institutions, many dating back to Pre-Civil War construction.

This strategy was largely successful, as federally seeded grants established community mental health services all over the United States. A corollary was the downsizing, consolidation and eventual closing and demolition of numerous facilities for the housing of mentally retarded and psychiatric patients around the country. In 1970, there were approximately 21,000 patients in Ohio Department of Mental Health facilities throughout the state. By 2000, this number had diminished to 1,100 residents in nine locations for the entire State Of Ohio (Wilkinson, 1997).

While the majority of these previously institutional patients were reintegrated into the community by the 1970s and 1980s, it was clear that some of them had fallen through the cracks and had missed the safety nets. Many of these individuals became what society designates as the street people or homeless and were living in cardboard boxes under bridges. To cope, many of them turned to the use of illegal “street” drugs to self medicate and to survive. Many committed criminal acts. In both instances, a good number were arrested and incarcerated for felony violations. Often this became a continuous cycle, with a gradual increase of more incarcerated inmates having significant mental health issues. While some mental health services were routinely available to prison inmates, the increasing number of needy inmates began to overwhelm the available resources.

Mental Health in Prisons

In 2000, the Department of Justice (DOJ) released a national landmark study confirming the very trend that had been observed in Ohio. According to the DOJ, 15-20% of all incarcerated prisoners in the United States qualified as having a major psychiatric diagnosis (Ditton, 2000). In August 2001 there were 45,693 incarcerated prisoners in Ohio, of which 7,435 were on the mental health caseload (Gillespie, 2001). Complaining about this deteriorating situation, an inmate by the name of Dunn successfully petitioned the federal government to order the State of Ohio to provide adequate mental health services. In 1995, the State of Ohio, conceding the need for improvements, joined with the federal government in the Dunn Consent Decree (Wilkinson, 1995). A significant sum was spent to remedy the situation and the State Department of Rehabilitation and Corrections (ODRC) created positions for about 500 mental health professionals, including approximately 75 psychologists and 75 psychology assistants — making it the largest single employer of psychological staff in Ohio. The Dunn Consent Decree was lifted in 2000, crediting ODRC with having achieved a model mental health delivery system in the prisons. “As a result, the Ohio system is known to be one of the premier correction mental health systems in the country.” (Wilkinson, 2000)

Since 2000, ODRC has maintained about the same percentage of mentally ill inmates and services to them, although the overall prison census has dropped by about 5,000 inmates. Currently, the ODRC employees 65 licensed psychologists and has about 10 vacancies. The duties of these positions are similar to the standard provision of mental health services in traditional mental health settings. These tasks include screening, evaluations, testing, emergency intervention, case management, psycho-educational groups and group therapy. Also included are weekly treatment teams with a multi-disciplinary team of psychiatrists, social workers, and psychiatric nurses. Most services are delivered in the traditional outpatient method, though there are Residential Treatment Centers (RTUs) at some prisons, which are multi-level inpatient treatment facilities. The entire mental health delivery system was based on the community mental health model with outpatient services...
affiliated with inpatient services in a designated geographical area.

Other Opportunities for Psychology

In addition to a traditional mental health role, there are a number of other opportunities that have developed over time for psychologists in ODRC. ODRC has a large and elaborate program for alcohol and drug treatment of incarcerated inmates that is completely separate and independent from mental health services. If a psychologist is a chemical dependency certified counselor or has other expertise in this area, there are opportunities for direct service or consultation in the joint mental health/recovery services, dual diagnosis program, and Substance Abuse and Mental Illness initiatives.

Over time, the availability of trained mental health staff led to diversification into other areas of need within corrections. When the massive prison riot occurred at Lucasville in 1992, a large number of mental health staff was brought in to help corrections staff deal with the tremendous stress of the event. Critical Incident Support Teams (CIST) Teams were developed throughout the State after the Lucasville riot. There are 10 CIST regions in Ohio with staff trained and available in the event of major or minor disturbances. While organized around a peer support model, a significant number of psychology staff has been involved in training and service provision. While originally established to deal with large-scale incidents, CIST is frequently activated in the event of individual staff or inmate death or serious injury. There are a large number of opportunities for involvement for those with an interest in crisis intervention.

Another application for psychological input developed out of the Lucasville disturbance when hostages were taken. ODRC realized that a structure and method needed to be developed for hostage negotiation and, as a result, the Hostage Negotiation Team was organized. Like CIST, it relies on trained peers from all areas of corrections, but psychological input is has been sought in the training and evaluation of trainees. A psychologist is part of the advisory committee which is involved in the development of lesson plans and presentations of lectures at the Correction Training Academy (CTA). Training includes the psychological aspects of hostage negotiation and the effects of stress on the staff, as well as observation and debriefings on field exercises.

The Correction Training Academy is the main training facility for the 15,000 corrections staff of which more than 500 are mental health professionals. Along with the traditional security training that one would normally expect for staff working in prison, with the advent of expanded mental health services there is a significant curriculum for training in mental health topics, many of which are specifically geared toward psychologists. All training is free to DRC staff and continuing education (CE) credits are frequently awarded. In addition, the CTA sponsors special workshops and colloquia with local and outside speakers. There are numerous opportunities for psychologists to attend programs or serve as presenters in a specialty area. A review of recent and future topics workshops and classes are as follows:

- Clinical Peer Review
- Clinical Supervision
- Criminality and Substance Abuse
- Diagnosis of Treatment Substance Abuse Disorders
- Dialectical Behavioral
- Ethics for Clinical Health Care
- Leadership Skills for Healthcare Supervisors
- Legal Aspects of Correctional Healthcare
- Mental Health 2 Day Training
- Neuropsychological Assessment – Basic and Advanced
- Offenders with Mental Retardation
- Pastoral Care of the Mentally Ill
- Response to Sexual Violence/Rape Prevention
- SAMI: Substance Abuse and Mental Illness
- Sex Offenders and Addiction
- Suicide Assessment and Prevention
- Treatment of Psychiatric Disorders with Medication
- Understanding Depression

The above mental health-related trainings are offered in addition to all the security and corrections training, as well as management/leadership program and a modern computer laboratory offering all the latest office computer training.

For those interested in management positions, there are several opportunities in this area within ODRC. Most psychology supervisors also serve as Mental Health Administrators and are responsible for the complete operation of the mental health outpatient or Residential Treatment Unit (RTU) inpatient program in their prison. In addition, there are opportunities for management outside of mental health in the prison, and some psychology staff members have entered the management training curriculum at the Corrections Training Academy and have become Wardens or Deputy Wardens of various prisons.

Finally, there are a large number of research opportunities available for those interested in this area. ODRC welcomes inquiries and conducts studies both internally and in partnership with qualified researchers. The normal human subjects review procedures are followed and the protocols can be found on the ODRC website at http://www.drc.state.oh.us/.

The Ohio Psychologist 2003-2004
Summary
In conclusion, there is a very large mental health population among the prisoners of 32 correction institutions in Ohio. There are many positions available for psychology, mostly in mental health treatment, but also in other areas.

About the Author
Andrew Lee Hinkle received his PhD from Auburn University and completed his internship in the Department of Psychiatry at The Ohio State University Hospitals. He was Director of Health Psychology at JLC Camera Center for 15 years and came to the Ohio Department of Rehabilitation and Correction in 1998. He is the Psychology Supervisor at Pickaway Correctional Institution which houses about 2,000 inmates. In addition to the provision of traditional mental health services, he has also been involved in The Critical Incident Response Team, the Hostage Negotiation Team and a consultant on various security matters. He is the author of more than 50 papers and presentations.

References

Ohio Psychological Association Homestudy Offerings

OPA has recently added a new ethics course to its stable of distance learning courses. The latest offering is approved by the OPA-MCE office as meeting the requirement for 3 hours of mandatory continuing education coursework in Professional Conduct and Ethics mandated for license renewal.

Ethics Course: A Review of the American Psychological Association’s Guidelines for Psychotherapy with Lesbian, Gay and Bisexual Clients
Author: Jenny O’Donnell, PsyD
Contributors: Howard Fradkin, PhD, and Xavier University PsyD students: Giselle Johnson, Rebecca Pershing and Daniel Judge
Online version: $60 Members / $90 Non-members
Hardcopy version: $85 Members / $115 Non-members
Go to www.ohpsych.org/Events/homestudy.htm and follow the step-by-step instructions.

In addition to its own unique homestudy offering in Ethics, OPA has also teamed with the Florida Psychological Association to bring you homestudy courses*. All courses were designed by FPA, and it maintains full responsibility for the program. All courses are 1.0 CE credits, and they are all approved by the American Psychological Association to provide continuing education for psychologists.

Cost (per course):
$35 OPA Members / $55 Non-Members

1. Abuse in Families
   Author: Maureen Kenny, PhD  1.0 CE credit

2. Ethical Principles that Need Consideration when Providing Services Electronically
   Author: David J. Romano, PhD  1.0 CE credit

3. The Mind of a Batterer
   Author: Carolyn Stimel, PhD, ABPP  1.0 CE Credit

4. Understanding Depression: Diagnosis, Assessment, and Treatment
   Author: Thomas Joiner, PhD  1.0 CE Credit

* NO CE COUPONS CAN BE ACCEPTED FOR THE FLORIDA COURSES
Introduction

Traditional approaches to mental health practice have focused on white, middle-class client populations. Clinicians did not pay attention to the needs of culturally-diverse clients, assuming the universality of what they studied in their training programs. As the percentage of ethnic minorities in the USA population increases, the demand for a more culturally-sensitive clinical approaches became more salient. In 1993, the American Psychological Association adopted Guidelines for Providers of Psychological Services to Ethnic, Linguistic and Culturally Diverse Populations. In 1994, the National Institutes of Health (NIH) enacted regulations requiring the representation of women and ethnic minorities in NIH-funded research projects (U.S. Department of Health and Human Services, 2001). In November 2002, the “Competencies Conference: Future Directions in Education and Credentialing in Professional Psychology” acknowledged that “issues of individual and cultural diversity are relevant to all aspects of competence at all levels of professional development” (Vasquez, 2003). The American Psychiatric Association acknowledged the significance of culture in the 4th edition of its Diagnostic and Statistical Manual of Mental Disorders (1994). Doctoral training programs in clinical psychology have systematically increased their efforts in educating future clinicians about the clinical needs of diverse populations by requiring the instructors to address these issues in any didactic encounter and by inserting courses specifically designed to address these issues in the curriculum (American Psychological Association, 2002).

The Problem and Some Solutions

In spite of this increasing awareness, there is only limited literature addressing the applications of this new knowledge in clinical work with clients. Specifically, how do White, middle-class clinicians address their clinical work with culturally diverse clients? What are some of the differences in their approach to non-diverse and diverse clients? Most of the writings and demonstrations (e.g., via workshops) are produced by clinicians and researchers that belong to these very diverse populations. It thus seems important to increase communication between non-diverse clinicians about their experiences in treating culturally-diverse clients. This is the goal of the present paper.

A radical approach to this issue is calling for the development of new clinical paradigms and models that represent reality from the Non-Western viewpoint. Differences mentioned in this context are individuality and autonomy versus collectivism and communal values. Further, the question arises whether traditional clinical theories represent Western values and are therefore obsolete to some culturally different clients (Sue & Sue, 2003).

Another approach accepts the existence of differences, but places an emphasis on the actual meanings attached and attributed to the same behaviors in different cultures. Thus, several researchers pointed to the differences in the meaning of time, control, mind, body, health, healing, and termination (e.g., Hall, 1983). Take, for example, the meaning of “self.” The “individualistic” Western culture perceives the “self” as the originator, creator, and controller, of behavior. In comparison, in many “sociocentric” cultures the self takes the form of social roles: In other words, the self and the roles it occupies are unconsciously presumed to be synonymous (which could be perceived as psychopathology by traditional Western therapists). This second approach does not require Western clinicians to change their clinical theories, but to pay attention to the different unconscious meanings attached to different notions used in daily practice.

Akhtar (2000) recommends the following for a psychodynamically-oriented therapist:

1. The therapist must recognize the ethnic components of his/her own cultural identity before being able to compare them to the client’s.
2. Following this personal reflection, the therapist should devote time to learning about the specific culture of the patient (e.g., family structures, roles of individual members, rules of interpersonal interactions, rules of decorum and discipline, religious beliefs, cultural traditions, standards of health, etc.)
3. The therapist should strive to increase the number of culturally-diverse clients taken into his/her practice.
4. The therapist should attempt to lead an open, cosmopolitan life involving cultural diversity.
Reflections on personal experiences as a Caucasian therapist treating culturally diverse clients

Recently, I had the good fortune of working with several culturally-diverse clients. I must share with readers right away that this work was highly successful and rewarding. However, I wish to review here those areas that required special attention and modification of my customary practice in clinical work (Note that all specific references to real clients have been eliminated or changed, to protect anonymity).

1. In all cases (all females), there was an attempt made by a male member of their family (husband, father) to stay in touch with me throughout the therapy via e-mails or phone contacts. These contacts involved practical matters, such as payments and insurance issues. It was clear to me that the need was to remain “in the picture” and in the mind of both me and the patient, without taking a participant role in the treatment. They, as well as the patients, rejected the idea of engaging in the therapeutic process. My “traditional” inclination was to set boundaries and reject those ‘out of sessions’ contacts. My counter-transference was that of resentment for being intruded upon, controlled, and “supervised” by a third party who refused to avail himself to the therapeutic process. I attenuated my countertransference by doing some “homework” readings on family structure and relevant cultural rules for communicating family matters to an outsider. It became clear that this “intrusion” was nothing but an expected behavior on part of the protective males in these families toward other family members, especially females. Rather than perceiving this behavior as interference, I began to perceive it as facilitative, as it provided permission for the female client to continue her work in therapy without the concern of being sabotaged. In this example, I, as a Western therapist, had to weigh issues of autonomy and women liberation against the ultimate goal of achieving our therapeutic goals in alleviating certain sources of anxiety and depression.

2. In all cases, the goals of therapy were eventually determined by the clients according to their perception of their roles in life and future aspirations. My “traditional” assessment process, usually focused on matters of characterological defenses, history of object-relations, transference reactions, and emotional expressiveness, amongst others, came to a halt, as soon as I realized that the clients insisted on perceiving me as a “medical expert” who should remain distant and technical in her interventions. They became confused and depressed when asked to relate to modes of object-relatedness, including their feelings about me. They evidenced difficulties in perceiving connections between interpersonal patterns and their symptoms, more than most of the clients I usually see. I had to give up on pre-conceived notions of “resistance” and “rigidity of defenses” and allow the process to take shape according to their expressed needs and goals, namely: To learn from me whether their symptoms indicated a serious pathology, whether they had some moral or spiritual deficiencies, and whether they were hurting other people, especially in their families, due to their symptoms. Once I accepted their goals, they felt freer to look at some historical antecedents of their symptoms and gain some insight from this exploration. These clients determined that they achieved their desired outcome from their therapy when they felt once again in harmony with their families and surrounding environment.

3. I was repeatedly surprised by these clients’ perception of me. In spite of attempts to provide them with empathy and encouragement, they came back the next session feeling ashamed about their verbalizations in the previous session and my possible judgment of them as inadequate, and especially, as immoral human beings. They were most concerned about their character faults in terms of being nurturing, caring, and refined wives, mothers, and community members in other roles. I had not encountered this degree of self-blame even with my most obsessive clients. Rather than exploring the archaic sources of guilt in these clients, I learned to understand their cultural-based perception that people should be able to receive all their needs for caring and solace within the family and the community, and that requesting help from outside experts might indicate betrayal of family and community, a weakness of character, and a moral defect. Perceiving the therapist as sharing some of these perceptions, they also felt that their discussion of their difficulties might offend the therapist!

4. There is a special difficulty in conducting therapy with bilingual clients. Several psychodynamic writers had perceived that the issue was one of over-using language difficulties in the service of resistance against remembering uncomfortable or traumatic events or gaining access to unwanted feelings. In my work with multi-cultural clients, I did not find much evidence for that. They were happy to describe to me scenes and events from their original histories. Some of them even brought in pictures, books, poems, and records, and invested time in educating me about their memories and cultural customs. The language problem was more related to expression of feelings. Not all terms for affective states are readily translatable from one language into another. I soon
learned not to expect that these terms were clearly understood by these patients, nor could I expect to be fully clear about their use of emotional terms. There was a need to clarify again and again what the intended meaning was. For example, the term “depression” was understood and used by some of these clients to indicate their experience of failing the expectations of their family, rather than to describe an internal state of sadness.

Summary

In summary, the work with multi-cultural clients is exciting and rewarding, but special care should be taken by the therapist to explore his/her own inner sources of resistance to understanding the unique cultural background that determines the parameters of the therapeutic process in each case.

About the Author

Mia Biran Wienberger is an Associate Professor at Miami University. She is on the faculty of the doctoral clinical program. Dr. Biran has been working at Miami University since 1982. She also has a private practice in Oxford, Ohio. Dr. Biran received her MA from Haifa University, Israel, in 1977, and her PhD degree from Rutgers University in 1980. Her main line of interest and research has been in the area of anxiety disorders and social phobias. She also is interested in the areas of acculturation and immigration.

References

Global Psychology in the 21st Century: Sharing Data on Early Behavioral Development via the World Wide Web

By Jeanette Reuter, PhD, Joneen Schuster, MA, Jessica Burke, BA and Timothy Gallagher, PhD
Kent State University

Introduction

Data sharing has become common in the social sciences, yet psychology has lagged behind in adopting a data sharing approach (Johnson, 2001a; 2001b; 2001c; 2002). However, this situation is changing as the importance of data archiving is recognized by federal funding sources such as the National Science Foundation and the National Institutes of Health. Principal investigators are expected to share primary data, sample information, and other relevant materials created or collected during the initial research process (DeAngelis, 2004; Seiber, 1991). Merry Bullock (2004), APA’s Executive Director for Science, emphasizes that data archiving in psychology can contribute to building a scientific communication network, “making psychological data universally accessible, especially to developing countries and thereby bridging inequities in its use based on gender, geography and development (p.54).”

Data sharing and archiving may be especially useful for clinical psychologists who are interested in doing studies on data collected from their practices. These skills would make it possible to aggregate similar samples collected from several clinicians in order to increase sample sizes and make it possible to evaluate the success of specific assessment or intervention procedures. The KIDS Project, presented below, exemplifies the process of constructing an open-ended data bank comprised of data on the behavioral development of infants and young children.

The KIDS Project

The Department of Sociology’s Survey Research Laboratory at Kent State University (KSU), in collaboration with our international associates, and Western Psychological Services, the publisher of the English language version of the Kent Inventory of Developmental Skills (KIDS) (Reuter & Gruber, 2000), is creating a web-based, open-ended data archive. The KIDS is a caregiver report inventory comprised of 252 items covering five behavioral domains: Cognitive, Motor, Communication, Social and Self-Help. The KIDS is appropriate for assessing the developmental status of healthy infants who are less than fifteen months of age and children with developmental delays whose Developmental Ages are less than fifteen months (see Appendix for additional details on the KIDS). The archived data is primarily from the KIDS, but includes other valid measures of behavioral development of healthy infants, young children at risk for developmental delay and young children with handicaps. This data has been gathered in the U.S. and other countries, and includes demographic and diagnostic descriptors of the children. The KIDS has been replicated and normed by our international associates from six European countries (the Netherlands, the Czech Republic, Spain, Russia, Germany, and Hungary), with preliminary normative studies conducted in five additional countries (Croatia, Sweden, Chile, China, and Zimbabwe).

Historical Background on the KIDS Project

In 1974, The First Chance Project was funded by a federal HCEEP grant, to advance the habilitation and education of children with severe disabilities residing at the Hattie Larlham Foundation in Mantua, Ohio. As a part of this project, Lew Katoff created the Kent Infant Development (KID) Scale (recently renamed the Kent Inventory of Developmental Skills (KIDS)) to serve as a fine-grained behavioral measure to track small developmental gains and losses for the First Chance Project participants. The KID Scale has proven to be a reliable and valid measure of the behavioral repertoires of infants and young children developmentally below 15 months of age.

By 1986, more than 3,000 KID Scale assessments had been collected and it was realized that efforts should be made to make this unique data available to the general research community. Faculty and staff from the Applied Psychology Center at KSU designed and structured a data bank of KID Scale assessments, creating a codebook that set forth standards for data entry and analysis as well as the principles relating to the identification and privacy protection of individual participants.

Current Archiving Activities

In 2002, the KIDS data archiving endeavors were renewed through the Department of Sociology’s Survey Research Laboratory at KSU, supported by an endowment from Jeanette and Louis Reuter. A web-based data archive has now been designed as a repository to hold the numerous KIDS studies that have been collected over the past twenty-five years. The KIDS Project website was designed with the intention of providing a user-friendly means of accessing the data while maintaining the security and confidentiality of study participants. We modeled the site presentation, organization, and select forms after several university-
based internet archives (Johnson, 2002), but borrowed most heavily from the Murray Research Center of Radcliffe site (http://www.radcliffe.harvard.edu/murray). The KIDS site organizes the data according to individual studies, providing summaries of the data collection methods used, along with defined variable lists.

The databank’s current holdings include 25 data sets consisting of more than 12,000 test times or data points. The data sets have been compiled from studies involving a variety of caregivers including parents, extended family members, foster parents, teachers, therapists and habilitation aides, as well as psychologists and pediatricians. The studies were conducted using a wide range of methods, including longitudinal, cross-sectional, case study and experimental designs. They focus on topics devoted to understanding infant development and in the case of children with handicaps, the relationship between behavioral development and the integrity of the central nervous system. To date, more than 75 presentations and publications have been produced from the KIDS data archive. KIDS international associates from around the world have collected nearly half of the data currently stored in the archives.

Current Research Activities

In addition to archiving previously collected data, our colleagues are engaged in ongoing research projects that will soon be added to the data archive. The following are some of the current research projects being conducted. A Spanish pediatrician from the University of Barcelona Medical College is in the process of conducting a longitudinal follow-up of preterm infants receiving treatment at a neonatal intensive care unit. This study will examine factors impacting preterm infant development, while assessing the predictive validity of the Spanish version of the KIDS and the reliability of parental report in longitudinal assessment of at-risk infants (Alcover et al., 2003).

We have also recently obtained from the Institute for the Care of Mother and Child, Prague, two Czech longitudinal samples that follow premature and healthy infants during the first year of life. A secondary analysis using hierarchical linear modeling was recently presented, comparing the Czech sample of healthy infants to infants in the U.S. normative sample to examine the impact of cultural practices on early infant development (Reuter, Procházková, Schuster, Dittrichová, & Sobotková, 2004).

And finally, colleagues from Hiram College, Hiram, Ohio, and Bindura University, Zimbabwe, have begun collecting normative data for a Zimbabwean version of the KIDS in English, Shona, and Ndebele languages (Fischer, Dunwell, Reuter, Matambo, & Schuster, 2004). This effort to translate and norm the KIDS for use in developing countries has relied heavily on all of our European normative samples to demonstrate the cross-cultural invariance of KIDS assessments. In addition, this group of researchers will soon begin to collect data examining the impact of HIV on early infant development on babies in Zimbabwe.

Conclusions

We hope that the description of our work in creating a data bank will encourage practicing clinicians to archive their own data. We would like to encourage scientists from all levels and disciplines to access our data for secondary data analyses, to use the KIDS archival data for designing new studies, and hopefully contributing new data on early childhood development. The KIDS data site is scheduled to open September 2004. The address for the future site is: http://kidsweb.sociology.kent.edu.

Appendix

Additional Background on the Kent Inventory of Developmental Skills (KIDS)

The KIDS is a precise behavioral assessment instrument that yields reliable and valid measures of developmental status (Reuter & Gruber, 2000). To maximize reliability and prescriptive utility, the KIDS was constructed with 252 items composed of phrases that describe observable behaviors, characteristic of an infant in the first 15 months of life. It can be administered to a caregiver using a paper-and-pencil format or computer-assisted administration. A computer-scoring disk sold by the publisher, Western Psychological Services, provides the most efficient means of scoring. The KIDS manual and scoring disk provide Developmental Ages and Standard Scores for the Full Scale and each of the Domains, derived from a normative sample of healthy infants.

A number of studies have been conducted to examine the concurrent validity of the KIDS through comparison with the Bayley, Vineland, and Brunet-Lézine. Correlations between the KIDS and the comparison instruments vary but are typically in the range of .75 through .9. KIDS test-retest and inter-rater reliability data, collected with a variety of populations, are consistently strong. This is an indication that the KIDS items are clear and objective, and that the instrument measures developmental status reliably over time and across raters.

References


Psychology, 35, 48.


Contact Information
Corresponding author: Joneen M. Schuster, Department of Sociology, Kent State University, Merrill Hall, Kent, OH, 44242-001; email: jschuste@kent.edu

About the Authors

Jeanette Reuter, PhD, FAClinP, ABBP is an Emerita Professor of Psychology from Kent State University and an Ohio licensed psychologist. Her life-long clinical and research interests are the behavioral development of infants and young children at risk for developmental delay. She is the author of the Kent Inventory of Developmental Skills (KIDS). Dr. Reuter received the Ohio Women in Psychology Lifetime Achievement Award in 1990.

Joneen Schuster received her MA in Experimental Psychology, through the Psychology Department at Kent State University in 1990. She has worked as a research consultant at the University of Washington, Child Development Mental Retardation Center and as a neuropsychology technician at the Cleveland Clinic Foundation. She expects to receive her PhD in Psychology in the Fall of 2004. Joneen worked as a research manager for the KIDS Project when it was located at Kent Developmental Metrics, Inc. Since 2002, she has been managing the transition of the KIDS Project to the Survey Research Laboratory at Kent State University.

Jessica Burke received her BA in psychology from Kent State University in 2002. She is working toward her MA in sociology from Kent State University. Since 2003, Jessica has been a research assistant for the KIDS project where she has collaborated with the KIDS project team on the design of the KIDS website and assisted in the preparation of data for archiving. Jessica will be attending the University of Maryland in the fall of 2004 where she will earn her MS degree in survey methodology. She will also be completing her assistantship at Weststat, Inc., a large survey research firm in the Washington, D.C. area.

Timothy Gallagher received his PhD from Western Michigan University in 1993. He went on to postgraduate training at the University of Michigan and Washington University School of Medicine where he was a National Institute of Mental Health Postdoctoral Research Fellow and received a Masters of Psychiatric Epidemiology. He joined the Department of Sociology at Kent State in 1996. Dr. Gallagher's specialty areas are Medical Sociology and Quantitative Methodology. His primary research areas are doctor-patient interaction and health care access. He is currently Chair of the Survey Research Committee in Sociology at Kent State.
The Ohio Psychological Association invites students conducting research on psychology-based topics to present poster summaries at its Annual Convention, October 20-22, 2004. This year’s poster session will offer special recognition to the student who has the most exemplary poster. Judging will occur the morning of Friday, October 22.

The recipient of the 2004 “Poster Winner Award” will be announced during Friday’s lunch at the Convention, and the lead author will be entitled to the following:

- Opportunity to highlight recipient’s research in a 2005 Ohio Psychologist article based on the poster
- One-year free membership to the Ohio Psychological Association;
- Free attendance to the 2005 OPA Annual Convention (dates and location TBD)
- Cash prize

The posters will be displayed from 8:00 am to 2:00 pm on Friday, October 22, 2004. It is required that you accompany your poster at breaks throughout the day on Friday. Student presenters may audit breakout sessions at no charge on this day only - if space allows.

One free lunch is included per poster entry. Additional lunches are available for $10 which can be requested up to one week before Convention.

The deadline for entries is September 30, 2004. An online entry form may be filled out or downloaded from OPA’s Web site at: https://www.ohpsych.org/Registration/PosterRegistration.htm. 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, October 22, 2004.
Abstract

This study examined relationships between psychosocial attributes and adherence to medications in middle-aged and older adults living with HIV disease. An additional focus was placed on intentional and unintentional medication nonadherence. No psychosocial variables predicted overall medication adherence in logistic regression analysis. Ethnicity and income were related to intentional medication nonadherence in multiple regression analysis, while more frequent use of escape-avoidant coping strategies significantly predicted unintentional medication nonadherence in multiple regression analysis. Findings from this research can inform the conceptualization of interventions intended to optimize rates of adherence in this understudied population.

Predictors of Nonadherence to Antiretroviral Therapies in HIV-infected Older Adults

Antiretroviral medical management has improved periods of survival in people living with HIV disease (Kalichman, 1998), enabling some individuals who were initially infected in their 30’s and 40’s to live well into their 50’s, 60’s, and 70’s. Previous research using diverse samples of persons living with HIV disease has identified strong positive relationships between greater depression and medication nonadherence (Catz, Kelly, Bogart, Benotsch, & McAuliffe, 2000; Gordillo, del Amo, Soriano, & Gonzalez-Lahoz, 1999; Paterson, Swindells, Mohr, Brester, Vergis, Squir, et al, 2000). To date, most research on AIDS medication adherence has been conducted with relatively younger samples; because of this focus on younger HIV-infected persons, very little is known about adherence to antiretroviral medications in middle-aged and older adults living with HIV disease. The purpose of the current study was to characterize rates and predictors of intentional and unintentional medication nonadherence in the growing population of middle-aged and older adults living with HIV/AIDS.

Theoretical Framework

Ewart’s social action theory (1991) provided the theoretical framework for the current study. Ewart (1991) suggests that internal and affective states, self-regulatory processes, and interactions with one’s environment are related to the enactment of health supportive behavior. In this study, the internal and affective states of interest were depression, pain, and self-perceived cognitive functioning, while coping strategies were considered a major self-regulatory process for health behavior. Finally, social support and barriers to health care and social services (e.g., lack of transportation and long distances to medical facilities and personnel) represented interactions with one’s environment. The health-related behavior outcome variable examined in the current research was self-reported adherence to highly active antiretroviral therapy (HAART) in the past seven days.

Method

Participants

Inclusion criteria were proficiency in the English language, age (45 years or older), and self-reported HIV-seropositive status. One hundred (N=100) participants satisfied eligibility criteria and comprise the final sample. Eighty-five percent (N=85) of participants were currently on HAART. Of these individuals, 84% were male and 16% were female. Ages ranged from 46 years to 76 years with a mean of 54 years. There were 63 White participants and 22 Non-White participants. Most participants (38%) were earning between $10,001 and $20,000 followed by 35% who were earning between $0 and 10,000. The majority of the participants (32%) had completed 14 years of education. Thirty-nine percent of the participants prescribed HAART had missed one or more medication doses in the week prior to filling out the questionnaire.

Materials

Self-administered surveys were sent to each participant who completed them in the privacy of their place of residence. The survey included the following measures:

Adherence to Antiretroviral Medications Questionnaire (ACTG; Chesney, Ickovics, Chambers, Gifford, Neidig, Zwickl, et al., 2000). This measure assesses how frequently participants skipped antiretroviral doses or were late taking scheduled doses during the previous week. Respondents also rated reasons why they skipped their medications.
Because medication adherence is crucial in order to benefit from HAART, participants were categorized into a “Consistently Adherent Group” (i.e., participants who had not missed a medication dose in the past week) and a “Nonadherent Group” (i.e., participants who missed one or more medication doses in the past week).

Medication Nonadherence. Ten questions were extracted from the adherence questionnaire on a conceptual basis to examine intentional (wanted to avoid side effects, did not want others to notice the taking of the medication, felt like the drug was toxic/harmful, felt sick from side effects, and had problems taking pills at specified times) and unintentional nonadherence (being away from home, were busy with other things, simply forgot, has a change in daily routine, and fell asleep/slept during dose time). A factor analysis with varimax transformation confirmed a 2 factor solution of the ten items.

Geriatric Depression Scale (GDS; Yesavage, Brink, Rose, & Leirer, 1983). Depressive symptomatology was assessed using the GDS. The GDS was employed because it does not assess somatic symptoms of depression, thereby reducing overlap between somatic symptoms of depression, HIV manifestation, and HIV medication side effects.

West Haven-Yale Multidimensional Pain Inventory (WHYMPI; Kerns, Turk, & Rudy, 2000). The WHYMPI assesses chronic pain and measures: (1) the impact of pain in people’s lives; (2) the responses of others to the individual’s communication of pain; and (3) the extent to which pain sufferers participate in daily activities. In the current study, particular attention was devoted to the 20 items that focused on perceived pain in participants.

Cognitive Difficulties Scale (CDS; McNair & Kahn, 1983). The CDS consists of 39 statements that assess self-reported cognitive difficulties. Correlational analyses indicated that depression was significantly and positively correlated with self-reported cognitive difficulties in this sample ($r = .69$, $p < .01$). To account for this high correlation, the scale was reduced by deleting CDS items that correlated highly with the Geriatric Depression Scale. This new scale was used in all subsequent analyses to avoid overlap between depression and cognitive compromise due to depression.

The Provision of Social Relations Scale (PSR; Turner, Frankl, & Levin, 1983). This scale measures perceived social support and has been associated with the availability of social resources.

The Barriers to Care Scale (BACS; Heckman, Somlai, Otto-Salaj, Peters, Walker, Galdabini, & Kelly, 1998). The 13-item BACS enables HIV-infected persons to rate the problem severity of various geographic, economic, and structural barriers that prevented them from accessing health care and social services.

The Ways of Coping Checklist (WOCC; Folkman & Lazarus, 1988). The WOCC was employed to assess how participants cope with prominent life stressors. The eight WOCC subscales are: Accepting Responsibility; Confrontive Coping; Distancing; Escape-Avoidance; Planful Problem Solving; Positive Reappraisal; Seeking Social Support; and Self-Controlling. In the current study, only escape-avoidant coping was utilized in study analyses.

Predictors of Nonadherence

Results

Correlation Analyses

Predictors of overall adherence. Pain and cognitive functioning showed no relationship in point-biserial correlations with overall medication adherence. Older age significantly predicted more consistent adherence. Escape-avoidant coping and depression were significantly and negatively associated with medication adherence. White participants were more adherent than non-White participants (see Table 1).

Correlates of intentional nonadherence. Demographic variables that were significantly and negatively related to intentional medication nonadherence were older age and higher annual income. Escape-avoidant coping strategies, barriers to health care and social services and perceptions of physical pain were positively related to intentional mediation nonadherence. In addition, non-White participants evidenced more intentional treatment nonadherence (see Table 1).

Correlates of unintentional nonadherence.
Unintentional medication nonadherence was negatively associated with age and positively related with escape-avoidant coping strategies, barriers to care, depression, and pain (see Table 1).

**Hierarchical Logistic Regression Analysis**

**Overall Adherence.** In a multiple logistic regression analysis, none of the four variables that were associated with overall adherence in bivariate correlations predicted adherence. Escape-avoidant coping was significantly and negatively related with medication adherence when depression was not included in the model, $z = 5.12, p = .01$. Depression was significantly and negatively related with adherence in this group, $z = 4.34, p = .04$; however, this association only appeared when escape-avoidant coping was not included in the model. To better understand how depression and escape-avoidant coping were related to adherence in this group, the logistic regression analysis was re-conducted and included the “Depression x Escape-Avoidant Coping” interaction term. This interaction term significantly predicted adherence, $z = 7.02, p = .01$. The form of the interaction was examined using median-splits on the two variables (please view Figure 1). Almost 90% of the non-depressed participants who did not use many escape-avoidant coping strategies were adherent to their medication regimen in the week prior to the assessment. Seventy percent of the persons high on depression scores but who did not use a lot of escape-avoidant coping strategies also adhered perfectly. This picture changed when participants disclosed using a lot of escape-avoidant coping strategies. The percentage of persons adherent to their medication regimen decreased significantly when they were using escape-avoidant coping strategies.

**Hierarchical Multiple Regression Analyses**

**Intentional Medication Nonadherence.** Only

### Intercorrelations Among Selected Dependent and Independent Variables (Table 1)

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fitness</td>
<td>.09</td>
<td>.01</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Presence</td>
<td>.45</td>
<td>.24</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avoidant Using Strategies</td>
<td>.25</td>
<td>.15</td>
<td>.05</td>
<td>.60</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Barriers to Care</td>
<td>.14</td>
<td>.12</td>
<td>.11</td>
<td>.69</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>.12</td>
<td>.30</td>
<td>.07</td>
<td>.58</td>
<td>.58</td>
<td>.01</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Error</td>
<td>.18</td>
<td>.38</td>
<td>.17</td>
<td>.46</td>
<td>.49</td>
<td>.08</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-appraisal Cognitive Distancing (median split)</td>
<td>.49</td>
<td>.36</td>
<td>.36</td>
<td>.25</td>
<td>.20</td>
<td>.22</td>
<td>.25</td>
<td>.20</td>
<td>.09</td>
<td></td>
</tr>
<tr>
<td>Peers</td>
<td>.23</td>
<td>.28</td>
<td>.36</td>
<td>.25</td>
<td>.20</td>
<td>.23</td>
<td>.25</td>
<td>.22</td>
<td>.20</td>
<td>.09</td>
</tr>
<tr>
<td>Self-appraisal Medication Tolerance</td>
<td>.54</td>
<td>.48</td>
<td>.38</td>
<td>.26</td>
<td>.24</td>
<td>.22</td>
<td>.24</td>
<td>.20</td>
<td>.20</td>
<td>.09</td>
</tr>
<tr>
<td>Treatment adherence</td>
<td>.17</td>
<td>.01</td>
<td>.01</td>
<td>.01</td>
<td>.01</td>
<td>.01</td>
<td>.01</td>
<td>.01</td>
<td>.01</td>
<td>.01</td>
</tr>
</tbody>
</table>

* $p < .05$
* $p < .01$
ethnicty and income were associated with intentional medication nonadherence. Non-White participants evidenced greater intentional nonadherence than White participants, $t = 2.18$, $p < .05$, and persons of lower socioeconomic status also showed more intentional medication nonadherence, $t = -.215$, $p < .05$.

Unintentional Medication Nonadherence. Escape-avoidant coping was significantly and positively related with unintentional medication nonadherence, $t = 3.60$, $p < .05$.

Conclusion and Implications for Future Research
As people living with HIV disease live longer due to better clinical care and HAART, it is important to characterize rates of adherence in this group and identify factors that may hinder one’s efforts to consistently adhere to these complex regimens. In the current study, almost one-third of middle-aged and older adults living with HIV disease had missed one or more doses of HIV medication. This is disturbing, given that HIV-infected persons must be at least 95% adherent to produce significant reductions in HIV viral load and increase CD4 cell counts (Paterson et al., 2000).

Results from the current study suggest that HIV-infected middle-aged and older adults who were at greatest risk for being nonadherent to HAART were persons of color, persons who were relatively younger (i.e., closer to age 50), and those who employed more escape-avoidant coping strategies.

Data from the current study suggest that behaviorally-related treatment to increase adherence in this population should focus on addressing depression and, perhaps more importantly, reducing one’s reliance on escape-avoidant coping strategies in response to life stressors. Also, interventions that seek to improve treatment adherence in communities of color and in persons who are economically impoverished may be particularly helpful.

About the Authors
Andrea Waltje, MA (Ohio University, Athens, 2003)
Andrea Waltje is a Ph.D. candidate at Ohio University. Her education includes a degree in nursing and a master’s degree from Ohio University. Among other employments, Andrea worked as a registered nurse in Germany as well as in Colorado, as a Residential Living Specialist for persons with mental retardation, and a graduate assistant in Dr. Tim Heckman’s HIV/AIDS research lab. Andrea’s interests are in the field of health psychology and include: (1) health behaviors of persons infected with HIV and (2) interventions related to the improvement of coping strategies of informal caregivers.

Tim Heckman, PhD (University of Vermont, Burlington, VT, 1993)
Dr. Heckman is Associate Professor of Psychology and Director of the Health Psychology Group at Ohio University. Dr. Heckman’s NIMH funded research focuses on the life quality of individuals living with HIV/AIDS. In particular, his research team attempts to examine the mental health needs of two groups largely overlooked by contemporary AIDS research: rural residents and older adults. He has published numerous articles on HIV related topics.

Julie Suhr, PhD (University of Iowa, Iowa City, 1994)
Dr. Suhr is an Associate Professor Psychology at Ohio University. Her research focuses on neuropsychological functioning in patients with dementia and in various medical conditions, and on the role of non-neurological factors in neuropsychological test results. She teaches undergraduate- and graduate-level courses in Clinical Practicum, Intellectual Assessment, and Neuropsychology. Dr. Suhr is a Co-Investigator for a NIMH funded grant on “A Coping Improvement Intervention for HIV-Infected Older Adults.”

John Garske, PhD (University of California, Berkely, 1972)
Dr. Garske is a licensed clinical psychologist and Professor of Psychology at Ohio University. From 1988-1990, he served as the Director of Clinical Training and is currently Assistant Chair for Graduate Studies. His research focuses on characteristics of effective psychotherapeutic interventions and time-limited psychotherapy. He has published numerous articles on the relationship between therapeutic alliance and treatment outcome. Dr. Garske regularly teaches undergraduate- and graduate-level courses in Clinical Psychopathology, and Individual Psychotherapy.

Monica Silverthorn, MSW (Ohio University, Athens, 2004)
Monica Silverthorn has her Master of Social Work degree from Ohio University, and has been a social worker for the last twenty years. She has worked in a variety of fields, including children’s services, mental health, AOD, and as a Ryan White funded rural casemanager. She has been a mental health volunteer for the Athens Red Cross. Currently, she is employed as a Project Coordinator for AIDS research grants in Dr. Tim Heckman’s research lab at Ohio University.

References
to antiretroviral medications among participants in HIV clinical trials: the AACTG adherence instruments. *AIDS Care*, 12, 255-266.


Science Day 2004
Aspiring behavioral scientists from grades 7-12 gathered at the OSU French Field House on May 8, 2004 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 $800.00 in cash prizes including a $25.00 prize from the Ohio Women in Psychology Marla Malloy Scholarship Fund. Awards ranging from first place to third place were given out in grades 7-12, with first place winners being awarded $75.00, second place winners garnering $50.00, and third place winners earning a $25.00 prize.

Special thanks goes out to Michael Wagner, PhD, Joseph Bene Jr., MA, Michael Ranney, MPA (OPA Executive Director), John McCue, PsyD, Kay Rothman, PhD, Daniel Kuna, PhD, Lynda Williams, MA, Theodore Williams, PhD, Kathy Lewis, PsyD, Jeff Sherrill, PhD, William Friday, PhD, and Patricia Kirwin, PhD, (pictured below from left to right) for volunteering their time and energy and acting as judges for this year’s event.

The Future of Science Day
Students who want to participate in Science Day have, in the past, been guided by the following description:

“The Behavioral Science Award is given for relevance, creativity and understanding of behavior has demonstrated by the project.”

The problem with this description is that we have been asked to judge projects with titles such as “Can different environments affect the lifespan of the earthworm?” and “Fire-bellied codes choosing their favorite processed food.”. These projects don’t seem to have much to do with human behavior.

On the other hand, experimental psychology does involve sometimes experimenting with lower-level animals. After discussing this issue with the judges, we have tentatively decided to change the description of the award as follows:

“The Behavioral Science Award is given for relevance, creativity, and understanding of human behavior as demonstrated by the project. A project with animals may be considered if it is relevant to human behavior. Projects referencing psychologists and psychological science will be given preference.”

We would be interested in any feedback on the tentative change. If we don’t hear any objections, the change will be submitted to the Ohio Academy of Science for publication in time for the 2005 Science Day. (Send comments to Jeff Sherrill at jsherrill@meersinc.com).
2004 Science Day Winners
Congratulations to all of the 2004 Science Day winners:

Grade 7
Roisin McCord - Columbus, OH - 1st Place
The anchoring bias in estimation and evaluation
Zachary Ireson - Columbus, OH - 2nd Place
Legos and learning
William Kehl - Wilmington, OH - 3rd Place
My mesmerizing memory project

Grade 8
B. Zachary Hedges - Carroll, OH - 1st Place
Emotional intelligence in mental health practitioners vs. non-helping professions
Anna Balzer - Perrysburg, OH - 2nd Place
Brain power: Memory in the aging brain
Taylor Clark - Carroll, OH - 3rd Place
Physical discipline: Good or bad?

Grade 9
David Steingass - Defiance, OH - 1st Place
What is the effect of subliminal messaging on the subconscious mind?
Bridget Haile - Upper Arlington, OH - 2nd Place
A comparison of visual and auditory stimuli in color recall

Grade 10
Julia Ng - Sylvania, OH - 1st Place
The effect of autogenic training on the cortisol levels of students taking scholastic tests
Mary Runkle - St. Paris, OH - 2nd Place
The effects of repetition and association on humans’ short term memory

Grade 11
Allison Salewski - Independence, OH - 1st Place
Chemical dependency and cognitive functioning in chronic pain patients on addictive medications
Jennifer Tawes - Perrysburg, OH - 2nd Place
The effects of ethnicity and facial symmetry on the perception of beauty

Grade 12
Elizabeth Shine - Lima, OH - 1st Place
Psychophysiology and the art of lying
Anna Combs - Dayton, OH - 2nd Place
If you don’t care about doing well, don’t bother with sleep!

Obituary
OPA extends its deepest sympathy to the family and friends of Martha Risleley, MA. and Richard Kaiser, PhD. Ms. Risely was a life member who passed away this spring. She resided in Harrisonville, Missouri, at the time.
Dr. Kaiser was life member who passed away in December, 2000.

Candidate Receptions
The Coalition of Providers (psychologists, dentists, optometrists, podiatrists, pharmacists, chiropractors, osteopaths, physicians) will once again conduct a series or receptions for candidates for the Ohio House and Senate. These events will be from 5:30pm to 7:30pm. Members of each of the provider groups will be invited to participate, to meet the candidates, hear their views on provider issues, and educate them about our specific concerns.

We would like to have a good turn out of psychologists at each of these receptions.

SAVE THE DATES for the following Provider Coalition Receptions:

9/20 - Cincinnati (optometrists and podiatrists coordinating)
9/23 - Dayton (psychologists and pharmacists coordinating)
9/27 - Columbus (optometrists and others coordinating)
9/30 - Canton (chiropractors coordinating)
10/4 - Athens (osteopaths)
10/7 - Toledo (OSMA coordinating)
10/11 - Cleveland (Dentists coordinating)
CRITICAL INCIDENT STRESS MANAGEMENT (CISM)
TWO-DAY SEMINAR IN GROUP CRISIS INTERVENTION
FOR MENTAL HEALTH PROFESSIONALS

SPONSORED BY
CUYAHOGA COUNTY CISM
& PRESENTED BY
J. ROBERT GRIBBLE, PhD, KATHLEEN McCUE, MA, LSW, and JAMES A. DUNKLE, BS, NREMTP

FRIDAY & SATURDAY, OCTOBER 15 & 16, 2004
WESTLAKE RECREATION CENTER
28955 HILLIARD BLVD, WESTLAKE, OH 44145
440.808.5700

Seminar Description
This seminar will provide basic training in Critical Incident Stress Management (CISM). The CISM model, developed by the International Critical Incident Foundation (ICIF), as known as the "Mitchell Model," has been successfully utilized to combat stress among emergency personnel throughout the United States. The model has also been adapted to respond to critical incident stress in a variety of settings where individuals have been exposed to and negatively impacted by sudden, traumatic environmental stressors.

In addition to providing a first educational foundation for crisis response using a comprehensive, systematic, multicomponent approach, the basic training seminar is a prerequisite for anyone wishing to become a member of a CISM team. With an emphasis on incidents that occur in an emergency services environment, mental health professionals will gain additional insight and ability to intervene with multi-safety officials and emergency responders.

Critical Incident Stress
Stress is an acknowledged part of everyday life for the emergency service professional. However, certain incidents may have sufficient emotional power to overwhelm the usual coping abilities of emergency responders. The following events are among those that may lead to critical incidents: Line of Duty Death, Serious, Multiple Casualty Incidents, Traumatic Death, or Injury to Children, Events with Excessive Media Intrusion, Officer Suicide, Serious Injury to Emergency Personnel, Prolonged Incidents.

Seminar Schedule & Content
Day 1 (Friday, October 15, 8:00-5:00)
- Nature of Stress
- Emergency Services Stress
- Definition of a Critical Incident
- CISM Interventions
- Team Organization & Management
- Overview of Debriefing Process

Day 2 (Saturday, October 16, 8:00-5:00)
- Demonstration of Debriefing
- On-Site Support
- On-the-Scene Intervention
- Demonstration of Debriefing
- Debriefing
- Summary & Questions

Registration & Fee
Fee includes materials, continental breakfast, coffee breaks, lunch and refreshments for both days.

CE credits for continuing education units-15 CE credits

Course Fee is $150.00—Please make check payable to Cuyahoga County CISM.

Clip and send form to: CV-CISM, c/o Sue Magyaricz, 19978 Deer Path, Strongsville, OH 44136
ru for additional information, please call the CV-CISM Office at 216.441.7649

NAME

ADDRESS

PHONE

CITY STATE ZIP

CE Credits Desired? Yes No Discipline: Psychology Counseling Social Work Nursing Other

The Ohio Psychologist 2003-2004
SHORT A FEW C.E. CREDITS?

WE CAN HELP!

Read a Good Book, Take an Open-Book Test, Earn Credits Quickly

OPA members receive a $25 discount!

Our Best Sellers Include:

- Bipolar—Not ADHD (6 credits)
- Body Harm: The Breakthrough Healing Program for Bell Injuries (10 credits)
- Boundary Wars: Ethical Perspectives on Intimacy & Distance in Healing Relationships (3 credits)
- Good to Great: Why Some Companies Make the Leap and Others Don’t (10 credits)
- Instant Psychopharmacology (1 credit)
- S.T.O.P. Obsessing: Overcoming Your Obsessions and Compulsions (3 credits)
- Ethics and Values in I/O Psychology (12 credits)

To Order a Program or Get Additional Information, Call

Institute for Alternatives in Continuing Education
877-550-4223
Or Browse the Catalog Online at: www.institute4ace.com

WE GUARANTEE FAST, FRIENDLY, PROFESSIONAL SERVICE

Institute for Alternatives in Continuing Education, LLC is approved by the American Psychological Association to offer continuing education for psychologists. Institute for AEs maintains responsibility for the programs.

Glennon J. Karr
Attorney at Law

Legal Services for Psychological Practices

(614) 848-3100

Outside the Columbus area, The Toll Free No is:
(888) 527-7529
(KARRLAW)

Fax: (614) 848-3160
E-Mail: karrlaw@rrohio.com

1328 Oakview Drive
Columbus, OH 43235

Massachusetts School of Professional Psychology
221 Rivermore Street, Boston, MA 02113
Toll free (888) 664-MSPP or (617) 327-6777
E-mail: admissions@mspp.edu

www.mspp.edu
Classified Ads

JAN’S SECRETARIAL/TRANSCRIPTION SERVICES:
Need typing of social security reports/psychological reports? Refer them to me. I am an experienced secretary and have been involved in psychological typing for the last eight years. Free pick-up and delivery for local clients. Reasonable rates. Call Jan at 614/274-0662 or email JRAYB32031@aol.com for details.

SEEKING EXPERIENCED AND LICENSED PSYCHOLOGIST to work part-time with children and adults in busy Bexley practice. Please fax resumes and contact information to: 614-235-0414, c/o Donna G. Estreicher, PhD. Phone: 614-235-0211. Address: 3140 E. Broad St, Columbus, OH 43209.

For Sale: Columbus, Ohio. Very successful and established psychologist practice in same location for thirty years. Practice has six full and part-time therapists, specializing in children and families. Owner willing to assist with financing through profits and will assist with ownership change and marketing. Serious inquires only. Contact 614-294-8092 or italyoshi@juno.com

TENURE-TRACK ASSISTANT PROFESSOR: The Department of Psychology at Xavier University invites applications for an Assistant Professor tenure-track position in Clinical Psychology with an emphasis in older adults to begin Fall, 2005.

Applicants must have a doctoral degree in clinical psychology from an APA-accredited university. License or license eligibility in Ohio is preferred. Qualifications to teach applied doctoral courses in psychological practice with older adults are required. A commitment to excellence in both undergraduate and graduate teaching and a publication record or promise of outstanding empirical research regarding older adults are necessary. Duties include teaching graduate and undergraduate courses, supervising dissertations, developing a continuing research program, and participating in department and university service.

Xavier University is a Catholic institution in the Jesuit tradition with over 6500 students. The Department of Psychology has 16 full-time faculty members who teach in the undergraduate and graduate programs, including a five-year APA-accredited Psy.D. program in clinical psychology (practitioner-scientist model), and two-year master’s degree programs in industrial/organizational and general experimental psychology. The faculty has a commitment to excellence in training and has established an extensive network of professional training sites in the community. A Psychological Services Center on campus serves as the training clinic in psychological assessment and therapy for clinical doctoral students. The undergraduate program with approximately 160 majors has a strong liberal arts focus.

Applicants must submit a cover letter describing their teaching experience, research interests and accomplishments, a curriculum vitae, reprints, and three letters of reference (sent directly by the recommenders) to Christine M. Dacey, Ph.D., ABPP, Chair, Department of Psychology, Xavier University, 3800 Victory Parkway, Cincinnati, OH 45207-6511 or email. To ensure optimal consideration, applications should be received by November 5, 2004, but the search will continue until the position is filled. For more information, visit the Department of Psychology on Xavier’s Web Site at Xavier University has a strong commitment to diversity and, building upon recent success, seeks a broad spectrum of candidates including women and minorities.
Ohio Psychologists Elected to APA Division Leadership Positions

Division 10
Council Representative: Sandra W. Russ, PhD*

Division 17
Treasurer: Julia C. Phillips, PhD

Division 29
President-elect: Abraham W. Wolf, PhD*

Division 34
Council Representative: W. Bruce Walsh, PhD

Division 52
Secretary: Sandra Foster, PhD*

Division 54
Treasurer: Carolyn E. Ievers-Landis, PhD

*Indicates OPA Member

Benefits and Services of OPA Membership

- Ethics and Colleague Assistance Committee
- Extensive website with Consumer/Members Only sections
- Discounts on Continuing Education attendance/tracking
- Free online advertising
- Library, Media Guide, and Online Referral Program
- Monthly Publications
- Networking and Communication
- Political Advocacy on behalf psychologists and consumers
- Project FAIR (Focused Advocacy for Insurance Reform)
- Much more!

Call 800-783-1983 or visit www.ohpsych.org for more information on the benefits of membership in the Ohio Psychological Association.

Note-Taking Software
www.notes444.com

Are your session notes HIPAA compliant?

- Preserve your psychotherapy note exemption
- Set reminders for critical dates and OTRs
- Essential PHI are automatically entered
- Instant printouts of PHI requests
- Useful electronic sticky notes
- Completely customizable
- PC and Mac compatible
- Custom templates

Download a free, fully functional 30-day trial (see for yourself)

$175
Never an Annual Fee
SAVE THE DATES!

OPA Annual Convention
“Expanding Psychology: Current Challenges – Future Opportunities”
October 20-22, 2004

Keynote Address from Russ Newman, PhD, JD,
APA Practice Directorate Executive Director
“The Changing Face of Practicing Psychology”
Wednesday, October 20, 2004 at 9:00 a.m.

Special plenary session by Janice Kiecolt-Glaser, PhD
“Negative Emotions Can Be Deadly:
New Perspectives from Psychoneuroimmunology”
Thursday, October 21, 2004 at 9:00 a.m.

Holiday Inn Columbus/Worthington
I-270 at Rte. 23

400 East Town Street
Suite G20
Columbus, OH 43215-1599