The Roles of Science & Clinical Practice in Psychology
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"The Roles of Science and Clinical Practice in Psychology" is the theme of this year's *Ohio Psychologist*. Many of the issues raised in this publication's articles are relevant to the daily practices of psychology and warrant thoughtful consideration.

Dr. Karl Stukenberg describes some significant limitations for the exclusive use of the increasingly popular empirically supported treatment studies as the gold standard for evaluating psychological treatments. As the number of psychologists who are older grows, the likelihood of practicing psychologists who develop cognitive impairments and what can be done about it is reviewed by Dr. Jerome Gabis. Drs. Drude and Michael Lichstein give an overview of the need for developing and using e-mail guidelines that reflect ethical practices.

A personal perspective about working with Evangelical Christians and how to incorporate their worldview in treatment is provided by Dr. Lee Wetherbee. Dr. Alice Randolph, an advocate for seeking prescriptive authority for psychologists, gives reasons for the pursuit of this expansion of psychological practice and makes a call for action. Dr. James Werth Jr. and Ms. Adriane Bennett describe the complexities of understanding the different legal aspects of the duty to protect as they apply to psychologists in Ohio and make recommendations for practice. Also included in this issue is an article by 2004 OPA Convention Poster Session Winners Mr. Jeremy M. Bottoms and Mr. Nathan C. Whittier about neurological test findings with patients with multiple sclerosis.

Remember that you can obtain continuing education credit by reading the articles in this issue, completing the enclosed self-test and sending it to OPA with $15 (for OPA members) or $25 (for non-OPA members).

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When Psychologists Develop Dementia

By Jerome Gabis, PsyD

Fortunately, State Board Executive Director Ron Ross, PhD, notes that the State of Ohio Board of Psychology has not had a recent case regarding a psychologist who might be impaired because of dementia. One look at baby-boomer demographics, however, suggests that psychologists themselves are aging fast and may soon be affected by cognitive impairment that often accompanies aging.

Data available from the American Psychological Association (APA) Research Office indicate that the baby boomer cohort passing through American society is also going through the profession of psychology. For example, in 1985 the average age of APA members was 46. In 2004, it was 53. Similarly, in 1985, the modal age was 35-39, while in 2004, the modal age was 55-59. The same data show that APA members between 50 and 59 constitute 32.3 percent of full members of APA. A whopping third of APA’s full members were born between 1945 and 1954.

In Ohio, State Board of Psychology records indicate that there are 3,611 current Ohio psychology licensees. Of these, 1,390 (38 percent) were born between 1941 and 1950, and 485 (13 percent) are 65 or older.

A 2004 APA survey of 745 psychologists found that 64 percent of respondents were planning to continue working at least part-time after retirement and 61 percent indicated they plan to volunteer in some capacity that employs their skills and training.

According to the Alzheimer’s Association, 4.5 million Americans are estimated to have Alzheimer’s disease. Age is the greatest risk factor in developing Alzheimer’s disease. One out of every 10 persons over 65-years-old and 50 percent of those over 85 are likely to have Alzheimer’s disease. By 2050, probability estimates range from 11.3 to 16 million Americans who will be affected by the disease.

Let’s examine the operative regulations and codes of conduct applicable to situations of cognitive impairment.

The Ohio Administrative Code, Chapter 4732 - Rules Governing Psychologists and School Psychologists, states that a psychologist is said to be negligent if his or her behaviors clearly fall below the standards of acceptable practice. Further, psychologists should not undertake or continue professional relationships with clients, supervisors, or students when they are impaired due to mental, emotional, physiological, pharmacological, or substance abuse conditions. Psychologists are also required to report in writing to the State Board if there is substantial reason to believe that a psychologist has committed an apparent violation of statutes or rules resulting in harm.

Consider also APA’s Ethical Principles of Psychologists (2002) which called for an informal resolution of ethical violations by approaching the individual first. If this approach is ineffective in resolving the matter, further action is taken to refer to state boards and appropriate institutional authorities. Ethical violations are not reported just because they are violations of a rule, but because they result in harm.

Psychologists limit, suspend, or terminate work related activities if personal problems prevent them from performing in a competent manner. Psychologists take reasonable steps to avoid harming others. If harm is unavoidable or foreseeable, they attempt to minimize the harm.

When would someone begin to think that a psychologist is cognitively impaired? Statistically, the impaired psychologist is likely to be older, perhaps approaching retirement or semi-retired, and working part-time. One might notice frequent or increasing errors around scheduling, double bookings, missed appointments, showing up for work on a day off, or coming in late after getting lost on the way to work. A client reports concerns about a psychologist to a receptionist who then tells you. You notice a peer becoming increasingly withdrawn, quiet, and suspicious, blaming, or more easily agitated. A peer is having difficulty finding the right
words or even breaches confidentiality without apparent insight or awareness.

These behaviors could indicate any number of problems, but are often suggestive of dementia. In an institutional setting, policies often outline procedures that protect others from harm by an impaired professional staff member. However, in the solo practice setting, these checks and balances are not always present and the likelihood of continued work by the impaired psychologist is higher. Stan Sateren, MD, director of the Ohio Physicians Health Program, a colleague assistance program for Ohio physicians, notes that solo physician practitioners are most at risk because the accountability factor is not as strong. He also notes that the impaired physician may resist “hanging up their skates” because of strong identification with the profession.

Clarissa Rentz, MSN, APRN, program director for the Cincinnati Area Alzheimer’s Association, has encountered situations in which human resource managers, hospital administrators, and families have approached the Alzheimer’s Association seeking advice about how to address someone with possible dementia who is still working. She notes that professionals, lawyers, surgeons, and business executives may be more likely to experience the onset of dementia while they are working, since many often work beyond the usual retirement years.

Here are some sample suggestions to consider when impairment becomes apparent. Any number of individuals including spouse, children, employer, or colleague may approach the impaired person to present specific observations suggesting impairment. The person is encouraged to get an assessment to find out the cause and extent of possible cognitive impairment. Some causes of cognitive impairment are treatable and to some extent reversible, such as depression or normal pressure hydrocephalus. Others may require immediate and more dramatic interventions (brain tumor). When the impaired person is approached, the bottom line is a request to get an evaluation, which would include consultations with family, the primary care physician, a neuropsychologist, a neurologist, and colleagues. Nothing more is requested than the evaluation. A multidisciplinary approach is best and the family often plays the most important role in addressing the situation.

In the event of resistance, an intervention similar to those conducted with problem drinkers may be considered. Denial may play a part in resistance, but often the affected person lacks sufficient insight and self-awareness to understand fully the ramifications of the impairments. The State Board of Psychology is then informed. The board might then refer the psychologist to the colleague assistance program and require the evaluation as a condition of maintaining licensure.

If the results of the evaluation point toward dementia, then a plan is made with the psychologist, spouse/family, and employers to protect the public from harm and to feasibly accommodate the psychologist’s impairments. Ms. Rentz points out that the Americans with Disabilities Act (ADA) requires employers to accommodate employee impairments as much as is reasonably possible. She states that persons may no longer be employable anywhere from six to 12 months after the diagnosis is confirmed.

The employee assistance program may suggest a consultant who can help develop a plan to orchestrate benefits including accessing short- and long-term private disability, Social Security disability, and retirement benefits. The second phase of the plan would be to help the psychologist phase out of the profession with grace and dignity. By transitioning one’s practice, informing students, clients, and peers, one can put appropriate closure on a professional career. Ms. Rentz observes that professionals feel empowered and maintain their professional dignity when such a plan is employed. With such a plan, the psychologist voluntarily surrenders his/her license.

On a more personal level, the psychologist and family continue to plan for the progression of the disease by limiting or discontinuing driving, executing legal documents, anticipating care needs and criteria for independence, and making financial arrangements for the future.

The plan also acknowledges the emotional impact of the situation. Care is taken to provide the psychologist and family with grief support in a time of multiple and pervasive losses, to validate the psychologist’s contributions to society and the profession, and to help the psychologist maintain contact with colleagues and peers as long as desired or possible.

In a few years, the Board of Psychology surely will be asked to address concerns about cognitively impaired psychologists. The optimal situation is for psychologists to acknowledge impairments and limit or discontinue their professional work accordingly before any harm is done. Peer supervision groups might consider taking up this topic now and exploring how they might handle the situation if a member becomes cognitively impaired. Institutions, if they have not done so already, need to prepare for such an eventuality by adopting policies and procedures to address the situation of a cognitively impaired psychologist. The situation will also require a compassionate colleague assistance program that can help access resources to plan for the psychologist’s future. Perhaps these considerations are a good step in that direction.

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Ohio Psychologists' Duty to Protect when a Client is Potential Harm to Others

By James L. Werth, Jr., PhD, and Adriane G. Bennett, MA, Department of Psychology, The University of Akron

Deciding what to do when one has a client who may harm another person can be stressful for even the most experienced psychologist. This difficult situation can be even more distressing if the psychologist is laboring under some misconceptions about what she or he must do versus what she or he may do. Because of the frequent misunderstandings about options and obligations in situations involving potential harm to others, as well as the somewhat unique situation that exists in Ohio, we will review three issues in this article: the famous Tarasoff case, considerations in Ohio (for the text of statutes in the Ohio Revised Code [ORC], go to http://onlinedocs.andersonpublishing.com/revisedcode), and recommendations for practice.

Because this article is necessarily brief, we include references to more authoritative and primary source material (see, generally, VandeCreek and Kapp, 2005). In addition, we are not including situations where state law obligates breaking confidentiality, such as cases when a child, person with developmental disabilities under the age of 21 (see ORC 2151.421), or older adult is perceived to be in danger (see ORC 5101.61). Finally, we do not discuss assessing for harm to others, but there are many books and articles on this subject, including Monahan (1993); Truscott, Evans, and Mansell (1995); and, Tishler, Gordon, and Landry-Meyer (2000).

The Tarasoff Case

Tarasoff v. Regents of the University of California (1974, 1976) is probably one of the most well-known, but also misunderstood cases among mental health professionals. The most common misperception is probably that the court decided there was a "duty to warn," and this incorrect interpretation has implications for what professionals believe they must do. The first time the California Supreme Court ruled on Tarasoff, the justices did indeed say there was a duty to warn; however, the court heard the case again and, in 1976, changed the language of their holding to say that there was a duty to protect (i.e., "...once a therapist does in fact determine, or under applicable professional standards reasonably should have determined, that a patient poses a serious danger of violence to others, he [or she] bears a duty to exercise reasonable care to protect the foreseeable victim of that danger"; p. 345).

Yet, the justices took great pains to note that (a) they were not qualified to decide what would be acceptable interventions that would satisfy the duty (in other words, they deferred to the mental health community to determine the standards of care in such situations), and (b) warning was one option but should be a last resort. Because of the common misinterpretations of this case (and the incorrect summaries in many articles and books), we urge professionals to read the original ruling as opposed to relying on secondary sources (although see Fulero, 1988, and VandeCreek & Knapp, 2001, for overviews of relevant related material).

A recent Tarasoff-like case has received attention because of the implications of the court's ruling. In Bwing v. Goldstein (2004), a California court held that a person's warning about a dangerous client is the same as patient communication and a therapist has a duty to warn the victim or police. In our opinion, the court's ruling appears problematic from a number of perspectives, when reviewing California's state law and case law, but because the holdings of the court in that case are largely irrelevant in Ohio. For reasons discussed below, we will not review it here.

Developments in Ohio

The situation in Ohio is unique because of a state Supreme Court case and subsequent involvement by the state legislature. In an earlier article in The Ohio Psychologist, Baker and Fulero (1997) described Estates of Morgan v. Fairfield Family Counseling Center (1997) in some detail, so we will only briefly summarize it here. In this case, the court heard about a man who had been receiving treatment at Fairfield but killed his parents and wounded his sister. The court found the center to be negligent. The justices also said the consulting psychiatrist was negligent,
because although he obtained prior records, he apparently never looked at them. The court reasoned that if he had, his treatment decisions (and therefore the outcome) may have been different. The court ruled (see syllabus paragraphs 2, 3, and 4) that:

- [ORC] 5122.34 does not preclude the finding that a special relation exists between the psychotherapist and the outpatient which imposes a common-law duty on the therapist to take affirmative steps to control the patient's violent conduct.
- The relationship between a psychotherapist and the patient in the outpatient setting constitutes a special relation justifying the imposition of a duty upon the psychotherapist to protect against and/or control the patient's violent propensities.
- When a psychotherapist knows or should know that his or her patient represents a substantial risk of harm to others, the therapist is under a duty to exercise his or her best professional judgment to prevent such harm from occurring.
- Further, the court indicated that only if therapists tried to hospitalize someone would they be protected from liability.

The dissenting justices said the implications of the ruling were that in order to follow the court's requirements that whenever a client was believed to potentially be dangerous to others, the therapist must attempt to hospitalize the client. When these issues were made clear, the state legislature became involved, revised ORC 5122.34, and passed another statute (ORC 2305.51). These statutory changes were specifically designed to “respectfully disagree with and supersede the statutory construction holdings of the Ohio Supreme Court relative to section 5122.34 of the Revised Code as set forth in Estates v. Morgan...and thereby to supersede the second, third, and fourth syllabus paragraph holdings of the Court in that case” (see footnotes to the statutes). However, it should be noted that the legislature cannot render a Supreme Court ruling moot, so the effects of these statutes on case law are yet to be determined (G. Karr, personal communication, October 2004).

Basically, ORC 5122.34 gives professionals' protection for either breaking or not breaking confidentiality, as long as the determination was made in good faith while ORC 2305.51 spells out what the provider must do to meet legal requirements. Potential liability would be present “only if the client...has communicated...an explicit threat of inflicting imminent and serious physical harm to or causing the death of one or more clearly identifiable victims, the professional...has reason to believe the client...has the intent and ability to carry out the threat, and the professional...fails to take one or more of the following actions in a timely manner.”

Inside:

- Hospitalize the person on an emergency basis, as provided under ORC 5122.10
- Hospitalize the person voluntarily or involuntarily, under ORC 5122
- Establish and undertake a documented treatment plan that is reasonably designed, according to appropriate standards of professional practice, to eliminate the possibility that the client or patient will carry out the threat, and arrange for a second opinion
- Communicate to a law enforcement agency lives and, if feasible, the potential victim the following: the nature of the threat, the identity of the person making the threat and the identity of each potential victim of the threat.

In addition, the therapist must:

- Document what was done and not done, and why,
- Include consideration of what would be least harmful to the rights of the client and,
- Consider whether taking a particular action may increase danger to anyone

If acting to comply with this law, the therapist is protected from litigation/ethics charges and from licensure board actions.

As should be clear from this excerpt, in Ohio—to the degree that the statutes have the final word—there is no “duty to warn” because warning is but one of four options to be considered and it can be determined to be inappropriate in a given case. Thus, in Ohio there is a “duty to protect” and the psychologist can meet this duty in any one or a combination of several ways—emergency/voluntary/involuntary hospitalization, developing and following a treatment plan, or warning the police and perhaps the potential victim. In addition, similar to the ruling in Ewing v. Goldstein (2004), this statute includes a provision stating that communication from a “knowledgeable person” might lead to the duty to protect. Finally, it may be worth noting that responding in terms of a duty to “protect” is also consistent with the Ohio Rules of Professional Conduct for Psychologists (which can be found in Ohio’s psychology licensure laws and regulations); specifically, protecting confidentiality of clients (4732-17-01G2d). Further, neither these rules nor the American Psychological Association Ethical Principles of Psychologists and Code of Conduct (2002; see standard 4.05) requires breaking confidentiality, they do permit psychologists to do so in order to protect the client or others.

Recommendations for Practice
Because others have ably discussed how to decide on interventions in potential harm to others situations we will not focus on these here. Instead we have a few additional recommendations for practice (see also material distributed during OPA-sponsored CE workshops, such as those by Glenn Karr or Eric Harris). First, there is a model form that was drafted by Howard Sokolov, MD, assistant medical director, Ohio Department of Health, that walks the professional through the requirements of the statute (available on the OPA Web site at http://www.ohpsych.org/). The key components of the law are built into the form, and by filling out the information, one has created documentation.

Second, although Stadler (1969) was writing about child abuse, her set of alternatives for how to report (e.g., the therapist talking to children's services in the client’s presence) could be adapted to harm to others situations, as well as when clients may be a harm to self. An important related point is that the psychologist needs to have provided appropriate informed consent so that the client does not feel betrayed when the therapist says some action needs to be taken.
Third, although the focus on harm to others situations is most often on homicide, note that the statute does not limit the reach of the law to only those situations. In fact, if a structure is threatened then this may lead to the statute being in force because any “potential occupant” becomes an identifiable victim (see ORC 2305.51). Further, the statute specifies serious harm, not just death, so severe injury to others falls under the statute. But, again, note that this statute does not address suicidal clients.

Fourth, consultation on clinical aspects of care is often a good idea, but in situations such as this it is essentially required (and is actually written into the law if developing a treatment plan), both as a matter of good practice as well as risk management. Consultants should at least be licensed psychologists, but also could be content area experts, the board of Psychology, OPA Ethics and Colleague Assistance Committee members, and risk management experts. Similarly, supervisors must always review material with supervisors and there are often times when this is more important than in a potential harm to others situation. However, we would be remiss if we did not note that no non-clinical consultation or supervision are protected by privilege, so if there is a bad outcome, whatever was talked about and/or documented related to these discussions is discoverable in a legal case or Board hearing; thus, one would not want to make statements or case notes indicating one would be to blame for someone being injured or killed. Yet, if sufficient consultation/supervision has occurred, this can protect the therapist (and supervisor if applicable) from being found guilty of wrongdoing (see the Cleveland case of Penny Chang for a celebrated example of this at http://www.law.virginia.edu/home2002/html/alumni/uyalawyer/sprint04/48hours.html).

Consultation with an experienced mental health lawyer may also be a good idea because other clinicians, members of the board of psychology, and ethics committee members are not able to interpret the law, court cases, or rules from a legal perspective. Insurance carrier attorneys may be able to provide general guidance but not specific advice for Ohio. As opposed to clinical consultation, legal consultation is protected by privilege against discovery in ethics hearings or lawsuits.

Given the foregoing, it should be evident that the careful psychologist probably will want to keep copies of the statutes and related model form available and use them to help with treatment planning whenever a client is believed to be at risk of substantially harming others, either directly or indirectly, regardless of whether death is planned or results. He or she will also want to consult with an experienced peer or, if in supervision, his or her supervisor. Consulting a mental health attorney may also be useful. Finally, all actions taken, including the consultation/supervision, should be documented contemporaneously.

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Authors’ Note
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An Update on Prescriptive Authority for Ohio Psychologists

By Alice Harrington Randolph, EdD, MS, Clinical Psychopharmacology

It is so often true that it almost seems a cliché to say that the profession of psychology is changing, yet it is in a significant way. Appropriately trained psychologists have prescriptive authority within their practice of psychology in two states, in the military and in other federal programs. At least 19 other states have pending legislation and many more are forming action plans.

For more than a decade the profession has been discussing, preparing, and advocating for this addition to our scope of practice. The pros and cons have been articulated, visionaries have passed legislation, educators have created advanced training programs, and leaders are drafting codes of ethics and standards of practice. At each juncture there are safeguards to protect the core values of psychology and the rights of individual psychologists to choose if and how to expand their knowledge and practice to include prescriptive authority. Most who initially feared that some fundamental erosion of psychology would occur have been satisfied and it is time the debate ends. Prescriptive authority for appropriately trained psychologists is a reality and, with continued effort, prescriptive authority will be a choice for psychologists in every state. This national picture provides challenges and opportunities for Ohio psychologists and the patients they serve.

There are important reasons for psychologists to be able to manage medications for the patients they treat. The first and most significant reason is to expand access to necessary mental health services to a greater number. Too many Ohio citizens are currently experiencing long waiting times for initial and follow-up appointments with psychiatrists both in the private sector and community mental health system.

Many family practitioners and other specialists lament that they do not have the time to be current on all medications and are particularly challenged by the rapidly expanding array of psychoactive medications. However, with depression and anxiety co-morbid to so many other medical problems, they welcome the assistance of well trained professionals. The geriatric and pediatric populations, in particular, are in need of medication management for behavioral health issues and the shortage of psychiatric specialists is even more pronounced for them.

The patient’s ability to choose healthcare providers is another benefit when the psychologist can manage medications. Having one professional address the full scope of behavioral health treatment provides continuity of care and increases the likelihood of compliance. Patients tell us that follow-up visits for medication monitoring are brief and they feel that doctors do not have time to listen. Psychotherapeutic interventions such as active listening, reflection, and clarification are fundamental tools of psychologists that enhance accurate disclosure. Assessing medication effectiveness, true compliance and tolerance of side effects is aided by the core of the psychologist client relationship, trust and rapport.

It is efficient for behavioral health care to be coordinated by a single provider. An appropriately trained prescribing psychologist has the benefit of training in the traditional areas of psychology as well training in the basic sciences and pharmacology. There is savings in cost and time for one appointment rather than two when therapy and medication are concurrent. Lost work time for patients or caregivers is reduced and this is a critical issue. Most therapy is provided on a weekly or frequent basis which allows for immediate identification of therapeutic effects and side effects enabling immediate adjustment or patient education and support.

An often repeated myth regarding prescriptive authority for appropriately trained psychologists is that it will result in harm to patients. This myth is the primary objection raised by the organized psychiatric community. The data indicate just the opposite. Psychologists in the military have been prescribing for over a decade and the safety of their practices have been tracked and verified. Unfortunately, as each
profession has increased their scope of practice to include medication management, the physician organizations have predicted dire consequences to patients. Nurse practitioners, optometrists, physician assistants, pharmacists etc. have all been accused of wanting to expand their practices at the expense of patient safety and none of these predictions has been true. In every state there is at least one non-physician profession with prescriptive authority.

How does a psychologist get prescriptive authority? Psychologists who are granted prescriptive authority must be first licensed as psychologists. They must complete an organized, integrated, accredited advanced degree or certificate program with at least 400 hours of didactic instruction and a supervised practicum or residency of at least 100 patients, pass a national exam and be certified in their state. Appropriately trained psychologists prescribing within their practice of psychology enhance patient care and do not pose a risk to patients.

For Ohio psychologists, now is the time for individuals to decide how prescriptive authority will fit into their professional future. Some knowledge of psychopharmacology is essential for all psychologists, but not all psychologists will need or want to pursue full prescriptive authority. The professional factors to consider are type of practice, the location and availability of psychiatrists and other specialists, personal interest in this knowledge and skill set, and availability of personal financial resources and time to acquire additional training. OPA has resources and members willing to assist psychologists who want more information. Whatever your personal decision, the profession needs the support of all members. Our clients and their physicians, our referral sources, legislators, friends, and the community at large need to understand the importance of prescriptive authority. Help spread the message of access, choice, efficiency and safety (ACES). A PowerPoint presentation is available to enhance public education. Attend continuing education offerings. Follow developments on the OPA and Division 55 Web sites. If you are interested in advance training or working on legislation in Ohio contact the OPA Executive Director Michael Ranney, MPA, or Alice Randolph, EdD, MS, chair, task force on prescriptive authority.

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Alice Harrington Randolph, EdD, received an MS in Clinical Psychopharmacology from NOVA Southeastern University in Dania, Florida in August, 2004. She is also licensed in Louisiana as well as Ohio and Nevada. Dr. Randolph’s practice, Psychological Transitions, will be opening a practice in New Orleans in the fall.
Empirical Support for Clinical Interventions

By Karl W. Stukenberg, PhD, ABPP

APA President Ronald F. Levant, EdD, MBA, ABPP, appointed a Presidential Task Force on evidence-based practice (EBP) to develop a definition of evidence-based psychological practice that could be widely supported across the many constituencies of APA and could be adopted as APA policy. A draft of the policy was posted on APA's Web site this winter (EBP Task Force, 2005). If these materials are adopted, they will promote sound psychological practice while guarding against misusing the concept of evidence-based practice in the healthcare delivery system.

Because psychology has been an empirical science and has tested the efficacy of interventions since its inception (McReynolds, 1997), you, like me, may wonder why the definition of evidence-based treatment is currently so important or potentially controversial. Evidence-based treatment is being proposed as a measure of the validity of psychological interventions to counter the movement in psychology toward the (exclusive) use of empirically supported treatments (ESTs) (Kendall, 1998) to validate treatments and the equation of EST with evidence-based treatment. EST methodology relies heavily on the use of random clinical trials (RCTs) which have greatly improved the treatment of many medical conditions including cancer and heart disease. RCTs, a powerful research tool particularly well suited to evaluate and compare certain types of interventions, are virtually identical with EST methodology in psychology when symptoms or syndromes involve a direct link between specific stimuli and specific responses that are not embedded in other symptoms or maladaptive personality traits (e.g., the treatment of simple phobias; Westen, Novotny, and Thompson-Brenner, 2004). There are severe limitations for this methodology; however, as the complexity of the psychopathology and the complexity of the relationship between the pathology and the person presenting with it increases. Despite the limitations, some writers are promoting ESTs as the gold standard that should set clinical, research and training agendas in clinical psychology as a whole (e.g., Calhoun, Moras, Pilkinson, and Rehm, 1998).

The following is a vastly reduced synopsis of arguments against reducing evidence-based treatment to ESTs that others have made more eloquently elsewhere (e.g., EBP Task Force, 2005, Westen, et al., 2004). This summary may serve as an introduction and a resource for clinicians, educators, and researchers who are concerned about preserving clinical psychology as a discipline that takes on tough problems with the best available techniques, including treatments that are most appropriate to the difficulties that people actually bring to the clinic.

Brief treatments have dominated EST research and have done so for a variety of reasons, some of which are based in research design. For instance, comparing treatments is less complicated when the length of treatment is held constant. Some of the reasons for EST dominance are theoretical and cast a long shadow. Individuals with a behavioral or cognitive-behavioral (CBT) orientation have performed most EST studies. Even after most CBT clinicians have moved away from the assumption of human behavior being largely under environmental control, that assumption continues to be implicit in EST research designs. Drew Westen, PhD, who served on the committee that drafted the evidence-based practice guidelines, has characterized EST methodology as requiring a set of assumptions that are empirically problematic when considering the range of pathology that clinicians encounter (Westen, et al., 2004). These assumptions include the above mentioned idea that psychopathology is largely under environmental control and therefore highly malleable, as well as assumptions that a) most patients present with a single symptom or disorder; b) personality variables are unrelated to the treatment of psychopathology; and, c) the experimental method should be the gold standard for determining psychotherapeutic efficacy. I will briefly relate concerns about each of these assumptions in turn.

Naturalistic studies are inconsistent with the malleability hypothesis and instead consistently report greater effectiveness of treatment over greater periods of time (Howard, Kopta, Krause, and Orlinsky, 1986; Kopta, Howard, Lowry, Beutler, 1994; Seligman, 1995).
The best evidence for the intractability of psychological disorders, however, may come from the EST studies themselves. Meta-analytic data from EST studies demonstrate that for a range of disorders other than the specific stimulus/response disorders, the modal patient relapses or seeks additional treatment one to two years after "completing" treatment (Westen et al., Morrison, 2001). Laboratory based studies of depressed individuals, using a variety of methodologies including depressive language in a Stroop task, also suggest that even when there are demonstrable state related changes in treated depressed individuals, there may still be a bias towards depressive thinking, and therefore a continuing depressive diathesis (Williams, Mathews, & MacLeod, 1996; see also Wenzlaff & Eisenberg, 2001).

ESTs almost always have included remarkably limited samples in the range of disorders that individuals experience. The empirically untested assumption is that in more complex populations, discreet syndromes can be treated using a sequence of protocols appropriate to the individual presenting disorders (e.g. Wilson, 1998). While keeping the research samples relatively "clean" increases the internal validity of the research design (Campbell & Stanley, 1963), it is likely a distortion of the experience of the population that seeks treatment from clinical psychologists, and thus severely limits the generalizability of the studies. It is unknown whether most patients seek treatment with a single axis I disorder as their presenting concern (Persons, 1991), but between one-third and one-half of patients who seek treatment in both naturalistic and catchment area studies cannot be diagnosed by DSM because their symptoms do not fit the manual's categories (Howard, Cornille, Lyons, Vessey, Lueger, & Saunders, 1996); thus, at the least, EST populations are very different from the individuals seen in practice.

The issue of generalizability is an even greater concern when we realize that personality disorders are explicitly excluded from most EST research protocols. This is done by specifying that a single syndrome is the inclusion diagnosis for a study, because multiple syndromes are not simply additive, but likely indicate the presence of an Axis II condition (Newman, Moffitt, Caspi, & Silva, 1998). No theory or data suggests that personality can be changed in under 20 sessions. Linehan's Dialectical Behavioral Therapy is the only EST for personality disorders, and it requires at least a year of treatment for the first of three stages (Westen, et al., 2004). Even when we consider the "clean" patient who has only one Axis I disorder, if that is an anxiety or a depressive disorder, the disorders are related to what are generally considered personality characteristics: high negative affect and low positive affect (See Kreuger, 2002).

The assumption of using the experimental method as the gold standard for evaluating psychotherapy treatment is at the heart of the issue. This complex assumption includes the issues such as to whether therapy sessions should be standardized. Because that is required to increase internal consistency, therapists structure the sessions to decrease the variability between sessions that emerges when patients direct the hour which necessarily creates a situation minimizing patient active involvement that is "essential to good outcome but destructive of experimental control" (Westen, et al., 2004, p. 639).

When a treatment does not adhere to EST requirements, it is eliminated from the pool of potentially testable treatments, meaning that alternative treatments are NOT compared, and simply not evaluated. Unfortunately, it leads researchers to conclude that non-EST tested treatments have been invalidated—a logical error. In order to separate gold from lead, the lead must be evaluated. To compound the difficulty, when short term treatments fail, researchers propose extending them into long term treatments without testing the longer term effects and without comparing them to treatments intended to be longer term (Hollon, Thase, and Markowitz, 2002).

Finally, emphasizing experimental cleanness leads to changing therapeutic interventions for no reason other than to improve the differentiation between interventions, but this change can then become an unempirically tested inclusion in the treatment protocol, and potentially useful interventions are excluded. It occurs not infrequently in the EST literature so that, for instance, an interpersonal psychotherapy treatment (IPT) that was not expected to be superior to a CBT treatment for bulimia was manualized with the instruction to NOT talk about eating (Fairburn, 1997). This was done to further distinguish the two treatments, not to improve IPT. The element was not tested by itself, but was included in the final, published protocol, because it was part of the treatment as tested.

If we do not engage in EST methodology as the sole means of evaluating treatments, then how are we to have evidence-based treatment? The short answer is to ask the task force (EBP Task Force, 1995). A slightly longer answer is that we look at what treaters are doing (Jones, 2000, Jones & Pulos, 1993, Wilczek, Barber, Gustavsson, Asberg, & Weinhry, 2004) rather than prescribing that through manuals, and then evaluate through multiple means, including meta-analysis and other correlational techniques to see what is effective in helping patients improve. Westen, et al. (2004) propose a transactional relationship between clinicians and researchers where information is seen to flow back and forth between the two camps, rather than flowing from the top (research) down or, in reality, not flowing at all. In any case, we have long established techniques for evaluating process and outcome, and we need to use these to
evaluate a broad range of therapies in a broad range of settings.

EST methodology is a seductive siren call to third party payers, researchers, grant funding agencies, and some of our young trainees. All of these individuals, for a variety of reasons, would like to believe that the world the clinical psychologist and his or her patient inhabit is a relatively simple and easily mastered world. In fact, that is not the case. It requires considerable knowledge, experience, and time to understand and treat the majority of the individuals who seek our services, which, in turn, creates fiscal and moral dilemmas as we consider who should receive what treatment and who should pay for it. We should not shy away from these dilemmas by pretending that the world is what others would have it be, and we should not put blinders on ourselves as we evaluate what will be helpful and thereby sell all of our clients (including third party payers) a bill of goods. The draft of the task force does a nice job articulating the complexities of being a clinical psychologist and a patient, and the importance of respecting the professional requirements of undertaking a task as noble as that of improving the lives of individuals who are suffering. I encourage you to read it.

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Karl Stuckenberg, PhD, ABPP, completed his graduate training 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 six-year-old son, John.

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Psychologists’ Use of E-mail with Clients: Some Ethical Considerations

By Kenneth Drude, PhD, & Michael Lichstein, PhD

Introduction
The time from the end of World War II until the present has been one of unprecedented technological change. Every facet of our lives has been impacted by the “digital revolution.” Even those psychologists who proudly identify themselves as “technophobes” probably have a cellular phone, a photo copier, a facsimile (FAX) machine, and a personal computer in their outer office.

Despite all the wonderful uses of technology, there is the potential for confidentiality to be breached. Indeed, who of us has not talked on the telephone with a client, whether about some routine issue or in hopes of averting a crisis. Each type of electronic communication has potential strengths and limitations and the risks of each need to be managed (Maheu & Gordon, 2000). But what are these risks?

How can they be minimized? What are the ethical and legal implications of using such communications? How can psychologists stay informed about what are best practices? As VandenBos and Williams (2000) point out, it is not a matter of “whether” psychologists will be providing services using technology, but “how.” They state further a belief that the use of technology, particularly Internet communications, will increase in the future to become “as routine, readily accessible, and expected as the telephone.”

In this article, we provide a brief overview of the development of guidelines and standards for the use of technology in clinical practice. We then focus on specific issues that have been identified as important when using e-mail with clients.

Technology Use Guidelines and Standards
Many psychologists are already using e-mail to communicate with their clients (Maheu and Gordon, 2000; Welfel and Bunce, 2003; Drude, 2005). Practitioners can now receive authorizations, request additional sessions, and communicate with care managers by e-mail or online through insurance companies’ Web sites. Medicare is moving toward requiring electronically submitted billing and it is only a matter of time until most insurance claims submitted by psychologists will be transmitted electronically. In the meantime, our profession is left with a substantial lag between emerging technologies and their uses in practice (Koocher and Morray, 2000).

As psychologists increasingly adopt technology in their practices, it becomes important to address the effect that this may have upon the ethical practice of psychology. There is little guidance from the literature about how to proceed. A 1997 “American Psychological Association (APA) Statement on Services by Telephone, Teleconferencing, and Internet” by the APA Ethics Committee briefly acknowledges that the APA “...Ethics Code is not specific with regard to telephone therapy, or teleconferencing, or any electronically provided services as such, and has no rules prohibiting such services.” Psychologists are told that after reviewing these services, they “...must then consider the relevant ethical standards and other requirements, such as licensure boards.” No further guidance has been forthcoming from APA, although in 2002, references to “electronic transmission” were added (APA, 2002).

Even after several years of consideration, there remains no agreed upon method of applying the APA Ethics Code to analyze any new tool and its application in clinical practice. Without some guidance, psychologists are on their own in navigating the myriad technical and ethical issues that arise when using e-mail to communicate with clients. Some psychologists are reluctant to begin communicating with their clients via the Internet because they are unclear about potential liability, lack of reimbursement, and security concerns. Federal government privacy and security rules required by the 1996 Health Insurance and Portability and Accountability Act (HIPAA) seem daunting and only serve to heighten these concerns. Psychology can no longer take a laissez faire attitude toward the uses of technology in psychological practice. VandenBos and Williams (2000) are correct in concluding that “efforts should begin now to develop standards and guidelines “before such service delivery is widespread.” Despite such urgings, it appears that psychologists continue to take a “wait and see” attitude while others act.

Ragusea and VanCreek (2003) propose that psychologists need to begin developing guidelines as to how the current APA Ethics Code could be applied to psychological services that are conducted electronically. It is our belief that psychologists need to be proactive rather than reactive when it comes to the ethical use of technology in clinical practice. By not taking action ourselves,
we run the risk that standards will likely be imposed on us by the legal system or by legislation, possibly without input from psychologists.

A number of professional healthcare organizations have attempted to foresee the ways in which developing technology is likely to impact services provided by their members, and to shape expectations of how it should be used. Various guidelines have been proposed, and several professional organizations have formally adopted detailed standards for the use of technology and the Internet in providing services (e.g., American Counseling Association 1999; American Medical Association 2000; American Mental Health Counselors Association 2000; Clinical Social Work Federation 2001; HI-Ethics, 2000; Health on the Net, 1996; Interdisciplinary Telehealth Standards Working Group, 1999; International Society for Mental Health Online 2000; Kane and Sands, 1998; NBC.C 2001; Reed, McLaughlin and Milholland, 2000; Rippen and Risk, 2000). Some guidelines and standards are broad and inclusive of different forms of telehealth and types of Internet communication, and others are more specific to a particular technology (e.g., use of e-mail or teleconferencing).

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E-Mail Guidelines

In this article, we restrict ourselves to identifying key ethical and legal issues involved with psychologists’ use of e-mail with clients. We have further narrowed our focus to e-mail communications with clients with whom a psychologist-client relationship already exists. That is, we consider the use of e-mail as an adjunct to face to face services with already existing clients. We specifically exclude situations in which clients are solicited, enrolled, and provided services either exclusively or primarily through e-mail, as described by Shapiro and Schulman (1996) or where psychologists respond to unsolicited e-mail from individuals seeking services, as described by Eysenbach (2000).

Studies that have looked at how psychologists currently use e-mail with clients have typically found poor compliance with the APA’s Code of Ethics (Welfel and Bunce, 2003; Maheu and Gordon, 2000). Concerns about ethical issues such as informed consent, confidentiality, and relevant laws, have been identified as factors in some psychologists choosing not to use e-mail with clients (Welfel and Bunce, 2003).

One of the most comprehensive efforts to develop guidelines for the use of e-mail with clients are those adopted by the American Medical Association (AMA) (2000) and are based upon guidelines previously published by Kane and Sands (1998). Other guidelines or statements relevant to e-mail use have been adopted by mental health professional organizations including the American Counseling Association (1999), American Mental Health Counselors Association (2000), and the International Society for Mental Health Online (2000). A review of many of the key standards and guidelines relevant to clinical practice using the Internet is provided in Ragusea’s doctoral dissertation (2005). Additionally, a summary of issues specific to e-mail is included in the guidelines developed by the e-Risk Working Group for Healthcare (2002). A review of the different statements, comments, opinions, and official
guidelines regarding the use of e-mail with clients reveals a number of common issues including the following:

E-mail Policies and Procedures
The AMA's guidelines include a recommendation that the first step in the use of e-mail with clients is to develop written internal policies and procedures. For instance, which office personnel are authorized to read and respond to e-mail from clients? How will messages from the psychologist's office be identified so that it is clear who is writing, i.e., the psychologist or a staff member.

Standard Turnaround Time for Responding
Clients need to know how long it will take for their messages to be answered, and what steps should be taken if a timely response is not forthcoming.

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Message Content
The psychologist should educate clients about what information and types of discussions are appropriate for e-mail and those that are not. Some psychologists may wish to limit e-mail communication to scheduling or brief follow up messages and to avoid more sensitive issues altogether. It has been suggested that clients identify the topic and importance of the message in its subject line. Healthcare providers are urged to exercise extreme caution whenever a message contains information which might identify the client.

When Not To Use E-mail
Psychologists should identify when it is more appropriate for clients to meet face to face, or by telephone, rather than using e-mail messages.

Emergencies or Crises
Three issues about emergencies or crises appear frequently in the literature. These need to be addressed with the client, probably while documenting informed consent. First, e-mail is not considered to be an appropriate means of communication when the client is in crisis. Second, in the event of an emergency, or if e-mail is temporarily unavailable, both the healthcare provider and the client must have an alternative means of getting in touch with one another—such as by telephone. Third, the psychologist needs to know what emergency resources are available to the client, and how to contact them.

Confidentiality and Privacy
E-mails to and from clients should be regarded as confidential, and maintained in a manner that protects client confidentiality and unauthorized access to client information. Some authors suggest the use of a word or phrase, agreed upon in advance, which might serve as a low-level verification of the sender’s identity, similar to the use of a password to protect sensitive information. Unfortunately, the information would be available to anyone who possesses the password. Another suggestion is to use the auto reply features of e-mail programs to let the sender know that the message has been received. However, this does not guarantee that the message has been read by its intended recipient.
Security

Proponents of using e-mail with clients frequently point out that, given the insecurities of this type of communication, it is advisable to encrypt all e-mail (Maheu and Gordon, 2000). Some guidelines state that communication should only be over a secure network, with provisions for authentication and encryption (Eklis, 2002). Any type of encryption requires that both the psychologist and the client agree to use the same software to encrypt and decode all messages. For the sake of consistency, it might be that the psychologist would provide such software to all clients wishing to communicate via e-mail. At the present time, most e-mail is not encrypted. If encryption is not used, the privacy limitations should be explained to the client and should be clearly stipulated in the informed consent.

Once an e-mail message leaves your computer, it enters the Internet, a World Wide Web of computers, over which the psychologist has no control. The security of the communication is only as good as the security of these computers. At a minimum, each message passes through the computer of your Internet service provider. This computer, often called a server, retains a copy of your message. Anyone who has followed the popular press is aware that these computers have often been compromised either by a disgruntled employee, or by individuals seeking information which might be of some use to them—so called "hackers." Security precautions are extremely important when using computers to communicate with clients (Stein, 2005). Without adequate protection, the psychologist's personal computer is open to attack with the possible outcome being disclosure or corruption of confidential information. It seems essential that psychologists become familiar enough with such threats that they are able to reassure clients that reasonable efforts are being made to protect confidential information. Features such as firewalls, antivirus software, and backups of computer contents need to be kept up to date, and need to be used, preferably on a daily basis. While this may seem to be a daunting task, most routine computer protection and maintenance can be automated.

Informed Consent

In addition to the usual informed consent requirements that psychologists are expected to obtain from clients at the time services are started, consent to use e-mail is advised. This could be a statement about the use of e-mail that is signed by the client and documented in the client's chart. Such a statement should include relevant issues such as the limitations, potential risks and benefits of using e-mail.

Fees

Will clients be charged for time spent reading and responding to their messages, and if so how much? Although there is a CPT code for online evaluations and management services, it may not be reimbursed by some insurance companies. This should be discussed with clients prior to any email exchange.

Documentation/Recordkeeping

Psychologists are cautioned to maintain printed copies of all messages to and from clients. These copies should be kept in the client's chart. This step recognizes that communication is professional rather than casual, and that they have potential clinical, legal, and ethical implications (Maheu and Gordon, 2000).

Licensing Jurisdiction

Providing services via e-mail to clients outside of the state in which a psychologist is licensed may be questioned, and may put the psychologist at legal risk. The possible relevance of this legal issue should be given consideration when deciding to use e-mail with a client. Different states have different laws regulating this issue (Koocher and Murray, 2000).

Competency

How knowledgeable are clients and psychologists in the use of computers and e-mail? Cautions about writing skill competencies, potential misunderstandings and other differences between the spoken and written word have been raised as being important issues to consider in choosing to communicate with clients via e-mail (Fenichel, 2000).

Summary

It is past time that psychologists begin developing guidelines for the ethical use of technology in the clinical setting. E-mail, which is becoming more common between psychologists and clients, is a logical place to begin this analysis. Guidelines for the use of e-mail with clients have been developed by a number of professional groups other than psychologists. These guidelines identify a number of common areas of concern that need to be considered when deciding whether to correspond with clients by e-mail. A summary of these issues has been presented here to assist psychologists in making such a decision. Having a comprehensive written informed consent, describing potential risks and expectations, is a crucial component. It is our hope that this paper will rekindle a discussion of how technology can be ethically used in clinical practice, and that such a discussion will eventually lead to well-defined guidelines for the use of e-mail with clients.

Acknowledgments

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Footnotes

1 encrypt is to translate data into a coded form requiring a decrypting to view the original data
2 a secure network uses a security software protocol to automatically encrypt data being transmitted
3 authentication is the process of identifying an individual, usually using a username and a password

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degree of the patients' physical disability. However, the researchers did uncover a significant correlation between self-report of memory impairment and depression.

Of clinical importance to assessment in patients with chronic disease(s), including MS, is their ability to recall accurately past physical activity. Durante and Ainsworth (1996) suggest several problems in recall that reduce the accuracy and therefore the utility of self-report measures including those that measure past physical activity. They report that surveys of physical activity often fail to account for more than 45% of the variance in the measures. Durante and Ainsworth believe that errors in the cognitive operations employed in recalling and reporting physical activity are responsible for the unexplained variance in these measures. Their hypotheses, if applied, may also explain error in the self-report of domains other than physical activity.

The research cited above indicates that several authors have found individuals with MS often have impaired self-report accuracy for memory (Landro, Sletvold, & Celius 1999) and for metamemory (Randolph et al., 2001). Moreover, individuals with MS demonstrate physical and cognitive fatigue (Paul et al., 1998) and depression, which may play a role in inaccurate self-reports of impairment (Heinze, L., Denney, D., & Lynch, S., 2004).

The purpose of this study is to investigate how cognitive and psychological factors are related to self-report accuracy in individuals with MS, to suggest ways to improve self-report accuracy leading to improved treatment for patients, and to determine if an "MS Personality" can be defined.

Methods
Participants
Research was conducted in collaboration with the Dayton Veterans Affairs Medical Center (Dayton VAMC). Patients of the Dayton VAMC with a substantiated diagnosis of MS were recruited to participate in a larger grant funded study investigating the self-report accuracy of patients' reports of physical activity. The data used for this study was generated by 56 participants of the larger study. Of the 56 participants, 67% were female. The mean age of the participants was 53 years (SD = 12.28). The mean education level was 15 years (SD = 2.64) with a minimum education level of nine years and a maximum education level of 20 years.

The relationship status of the participants was as follows: 11.1% single, 63.0% married, 18.5% divorced, 1.9% widowed, 1.9% other, and 2 participants or 3.7% were unidentified.

Procedure
All 56 patients were administered the Personality Assessment Inventory (PAI), a 344 item self-report questionnaire designed to be scored on a 4-point ordinal scale (F = False, Not At All True; ST = Slightly True; MT = Mostly True; VT = Very True). The measure provides information on 11 clinical scales, five treatment scales, two interpersonal scales, and four validity scales. For the purposes of this study the patients' scores on the validity scales Inconsistency (INC), Infrequency (INF), Negative Impression Management (NIM), and Positive Impression Management (PIM) were correlated with the patients' results on one of two measures of memory functioning. A K-means cluster analysis was also used to determine if the MS individual's performance on the clinical scales of the PAI would fall into meaningful personality clusters.

Nineteen of the 56 patients completed the Rey Auditory-Verbal Learning Task (RAVLT; Rey, 1964), a list-learning task consisting of repeated presentations of a word-list. There are both free recall and recognition trials.

Thirty patients completed the California Verbal Learning Test – Second Edition (CVLT-II; Delis, Kramer, Kaplan & Ober, 1987), a list learning task that measures both free recall and recognition through repeated presentations of word lists. Unlike the RAVLT, the word lists are representative of four semantic categories which allows the examiner to discover information about the encoding strategies used by the patient.

Results
Mean elevations were seen on a number of the scales and subscales of the PAI. Perhaps the most notable is the elevation on the Somatic Complaints Scale (Mean T-Score = 60.1). Interestingly, subscales within this scale appear to differentially contribute to this overall elevation (e.g., Health Concerns = 60.26; Somatization = 53.37; Conversion = 62.8). Cluster analysis using a K-Means approach suggested a two group solution (with 37 and 17 cases in the two groups respectively) as the most effective classification.

With regard to memory functioning and the accuracy of patient's self-report, significant negative correlations were found between ICN on the PAI and overall performance on the CVLT-II (CVLT-II 5 Trial Total), short delayed free recall (SDF), short delayed cued recall (SDC), and long delayed free recall (LDF). Significant negative correlations were also found between NIM and five of the CVLT-II performance measures (CVLT-II 5 Trial Total, SDF, SDC, LDF, & LDC). A significant negative correlation was found between ICN and retention on the RAVLT. These results are summarized in Table 1.

| Table 1. Correlation matrix for PAI validity scales and Memory variables |
|-------------------|---|---|---|---|
|                  | ICN | INF | NIM | PIM |
| CVLT-II 5 Trial Total | -3.66* | -2.24 | -4.08* | 1.29 |
| SDF               | -4.94** | -2.78 | -4.11* | 0.046 |
| SDC               | -3.73* | -2.12 | -4.50* | 0.061 |
| LDF               | -3.78* | -1.89 | -4.70* | 0.034 |
| LDC               | -2.05 | -0.10 | -5.03** | 0.249 |
| RAVLT 5 Trial Total | -4.47 | -5.53* | -2.75 | 1.50 |
| Retention         | -5.07* | -2.93 | -0.94 | 1.94 |
| Delayed Recall    | -3.82 | -3.38 | -1.66 | 0.062 |
| Retention & Recall Total | -4.75* | -3.39 | -1.43 | 1.35 |

Note: * p<.05, ** p<.01

Multiple regression analysis indicated that the five trial total on the CVLT, the total score on the depression scale of the PAI, and the total score on the somatic complaints scale on the PAI account for approximately 37% of the variance in ICN scores. The depression scale total score and the somatic complaints scale total score of the PAI along with the retention trial score and the combined total of the retention and delayed recall trial scores from the RAVLT account for almost 36% of the variance in ICN scores.
Discussion

Personality Characteristics

The current findings suggest a two-group classification with regard to MS patient profiles on the PAI. It should be noted; however, that these two "clusters" were not readily definable. While one group was seen to cluster around the Somatic Complaints Scale of the PAI, the other was much more dispersed, making it more difficult to identify commonalities. Hence, future research efforts focused on defining these two groups are necessary.

The overall tendency for individuals with MS to show elevations on the Somatic Complaints Scale (SOM) also deserves mentioning. It is imperative that such elevations be interpreted in light of individuals with MS existing medical condition. For example, it would be dangerous to assume that these elevations represent a somatoform disorder as defined by DSM-IV. Such an interpretation has the potential to result in a misdiagnosis which could negatively impact the patient’s course of treatment.

The discussion above highlights a need for future research. First, future research efforts focused on further defining the two groups identified in the cluster analysis is necessary. Second, future research investigating the items contained within the Somatic Complaints Scale (SOM) and scale of the PAI with regard to their ability to differentiate between somatoform disorders and medical conditions is warranted. Such research will allow for improved diagnostic and, thus, treatment services for individuals with MS.

Memory Functioning

The current findings suggest that the evaluation of memory in MS individuals is important, as self-report of memory functioning appears to be inaccurate. Significant difficulties with both short-term and long-term memory suggest that not only will individuals with MS have difficulty remembering their levels of activity, but they will also have difficulty learning new information. In addition, the evaluation of memory can have implications beyond those of memory functioning such that results can provide the treatment provider with an indication regarding the validity of a patient’s self-monitoring and self-report accuracy as it relates to other domains. Strategies such as keeping logs of behaviors or symptoms as they occur are likely to lead to more accurate reports than having the patient provide these records from memory.

The current findings highlight not only the importance of memory as it relates to self-report accuracy, but also suggests that depression (e.g., DEP scale) and somatic complaints (e.g., SOM scale) contribute to individuals with MS self-report inaccuracy, as well as the clinical contributions of the scales themselves. Elevated Negative Impression Management (NIM) scale scores were also significantly correlated with memory impairment. If personality measures with scales similar to NIM used with individuals with MS and these scales are elevated, the practitioner would be well served by investigating the memory functioning of the patient. Memory impairment alone or in combination with depression and somatic complaints may explain these elevations more accurately than the notion that they represent an effort on the part of the patient to appear more impaired than they truly are.
behavior. Granted, individuals may indeed be attempting to manipulate the test. (There are validity subscales that are better indicators of this factor than the F-K protocol). I note this example to caution against the tacit interpretation of these particular subscales in this manner for this subculture. If testing data may be influenced by the Evangelical Christian worldview, it is important that as psychologists we remain vigilant for other subtle nuances of cultural influence in our work with members of this subculture.

Perhaps a clinical example will help. The following quote or others similar are common among my clients, nearly all of whom are Evangelical Christians: “I feel under attack by the enemy lately. I know what I ought to do, but he just keeps putting roadblocks in my way.” My training as a scientist practitioner leads me to explore whether the client has a thought disorder (e.g. ideas of reference), is using passive resistance as a defense, or is hallucinating. Each of these hypotheses could surely be explored with Christian clients, and competent practice may dictate this choice. However, we should also understand the worldview well enough to realize that the reality of “spiritual warfare” is neither pathological or the result of resistance. A daily reality for many Evangelical Christians, is that there are spirituality forces working in active opposition to God’s plans for them.

The acceptance by psychologists of a Christian worldview as valid and functional has the potential to reduce the sources of resistance to psychological services for many Christians. In the above example, it’s suggested that the psychologist respectfully explore with the client how the client might respond to the difficulties they are reporting, which could easily involve the psychologist obtaining a limited release to enable them to consult with the client’s
we should be connected to our local professional community to have psychologists specializing in the treatment of this subculture as referral resources.

I am enthused about the ongoing dialogue between my professional and faith communities. It has long been my observation that each of these communities benefit from the other, though there are many areas in which we “agree to disagree.” My prayer is that the psychological community will continue to reach out to the Christian community with respect and appreciation.

Evangelical Christians are in need of psychological services from psychologists who are competent to work within their subculture. It is refreshing for them to find that many psychologists do not, and perhaps never did subscribe to Freud’s “universal obsessive neurosis” (Freud, 1961) perspective on their worldview. At the same time, psychologists can benefit from participation with this growing subculture by focusing on the healthy rather than the dysfunctional effects of Christianity.

About the Author:
Lee Wetherbee, PhD, is an associate professor in the counseling department at Ashland Theological Seminary and continues part-time clinical work at EMERGE Ministries in Akron. Though he has been in the mental health field since 1980 (as a child protective services worker in Stark County), his licensure as a psychologist is recent (2002). The integration of faith and practice for psychologists and their clients is a growing research interest that informs his practice and life. His most important role is as the husband of nearly 28 years to his high school sweetheart. He also has two adult children who will both attend Ashland University in the fall.

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Students in grades 7-12 journeyed from schools across Ohio to display their behavioral science projects at the 57th Annual State Science Day on Saturday, May 7.

Columbus psychologists and Central Ohio Psychological Association (COPA) members again served as judges for the event, which was held at the OSU French Field House. A total of $675 in cash prizes was awarded by The Foundation for Psychology in Ohio, including a $25 prize from the Ohio Women in Psychology Marla Malloy Scholarship Fund.

First, second and third place prizes were awarded to grades 7-11 with first place winners receiving $75, second place winners getting $50 and third place winners receiving $25. This year’s event saw the return of many students who had presented their work in the behavioral sciences the previous year.

Special thanks to Esther Hampton, Daniel Kuna, PhD, Jason McCray, MA, John McCue, PsyD, Michael Ranney, MPA, COPA executive director, Kay Rothman, PhD, William Schonberg, PhD, Jeff Sherrill, PhD, and Jason Sunbury, PhD, for contributing their time and energy to acting as judges in this year’s event.

(Left to right) Science Day judges for grades seven and eight were: James Sunbury, PhD, Jason McCray MA, Kay Rothman, PhD, John McCue, PsyD, and Dan Kuna, PhD. Not pictured are ninth, tenth, eleventh and twelfth grade judges: Esther Hampton, MA, Jeff Sherrill, PhD, William Schonberg, PhD, and Michael Ranney, MPA.

2005 Science Day Winners
Congratulations to all of the 2005 Science Day Winners:

**Grade 7**
Meghan Crawford - Columbus, OH - 1st Place
*The effect of self-monitoring on spelling test performance*
Drew Ritzel - Dayton, OH - 2nd Place
*Turn up the heat?*
Miranda Anandappa - Columbus, OH - 3rd Place
*Piagetian task*

**Grade 8**
Roisin McCord - Columbus, OH - 1st Place
*The strength and persistence of the anchoring bias*
Amanda Rhonemus - Bluffton, OH - 2nd Place
*Who has a better short term memory, males or females?*
Bradley Turnwald - Jennings, OH - 3rd Place
*Audio memory vs. visual memory*

**Grade 9**
Brian Hedges - Carroll, OH - 1st Place
*A comparison of emotional intelligence in mental health practitioners, mental health students, and non-mental health practitioners*
Taylor Clark - Carroll, OH - 2nd Place
*Physical discipline: Harmful or helpful Part II*

**Grade 10**
Nicholas Waggy - Upper Sandusky, OH - 1st Place
*Bior warfare: Where are the frontlines?*
Andrea Teggart - Bowling Green, OH - 2nd Place
*Does brain dominance affect eye-hand coordination?*

**Grade 11**
Jennifer Pelton - Hicksville, OH - 1st Place
*Is age a gauge of political awareness?*
Julia Ng - Sylvania, OH - 2nd Place
*The effect of long-term autogenic training on the cortisol tests*
OPA CALENDAR OF EVENTS
2005-2006

SEPTEMBER
• Executive Committee Meeting: September 16 (Central Office)
• Special Membership Meeting: September 16 at 5 p.m.
  – Approve Slate (Holiday Inn City Center)
• Board Retreat: September 16-17 (Holiday Inn City Center/Central Office)

OCTOBER
• Executive Committee Meeting: October 14 (Central Office)
• OPA Annual Convention: October 26 – 28, 2005 (Conference Center at North Pointe)
• Psychologically Healthy Workplace Awards Ceremony: October 26 (at Convention)
• PAC Fundraiser: October 27 (at Convention)
• Awards Presentations: October 28 (at Convention)
• Small College/University Roundtable: October 28 (at Convention)

NOVEMBER
• Executive Committee Meeting: November 11 (Central Office)
• Interpreting HIPAA’s Security Rule, November 17 (Vernon Manor Hotel, Cincinnati)

DECEMBER
• Executive Committee Meeting: December 16 (Central Office)
• Board of Directors Meeting: December 17

JANUARY - 2005
• Executive Committee Meeting: January 13

FEBRUARY
• Executive Committee Meeting: February 10 (Central Office)
• Board of Directors Meeting: February 11 (Central Office)

MARCH
• APA/State Leadership Conference: March 4-7 (Washington, DC)
• Legislative Day: March 28 (YWCA, Columbus)

APRIL
• Executive Committee meeting: April 7 (Central Office)
• Board of Directors Meeting: April 8

MAY
• Executive Committee Budget Retreat: May 5 (Central Office)

JUNE
• Executive Committee meeting: June 2
• Board of Directors Meeting: June 3

JULY
• Executive Committee Meeting: July 14 (if needed)

AUGUST
• APA Convention: August 18-21

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Benefits and Services of OPA Membership

- Ethics and Colleague Assistance Committee
- Extensive Web site 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)
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Call for Posters
for the OPA Annual Convention Student Poster Session
at The Conference Center at North Pointe, October 28, 2005
Lewis Center, Ohio (near Columbus)

The Ohio Psychological Association invites undergraduate and graduate students conducting research on psychology-based topics to present poster summaries at its Annual Convention, October 26-28, 2005. This year’s poster session will offer special recognition to students who have the most exemplary poster in two different categories: empirical or non-empirical research. Judging will occur between 8 a.m. and 11 p.m. on Friday, October 28.

The award winners will be announced during Friday’s lunch during the Convention, and the lead author will be entitled to the following:

• Cash prize
• Opportunity to highlight recipient’s research in a 2006 Ohio Psychologist article based on the poster
• One-year free membership to the Ohio Psychological Association, and
• Free attendance to the 2006 OPA Annual Convention (dates and location TBD)

The posters will be displayed from 8 a.m. to 3 p.m. on Friday, October 22, 2005. It is required that you accompany your poster from 8 a.m. to noon and 2:30-3 p.m. Friday. Student presenters may audit breakout sessions at no charge on this day only, if space allows.

Posters will be judged on the following: professionalism, conceptualization, methodology, conclusions and overall value. For a detailed list of judge’s criteria, please visit www.ohapsych.org.

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

An online entry form may be filled out or downloaded from OPA’s Web site at: https://www.ohapsych.org/Registration/PosterRegistration.htm

Please submit your proposal by September 30, 2005 to:
Poster committee
Ohio Psychological Association
400 East Town Street, Suite G20
Columbus, OH 43215-1999

E-mail: kcrabtree@ohapsych.org
call 800-783-1983 with questions
Include the following information so that we may review your proposal:

• Name, address, e-mail and phone number
• Title of research (empirical/non-empirical)
• Submit full paper that includes introduction, method, result and discussion
• University affiliation
• Faculty advisor name
• Abstract 50 words or less
• $20 presentation fee (make checks payable to the Ohio Psychological Association)

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 28, 2005.

New Members
Welcome to the following new OPA members, approved at the June 11, 2005 Board of Directors meeting:

Aaron P. Armelie, BA
Joseph A. Grochowski, PsyD, MDiv
Joyce A. Kubik, BA
Anne A. McVey, PhD
Steven D. Nichols, PhD
Lisa A. Paul-Bramer, PhD
Kathleen M. Payne, PhD
Lynn A. Yoshua, PhD
5 e-student members

WANTED:
Sponsors for OPA’s 2005 Convention Student Poster Session

OPA’s 2005 Convention is just around the corner, and OPA is looking for sponsors for its 2005 Student Poster Session. Sponsors will be recognized in OPA’s publications, the on-site Convention brochure, on OPA’s Web site as a sponsor and during the Awards Ceremony. The sponsor also will be given a photo opportunity with the poster session winner which would appear in future publication. Please contact Katie Crabtree Thomas at 800-783-1983 or kcrabtree@ohapsych.org if you are interested in this opportunity.
The OP Quiz for Continuing Education

This issue's articles are sponsored by the Ohio Psychological Association, an OPA-MCE approved provider of CE. Please complete this form in its entirety. All responses must be correct to receive 1.0 CE credit. For each question there is only one right answer. Please submit this form and payment (OPA members: $15; Non-Members: $25) by December 31, 2006 to OPA OP Home Study, 400 E. Town St., Suite G-20, Columbus, OH 43215-1999. Pending successful completion of this test, you will receive a certificate of completion within 30 business days of receipt.

Name: ___________________________ Address: ___________________________

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Signature: ___________________ Date: ___________ Print Name: ___________________________

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When psychologists develop dementia

1) Dementia is the most common cause of impairment among psychologists.
   True False

2) The average age of APA members in 2004 was...
   a. 46 b. 53 c. 35 d. 55

3) Psychologists should not conduct professional relationships with clients, supervisors or students when they are impaired due to mental, emotional, physiological, or substance abuse conditions as stated by which of the following:
   a. APA Code of Ethics
   b. Ohio State Board of Psychology
   c. Ohio Administrative Code
   d. Ohio Psychological Association Code of Ethics

4) Which is not a sign of a cognitively impaired psychologist?
   a. Increased errors
   b. Missed appointments
   c. Coming in late after getting lost on the way to work
   d. Spending more time at work

Empirical Support for Clinical Interventions

1) EBP stands for...
   a) Evidence Based Practice
   b) Evidence Based Psychology
   c) Evaluation Based Psychology
   d) Evaluation By Psychologist

2) According to the authors, empirically supported treatments have greatly improved the treatment of many medical conditions including cancer and heart disease.
   True False

3) Comparing treatments is more complicated when the length of treatment is held constant.
   True False

4) A limitation of EST methodology in psychology is that it doesn't account for the complexity of the pathology.
   True False

Ohio Psychologists' Duty to Protect When a Client is Potential Harm to Others

1) In 1974, the court in Tannos v. Regents of the University of California decided that psychologists had a duty to...
   a) protect
   b) warn
   c) control
   d) tell

2) In 1976, the court ruled again in Tannos and said there was a duty to...
   a) protect
   b) warn
   c) control
   d) tell

3) Which Ohio Revised Code gives professional's protection for either breaking or not breaking confidentiality?
   a) OGC 2305.5
   b) OGC 1114.32
   c) OGC 5122.34
   d) OGC 5675.5

4) In Estates of Morgan v. Fairfield Family Counseling Center, the court ruled that a relationship between a psychotherapist and the patient in the outpatient setting does not constitute a special relation justifying the imposition of a duty upon the psychotherapist to protect against and/or control the patient's violent propensities.
   True False

Use of E-mail with Clients

1) Psychologists need to be concerned about providing services via e-mail to clients in states where they are not licensed.
   False True

2) Which topics are key security issues relevant to use of e-mail with clients?
   a) use of firewalls
   b) use of antivirus software
   c) the type of computer hardware being used
   d) a & b & c
   e) b & c

3) There are no available professional guidelines or standards describing how to use technology and the Internet when providing client services.
   True False

4) The two most crucial components in using e-mail with clients are
   a) computer and writing skills of client and psychologist
   b) using the same e-mail program and computers
   c) description of potential risks and expectations
   d) establishing fees and times available for responding to messages

Working with Evangelical Christians

1) The author believes that historically Christians have been well served by psychologists.
   False True

2) Psychologists are cautioned to consider the worldviews of clients when interpreting psychological test scores.
   TrueFalse

3) Which is not an example of a topic of self disclosure recommended to help psychologists build trust and credibility with Christian clients:
   a) the role of spirituality in assessment and/or treatment
   b) the influence of the psychologist's spirituality on his or her practice
   c) level of comfort with addressing spiritual issues as part of therapy
   d) reservations about client religious beliefs

4) The author considers it unethical for psychologists to work with Evangelical Christian clients if their worldview is in opposition to that of their clients.
   False True

Prescription Authority for Psychologists

1) The primary reason that the psychiatric community objects to psychologists having prescriptive authority is
   a) it will adversely affect their income
   b) it will result in harm to patients
   c) only physicians have the necessary training to prescribe medications

2) Psychologists have prescriptive authority in how many states?
   a) 4
   b) 3
   c) 2
   d) 1

3) The most significant reason for psychologists to manage medications for clients they treat is to expand access to necessary services to more people.
   False True

4) ACES stands for
   a) Autonomy, Compliance, Economics, Security
   b) Authority, Continuity, Efficiency, Stability
   c) Access, Choice, Efficiency, Safety
   d) Access, Capable, Effective, Safety

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Psychologists/Psychology Supervisor
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Steven S. Schwartz, PhD, and Associates, 7870 Olentangy River Road #308, Columbus, Ohio 43235. Phone: 614-841-1101 Fax: 614-841-1957

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Keynote Address from Barbara Andersen, PhD, The Ohio State University
Special Plenary Session by Michael Sullivan, PhD, assistant executive director, APA Practice Directorate's state advocacy program