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Our theme this year is *OPA: Positively 60 and Beyond* as we celebrate 60 years as an organization. It is no coincidence that many of the articles in this year’s publication reflect concerns about aging and health. You will note that the articles recognize the diversity of opportunity for psychologists from private practice to public sector to academic. I hope that these articles, as well as the theme this year, will inspire you to consider writing about the changes you observe and the direction your orientation is headed for future OPA publications throughout this 60th Anniversary year. I invite you to consider participating in this celebration in whatever manner is most fitting.

Three of the articles included in this issue revolve around health issues. Gary Sipps, PhD, and Leon Howard, PhD, in the article *The Application of Health and Behavior Codes in a Pain Management Center* provide helpful information about using Health and Behavior Codes. They encourage psychologists to explore another avenue for providing services in a variety of settings as well as with a variety of populations. Kristi Barnes, PhD, looks at important dimensions of caregiving, and specifically the role of gender and technology in the article titled, *Redefining the Experience of Informal Care: Understanding the Role of Gender and the Implications of Technology in Shaping Caregiver Outcomes in Ohio.* This coincides with the article *“Mercy Killings” Among the Aging Population* by Julia King, PsyD, MBA, and Scott Bresler, PhD, which reviews current research on the prevalence of mercy killings.

In an effort to focus on hope for the future, we have three articles that provide an alternative perspective in dealing with the inevitabilities of life. One of those inevitabilities is death, and Richard Sears, PsyD, MBA, provides a review of an approach from the *Eastern Tradition in Death in Psychotherapy and Eastern Wisdom Traditions*. This complements a subsequent article titled *Mindfulness in Clinical Practice: A Basic Overview* in which Dr. Sears describe some of the basic principles in the practice of mindfulness. Janette McDonald, PhD, Kevin Eby, and Brittany Boch describe how hope interacts with systems thinking in the article *Systems Thinking and Hope: Designing a Transcendent Future for Psychological Well-Being.*

The article, *Protecting Human Participants in Research: What You Need to Know about the IRB*, written by OPA Ethics Committee member Elizabeth Swenson, PhD, JD, reviews important issues in conducting research and working with an IRB.

As is tradition, students who have won an award at OPA Poster Session during Convention are invited to publish their findings in this publication. Jessica Turchik is a winner for the second year in a row and I am sure you will understand why when you read her article *Sexual Assault in the Military: A Review of the Literature.* This is a compelling piece about a topic many are passionate about.

Don’t forget you can earn credit for reading the *OP*. Simply complete the quiz for continuing education at the back of the journal and send it to the OPA office.

We are very fortunate that as an organization we are able to continue to support a peer-reviewed publication. This reflects our maturity as an organization as we encourage members to participate in the process of having their work reviewed by their peers and raise the bar for expectations. I would like to extend my sincere appreciation to the peer reviewers who reviewed the manuscripts submitted for publication in this issue of the *OP*. They include; Kern Almos, PhD, Richard Ashbrook, PhD, William Bauer, PhD, Milton Becknell, PhD, Charles Dolph, PhD, Judy Fournier, PhD, Andrea Karkowski, PhD, Kathryn MacCluskie, EdD, Janette McDonald, PhD, Justin Perry, PhD, Sabato Sagaria, PhD, Elizabeth Swenson, PhD, JD and Michael Torello, PhD.

Ky Heinlen, PhD
Mindfulness in Clinical Practice: A Basic Overview
By Richard Sears, PsyD, MBA

Abstract
Mindfulness has been receiving growing attention in the clinical literature. This article describes the background, applications, and mechanism of mindfulness, and talks about how mindfulness can be used by the clinician.

Much attention has been given in recent literature to the concept of mindfulness and mindfulness-based interventions (Denton & Sears, 2009). This article presents an overview of the definition, mechanisms, and applications of mindfulness, and discusses the utility of the method for clinicians.

Background and Applications
Mindfulness involves learning to pay attention to and wisely working with our thoughts, bodily sensations, and emotions. The practice is learned through simple meditation exercises, through which one eventually comes to bring a richer awareness and presence into daily life. This reduces ruminating thoughts, helps prevent stress, anxiety, and relapses of depression.

Interest in the use of mindfulness is booming in the scientific literature and in the clinical community. The applications of mindfulness in clinical work are receiving growing empirical support, particularly in the prevention and treatment of stress, anxiety, and depression. The use of mindfulness for clients dealing with stress and chronic pain was pioneered by Kabat-Zinn, in a Mindfulness-Based Stress Reduction (MBSR) program (Kabat-Zinn, 1990). Subsequently, mindfulness has been incorporated into a variety of treatments, such as Mindfulness-Based Cognitive Therapy (MBCT) for prevention of depressive relapse (Segal, Williams, & Teasdale, 2002), Dialectical Behavior Therapy (DBT) for borderline personality disorder (Linehan, 1993), Acceptance and Commitment Therapy (ACT) (Hayes, Strosahl, & Wilson, 1999), and Mindfulness-Based Relapse Prevention (MBRP) for addictions (Witkiewitz & Marlatt, 2007). These programs are now considered evidence-based practices (Didonna, 2009; Germer, 2005).

Mindfulness-based groups (such as MBSR and MBCT) typically meet weekly for eight sessions. The meetings consist of education, discussion, practice of mindfulness, light stretching exercises, and homework assignments (Kabat-Zinn, 1990; Segal, Williams, & Teasdale, 2002). Mindfulness has been called the “third wave” in cognitive-behavioral therapy (behavioral therapy is seen as the first wave, and cognitive therapy as the second) (Hayes, 2004; Segal, Teasdale, & Williams, 2004). Though it has historical roots in meditative disciplines, there are many studies showing evidence of changes in brain functioning in individuals who regularly practice mindfulness (Siegel, 2007, p. 221). Kabat-Zinn defines mindfulness as “the awareness that emerges through paying attention on purpose, in the present moment, and nonjudgmentally to the unfolding of experience moment to moment” (Kabat-Zinn, 2003, p. 145). Through systematic exercises, clients learn new ways of working wisely with their own thoughts and emotions.

Mechanism
The mechanism of mindfulness is thought to be exposure, operating on the same brain mechanisms that are affected by behavioral interventions for anxiety. Worry can be seen as a cognitive strategy for reducing anxiety (Orsillo, Roemer, Lerner, & Tull, 2004). While thinking about all the possible things a person can change about a given situation, the person is attempting to avoid experiencing the anxiety in the moment, and the ruminations are maintained through negative reinforcement. In mindfulness, acceptance of whatever is present is learned. Although a person may choose to change undesirable circumstances, accepting the truth of the present situation is the first step. By allowing oneself to feel whatever physical sensations are present, whatever emotional reactions are occurring, and by observing what thoughts are in the mind, one can remove oneself from the sense of over-identification with them. This process is known as “decentering” (Segal, Williams, & Teasdale, 2002, p. 38). This is similar to the shift from content to process that is frequently used in individual and group psychotherapy.

This decentering process may, in fact, be a crucial mechanism for the success of traditional cognitive-behavioral therapy. In learning to recognize thoughts, and in challenging irrational thoughts, the individual becomes less identified with the thoughts and feelings themselves. However, in mindfulness training, this process of moving back to view one’s own thoughts, feelings, and sensations is explicitly developed. Rather than fighting thoughts with thoughts, one recognizes that thoughts are not necessarily facts (even the ones that say they are) (Segal, Williams, & Teasdale, 2002).

Mindfulness for the Clinician
As a prerequisite to competently using mindfulness in clinical practice, the clinician must be able to effectively use the techniques personally (Segal, Williams, & Teasdale, 2002). Daily practice conditions the clinician to be more aware of how thoughts and feelings manifest and dissolve. Using the technique before and after seeing a client can help to keep the clinician focused on being aware of the client’s issues while diminishing the distraction of extraneous or irrelevant feelings of countertransference.
Mindfulness can also be important in therapist self-care. From early on in graduate school training, clinicians are given a double message: take care of oneself, but be a high achiever. Too much is squeezed into a day, while counseling others on how to reduce stress.

As a simple introduction to mindfulness, therapists can practice the “three minute breathing space” (Segal, Williams, & Teasdale, 2002). In the first minute, one becomes aware of what is present in this moment. This includes any physical sensations, such as muscular tension, any feelings present, and any thoughts one is having. During this phase, repeating to oneself, “whatever is happening right now, just let me feel it” may be helpful. In the second minute, one focuses one’s attention on the breath. This allows one to stay focused on one simple thing in the present, and not get pulled off into ruminations. In the third minute, one then expands one’s awareness to the body as a whole, with a sense of gently holding one’s present experience in an accepting way.

Typically, clients are taught the three-minute breathing space after investing the time in doing each of the components as daily homework assignments for several weeks. The three-minute breathing space then becomes a “shortcut” for maintaining attention and presence. Using these exercises helps one to step out of the automatic pilot mode in which one too often lives, allowing old, unconscious, maladaptive patterns to be discarded.

Conclusion
In many ways, the concept of mindfulness is not new. However, the growing systematization of teaching the skills and attitudes, supported by a growing research base with diverse populations, may lead to more effective interventions that more fully bring out the best in clients and clinicians.

References


About the author

Richard W. Sears, PsyD, MBA, ABPP, is a core faculty member of the PsyD Program and director of the Center for Clinical Mindfulness & Meditation at the Union Institute & University in Cincinnati, where he also runs a small private practice and conducts mindfulness groups. He is co-author of “The Clinical Uses of Mindfulness” in Innovations in Clinical Practice and lead author of Consultation Skills for Mental Health Professionals. He can be contacted at richard@psych-insights.com.
Mr. R, a 76-year-old Korean War veteran with no known criminal history, had no history of mental health treatment, had a history of long-term, stable employment, and had been married 45 years. Mr. R killed his wife, age mid-60s, and his sister, age late-80s, with a gun.

So-called mercy killings in the elderly are not well understood. The literature, although limited to date, suggests that these events—either the killing of a female spouse or a homicide-suicide—are perpetrated by older male spouses (Canetto & Hollenshead, 2000-2001; Cohen & Grabert, 2001). These men are often times in the role of the primary caregiver, are likely to feel overwhelmed by stress, hopelessness, and isolation and often go untreated for depression (Beery et al., 1997; Malphurs & Cohen, 2005). There may be early undetected signs of dementia as well, further compromising coping capacities for stress. Although female caregivers may also experience such feelings, they are less likely to resort to killing or homicide-suicide (Canetto & Hollenshead, 2000-2001).

The aforementioned case of Mr. R is an actual case that recently occurred, which is being offered here with the family’s permission for its instructive value. This article will describe the literature relevant to this phenomenon in the context of a case presentation of an intrafamilial double homicide.

Mr. R, a 76-year-old Korean War veteran with no known criminal history, had no history of mental health treatment, had a history of long-term, stable employment, and had been married 45 years. Mr. R killed his wife, age mid-60s, and his sister, age late-80s, with a gun.

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The combination of these trends has led to an increase in the prevalence of mercy killings and intrafamilial homicide-suicides among the elderly, particularly with regard to situations in which male caregivers are the primary source of caregiving to their female spouses. This article offers a discussion of the literature relevant to this phenomenon in the context of a case presentation of an intrafamilial double homicide.

Mr. R described his sister as: “She didn’t have a life.” He admitted...
to feeling the burden of being primary caregiver to both his wife and sister.

This case has many features consistent with characteristics of mercy killings identified in the emerging literature (Cohen et al., 1990; Malphurs & Cohen, 2005) as often based on the premise that a person’s quality of life can deteriorate to the point that killing is considered by the perpetrator as an act of compassion, independent of consent. Although, in some instances, a victim may request to be killed, research suggests that in many cases, as was apparently the case with regard to Mr. R’s wife and sister, they were not knowing or willing participants in their deaths. Similar to this case, research on cases of homicide-suicide in the elderly (Cohen, 2000) revealed that most victims are often unaware of the plans for the homicide-suicide or are unwilling to participate. In addition, most victims are shot in the back of the head or chest in their sleep, and typically, no evidence is discovered from surviving informants that the victim wanted to be dead or killed (Cohen, 2000); both of these trends are consistent with our case example.

Similar to his wife and sister, Mr. R was also showing a decline in health in the time prior to the killings, suffering from congestive heart failure and pain (i.e., arthritis and gout). Also notable, three years prior to the killings, one of Mr. R’s daughters died unexpectedly and he experienced an ongoing complicated bereavement after her death. Mr. R had also suffered financial difficulties, taking out several large loans prior to the killings to pay for medical expenses.

The experience of caregiving burden, depression, and the presence of other significant stressors may help explain the motivations of perpetrators who carry out mercy killings. Malphurs and Cohen (2005) have shown that an elevated risk of depression is associated with the caregiving role, with caregivers being three times more likely to be depressed (Beery et al., 1997). Moreover, depression often goes untreated in this population, despite multiple, frequent visits to medical professionals (Cohen, 2000). Malphurs and Cohen (2005) have suggested that male caregivers may be more easily overwhelmed with the role of caregiving and may become impatient with its demands. They may project their own frustration onto the recipient of their care and become convinced that their ailing spouse is seeking a way to not be a burden. Despite the fact that they carry the greatest burden of caregiving, women are less likely to resort to mercy killing.

Mr. R was charged with two counts of aggravated murder and was court-ordered to undergo evaluations regarding his competency to stand trial and his mental state at the time of the offenses. He died in jail from health complications while awaiting trial. An autopsy revealed, amongst other findings, the presence of “mild neurodegenerative changes of the cerebral cortex and hippocampus (i.e., neuritic plaques).”

Regarding this specific case, there was clearly evidence to support the presence of multiple stressors impacting Mr. R to the degree that his ability to think rationally about his actions could have been negatively impacted or significantly degraded. That is, there appeared to be some support for the position that his ability to rationally consider his options and comport his behavior in a lawful manner was negatively impacted by compounded stressors in his life. Whether or not this stress reaction reached a level to be considered legal “insanity” and thereby exculpatory depends on how the case is presented and the jurisdiction in which it is heard.

In summary, as the elderly population continues to grow, and older Americans remain at the greatest risk for developing health-related disabilities, the families of these individuals, primarily their spouses, will continue to be their primary caregivers. Caregivers can experience an inordinate amount of stress, and develop symptoms of depression and other mental health problems because of their role as primary caregiver. The combination of these trends has led to an increase in the prevalence of mercy killings among the elderly.

“Mercy killings” in the elderly are not well understood. However, the limited available literature suggests that these events are predominantly perpetrated by older male spouses in the role of the primary caregiver with the incident resulting in the death of a female spouse or a homicide-suicide. As observed in response to caregiving burden in general, these men are likely to feel overwhelmed by stress, hopelessness, and isolation and often go untreated for depression, and may experience an early dementia process as well. Although female caregivers may also experience such feelings, they are less likely to resort to killing or homicide-suicide, despite the fact that they are much more frequently in the role of primary caregiver than their male counterparts. This observation could possibly be due to the differences in gender attitudes about caregiving and killing; and it has been suggested that it is possible that such attitudes may be more important than an individual’s actual involvement in, and stress experienced from, the practice of caregiving itself (Canetto & Hollenshead, 2000-2001).

It is imperative that aging caregivers be provided with support (e.g., respite care) and comprehensive mental health assessment, especially in cases involving male spousal caregivers who may be psychologically and physically ill-equipped to provide such care.

References


About the Authors

Julia A. King, PsyD, MBA, is currently serving as the director of forensic services at Forensic and Mental Health Services, Inc., in Hamilton, Ohio, as part of her private practice, is a member of the team at the University of Cincinnati’s Institute for Psychiatry and Law as a consulting psychologist. Having graduated from Widener University and completed a post-doctoral forensic psychology fellowship with the University of Cincinnati, division of forensic psychiatry, Dr. King is a licensed psychologist who has specialized her education, training, and experience in both forensic and organizational psychologies. She currently performs a variety of forensic psychological evaluation services (i.e., juvenile, criminal, guardianship, domestic relations, and risk assessment) to courts and attorneys, as well as organizational consulting services (i.e., needs assessment, program planning and implementation, program evaluation, pre-employment evaluations, threat assessment, and workplace violence) to agencies and businesses.

Scott Bresler, PhD, is presently serving as clinical director of the Center for Threat Assessment at the University of Cincinnati’s Division of Forensic Psychiatry. Dr. Bresler had been an assistant professor of psychiatry at the University of Massachusetts, department of psychiatry, where he served as associate director of forensic services at Bridgewater State Hospital for four years. Prior to that, Dr. Bresler was appointed research assistant professor at the University of Nebraska-Lincoln for eight years. There, he conducted forensic evaluations at the Lincoln Regional Center, and provided neuropsychological consultations for the Nebraska State Veterans Homes. Dr. Bresler has many years of experience in the assessment and management of persons who engage in high risk behaviors. In addition, he has taught many relevant courses, given multiple trainings and supervised students at both pre-doctoral and post-doctoral levels. Presently, he provides forensic psychology consultation in both criminal and civil cases. He teaches in the forensic psychiatry post-doctoral fellowship program at UC. He also conducts neurocognitive assessments in both inpatient and outpatient settings. He is a licensed psychologist in Ohio, Massachusetts, and Nebraska.
Redefining the Experience of Informal Care: Understanding the Role of Gender and the Implications of Technology in Shaping Caregiver Outcomes in Ohio

By Kristi Barnes, PhD

Abstract

Census data indicate that the number of older Ohioans will continue to grow, underscoring the importance of understanding factors that influence caregiver outcomes. This article focuses on the role of gender in influencing caregiver well-being. Specifically, research findings are inconsistent regarding the vulnerability of male caregivers to the negative effects linked to this role. The role of technology in creating new ways to satisfy the needs of caregivers is also a focus. Implementing Internet resources such as Ohio’s “Network of Care” is discussed. The utility of this method of service delivery in overcoming geographic isolation typical of rural areas and offsetting gender-related barriers male caregivers may experience in seeking traditional forms of social support are outlined as well.

The Increasing Need for Individuals to Assume Informal Caregiver Roles

As the number of adults over the age of 65 years grows, the number of caregivers to individuals who experience health-related issues affecting functional abilities will also increase (U.S. Bureau of the Census, 2005). These statistics are of particular importance to Ohioans, given that 13.4% of the state’s population are older adults (U.S. Bureau of the Census, 2007) which is higher than the national average of 12.3%. According to a review by McGuire, Anderson, Talley, and Crews (2007), recent statistics indicate that there are nearly 44 million Americans who have assumed the role of informal caregiver. McGuire et al. (2007) note that informal caregivers are those individuals who take on caregiving tasks with no financial compensation. Without informal caregivers to accept these healthcare responsibilities, thereby delaying the need for formalized care and reducing the associated costs, those expenses would overwhelm the community. Not only are the expenses considerable and the responsibilities arduous, but the negative physical and psychological effects many caregivers experience have been well-documented (e.g., Deiner, Suh, Lucas, & Smith, 1999; Ekwall, Sivberg, & Hallberg, 2004; Schulz, 1990; Zhang, Vitaliano, & Lin, 2006). It is important to recognize that a variety of factors influence the extent to which caregiver well-being is negatively affected. These factors pertain to characteristics of the caregiver, the care-recipient, and the availability and access to resources (e.g., Lawton, Rajagopol, Brody, & Kleban, 1992; Patrick & Hayden, 1999; Pruchno, Patrick, & Burant, 1996). Based on the research, the extent to which findings based on a specific caregiving context can extend to other situations is limited because of the multitude of factors that can affect the caregiving experience. These contexts include caregiver gender, the type of illness and related symptoms experienced by the care-recipient, the specific familial relationship between caregiver and care-recipient, and the pre-existing positive or negative relational dynamics between the two, etc. (e.g., Lawton et al., 1992; Patrick & Hayden, 1999; Pruchno et al., 1996).

Gender Issues Related to Caregiving

One caregiving context that received considerably less attention until the 1980s is caregiver gender (Stone, Cafferata, & Sangl, 1987). Specifically, researchers are interested in examining whether gender may uniquely contribute to different caregiving experiences (Ekwall et al., 2004; Kim, Loscalzo, Wellsch, & Spillers, 2006; Kim & Carver, 2007; Zhang et al., 2006). According to statistics cited by Gandel (2009), this interest coincides with the growing availability of male caregivers to study. Findings from this comparatively smaller body of research indicate a lower prevalence of negative physical and psychological outcomes among male caregivers (e.g., Chiu, Chen, & Wang, 2005; Zhang et al., 2006). However, these findings may be tenuous (e.g., Kim et al., 2006; Ekwall et al., 2004; Matthews, Baker, & Spillers, 2004). Caregiving may involve very different tasks, which may or may not be linked to socialization differences, for males and females in the caregiver role (e.g., Ekwall et al., 2004; Kim et al., 2006). Observed gender differences in caregiver outcomes cannot be separated from differences in the types of tasks that male and female caregivers typically assume. In addition, it is important to consider that self-reports of physical or psychological well-being may be biased. According to Brannon (2005), literature on the “Male Gender Role Identity” suggests that males may be less likely to report physical or psychological symptoms because doing so would be inconsistent with traditional definitions of masculinity. Moreover, it is important to recognize that the small numbers of informal caregivers who are males pose clear challenges to researchers attempting to identify differences that are statistically significant (e.g., Bookwala & Schulz, 2000; Hooker, Monoogian-O’Dell, Monohan, Frazier, & Shiffren, 2000).

Census data clearly substantiate the need for systematic research examining well-defined caregiving situations so that the most suitable resources to protect the well being of all informal caregivers, male or female, can be implemented. Given the large number of older Ohioans (U.S. Bureau of the...
Census, 2007), there is a significant probability that the role of caregiving will directly or indirectly affect the lives of many living in the state. It is of particular relevance to Ohioans that researchers carefully consider the factors related to caregiver outcomes and the viability and effectiveness of new technology supported by the state to improve the delivery of mental healthcare services.

Technology and Caregiver Interventions: Addressing Gender Issues and the Needs of Rural Caregivers

Nearly 200,000 of the older adults who live in Ohio are residents of one of the 29 Appalachian counties in the state (Ohio Department of Development, 2007). Consistent with regional trends for Appalachia, demographic profiles for a majority of these counties reflect more economic concerns and fewer healthcare resources. Therefore, caregivers in this area may face additional stressors and poorer outcomes. Yet, some research suggests that psychological outcomes among older Appalachians are comparable to those of older adults living elsewhere (e.g., Patrick, Cottrell, & Barnes, 2001). However, this may not apply specifically to those Appalachians who are informal caregivers. Given the geographic isolation that is common to many Appalachian areas, researchers have examined the effectiveness of alternative forms of delivering mental healthcare (e.g., Mohr, Hart, & Marmar, 2006; Shoffner, Staudt, Marcus, & Kapp, 2007). Results indicate this may be a way to promote psychological well-being (e.g., online support groups, etc.) among individuals who lack the time or resources that could be beneficial.

Specifically, findings focusing primarily on female caregivers provide evidence that social support may improve caregiver outcomes (e.g., Bisconti & Bergman, 1999; Gallant & Connell, 1998). However, the responsibilities of providing care frequently interfere with the time that is available to use formal social support resources (e.g., support groups). Respite care isn’t an option for many informal caregivers due to the expense. Moreover, the lack of compatibility between traditional ideas of masculinity and use of support groups that emphasize coping mechanisms that are traditionally feminine (Pickett-Schenk, 2003) may further discourage male caregivers from participating. Non-traditional forums would make receiving support more practical and accessible. These technology-based resources may be less “gendered” forms of support and therefore may be more useful to males and females who have adopted the role of caregiver.

“Network of Care:” Helping Caregivers in Rural Ohio

The President’s New Freedom Commission on Mental Health has favorably acknowledged the web-based “Network of Care” established by the state of California and adopted by Governor Strickland for Ohioans (Network of Care, 2009). This program uses existing technology to combine the resources used to provide mental health services. The program makes it easier for individuals to identify local professional services, communicate with insurance providers, and learn more about treatment options. Moreover, users have the option to permit different care providers secure-access to their records thereby enabling better communication and fostering the development of treatment plans that are comprehensive and effective. Although there may be concerns about the viability of this model for Appalachian areas, since its adoption the network has expanded to include all of the rural counties in the state (Network of Care, 2009). Programs similar to this are likely to redefine mental healthcare services. As Internet access spreads to rural areas and technology continues to evolve, the potential for crossing geographic divides and effectively addressing the mental healthcare needs of male and female caregivers will improve.

Consistent with national trends, the number of informal caregivers in Ohio will only continue to grow (U.S. Bureau of the Census, 2007). Research suggests that there are a variety of factors that impact caregiver well-being and that caregiver outcomes are not uniform (Lawton et al., 1992; Patrick & Hayden, 1999; Pruchno et al., 1996). The number of men adopting caregiver responsibilities has increased (Gandel, 2009), yielding closer examination of the influence of caregiver gender. Although findings suggest that males may experience fewer negative outcomes, these should be interpreted cautiously given the small number of male caregivers involved in systematic research (Brannon & Schulz, 2000; Hooker et al., 2000) and socialization differences that may bias male self-reports of well-being (Brannon, 2005). The use of technology to deliver informational and supportive resources to caregivers may prove particularly beneficial to men who are less likely to use support groups (Pickett-Schenk, 2007), as well as to those who live in rural Ohio who may be experiencing more pronounced stressors linked to the availability of fewer needed resources (Ohio Department of Development, 2007). The “Network of Care” provides information and access to all of the rural counties in the state (Network of Care, 2009). As a result, the number of resources has grown and these residents are better informed about these resources and how to access them. Technology-driven models such as this are making it possible to reach more people and likely provide individuals with a greater sense of control in shaping their own outcomes. Clearly, the profile of “caregiver” evolved to include men and so have the means for targeting and delivering resources to better protect all informal caregivers.

References


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**About the Author**

Kristi A. Barnes, PhD, received her BA in psychology in 1998 from Marietta College in Marietta, Ohio where she earned departmental honors. Kristi earned both her master’s degree (2000) and doctorate (2003) in lifespan developmental psychology from West Virginia University in Morgantown, WV. Her research interests include marital satisfaction, informal caregiving, gender differences, and social support. Kristi has examined these phenomena as they relate to middle age and older adults, as well as rural populations. Kristi is an assistant professor of psychology at Ohio University Southern where she has been a member of the faculty since 2005.
Death is not often systematically studied in clinical training, but often comes up in therapy. Being able to address death directly with clients is important for therapists, and can lead to a greater appreciation of life. This article briefly discusses the existential psychotherapeutic tradition in comparison with the Eastern wisdom traditions.

Death (or more symbolically, “change”) is an important factor in the existential psychotherapeutic tradition (Yalom, 1980). Physical death is guaranteed to occur to every human being without exception, and hence, creates a great deal of anxiety (Mikulincer & Florian, 2004). However, modern society in general rarely speaks about death. Clients often come to psychotherapy after the loss of a loved one because friends and relatives are uncomfortable with how to relate to death, often telling the grieving person to “get over it” or “get on with their lives.”

With certain notable exceptions (e.g., Becker, 1998; Freud, 1963; Kubler-Ross, 1997; Yalom, 1980), modern society has historically not prepared people very well for the inevitability of death, and most individuals try to avoid talking or thinking about it. Hence, when death does come, people are unprepared to process it. Although being educated about death does not remove the pain of being separated from a loved one, a little preparation can help one to grieve fully (whatever that means to the individual or culture) without adding additional anxiety or worries about the grieving itself.

In the Eastern wisdom traditions, death is meditated upon systematically. There are several components to this contemplation process. One is the idea of the universality of death (McDonald, 1984; Sogyal Rinpoche, 2002). One considers that all living creatures, without exception (including oneself), will one day die, including all loved ones, all pets, and everyone who has ever lived or will ever live.

Another component of the contemplation practice is to consider the inevitability of death (McDonald, 1984; Sogyal Rinpoche, 2002). One considers that there is no escape from death. This is important, as many individuals feel that certain people will always be in their lives. Even those who are fabulously wealthy can still get sick or die of cancer; even the most brilliant person can die in a car accident. There is no one in the world who has ever permanently cheated death, no one that death has simply forgotten about.

Another consideration is that one does not know when death will occur (McDonald, 1984; Sogyal Rinpoche, 2002). Sometimes children die before parents do. Sometimes babies die in their cribs. Not knowing when death will occur keeps one more appreciative of this moment, for the time that one does have to live.
A further consideration is that one does not know the manner of one’s death (McDonald, 1984; Sogyal Rinpoche, 2002). A person could die peacefully while sleeping, or die slowly and painfully of cancer.

In Western Existential psychotherapy, death is one of the “four givens” besides freedom, isolation and meaninglessness of human existence (Schneider, 2003; Yalom, 1980). By facing these existential truths directly, one becomes inoculated to the anxiety that grows from avoidance of these issues. One is then freed to appreciate each moment of life as it unfolds, and to create a meaningful existence.

By becoming more aware of and comfortable with death and change, clinicians may be able to be more fully present with clients as they face this inevitable given of life. The traditions of the East may inspire modern scientists into researching the effectiveness of systematically contemplating death.

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Systems Thinking and Hope: Designing a Transcendent Future for Psychological Well-being

By Janette E. McDonald, PhD, Kevin C. Eby and Brittany Boch

Abstract
What affect does hoping have on the design of our future? Philosophers, theologians and psychologists have studied and romanticized the phenomenon of hope for centuries. However, until recently, little attention has been given to hope from an interdisciplinary perspective. This paper integrates multiple perspectives concerning systems thinking and hope. Direct attention is given to the seminal works of systems theorists Erich Jantsch, Ervin Laszlo, and Ilya Prigogine. To illustrate the natural quality of “openness” in human systems concepts of dissipative structures, self-organization, and self-regulation are discussed in relationship to psychological health, transcendence, and hope. The human organism is a naturally open system that responds and contributes in meaningful ways to the design and evolution of life.

Introduction
It could be argued that humankind can and ought to play an active role in the design and evolution of worldly affairs and ultimately in our own future. For several decades, psychologists and sociologists have noted increasing attitudes of helplessness and despair (Slater, 1970). To illustrate a way to address these, we integrate the ideas of Ervin Laszlo (2007) and the two late physicists Erich Jantsch (1975) and Nobel Laureate, Ilya Prigogine. These ideas demonstrate how planning can lead to a higher (or transcendent) level of being. Jantsch (1975) emphasizes humankind’s purpose and meaning with the intentional shaping of destiny. He states: it will be man’s role to design his world in consonance with evolution, to regulate it in such a way that the cultural mutations become conscious and a matter for design, too, and the whole process of stepping up becomes smoother...I believe that the phase of evolution on the earth which Teilhard de Chardin calls noogenesis, includes an active role of man in designing and furthering evolution—in becoming, individually and through ever more complex human systems, the spearhead of evolution of this planet...a phylum of humanity may be actively guided through successive evolutionary steps, with human consciousness acting out internal factors of evolution—we have to try, without having the assurance of success—we have the consciousness and the tools to try—and a sense of meaning and purpose of human life which is perhaps the greatest uplift which the idea of evolution has given us. We are neither the manifestations of random fluctuations, nor the dumb children of some unpredictable god; we can indeed shape our own future and the course of evolution (Jantsch, 1975, p. 296-7).

Jantsch suggests that humankind may have a choice in the kind of world we create for ourselves and future generations. Like hope, Jantsch notes our evolutionary quest comes with no certainties, yet he affirms that we must proceed without these because there is indeed meaning and purpose in our existence. As mentioned above, noogenesis was a term used by Teilhard de Chardin (1959) to mean a higher level of human existence and consciousness. The above statement suggests that human potential and ability to consciously affect the design of the future did not begin with contemporary scientists. Teilhard de Chardin wrote about it nearly a 100 years ago. The statement further implies a quality that is inherent in systems thinking—the potential for purpose and meaning—and albeit, hope.

Systems Theory: A Rudimentary Understanding of Dissipative Structures
Systems theory grew from von Bertalanffy’s work in biology called General Systems Theory. Systems thinking is an emerging paradigm that evolved out of Systems Theory and views the universe as a holistic living organism with vast interdependent and dynamic connections. Related fields include chaos and complexity theory, neuroscience, integral theories, as well as quantum physics. In addition, Laszlo (2007) currently studies and writes about a recondite non-local phenomenon he calls the A-field, a field of energy where all universal knowledge resides. Jantsch (1975), in Design for Evolution, explores systems theory as an integrative model of biological, physical and spiritual components where human beings potentially design and take action toward their future and evolutionary processes (p. 47).

Through processes of self-organization, healthy systems evolve or transcend to higher more sophisticated levels of being. Although indigenous and ancient cultures have long understood a similar epistemological condition of existence, only during the last forty years has the paradigm grown in significance. Laszlo’s work is worthy of further reading in this regard.
In 1977 Prigogine won a Noble prize in chemistry for the discovery of dissipative structures, specifically noting that all structures and domains of reality behave in an orderly fashion, albeit a fluctuating order. His famous expression, “order through fluctuation” is the primary quality of a dissipative structure. At first glance, this fluctuating order may appear disorganized; however, this seeming disorder is simply a part of the self-organizing principle.

**Openness-Qualities of Dissipative Structures**

Dissipative structures have qualities of openness or at least partial openness because they are, by definition, in a state of non-equilibrium. Open structures interact with the environment by giving and taking energy from it while possessing a certain amount of freedom to respond to it. Environment usually refers to the physical aspect in systems thinking, but the environment is an expansive term and also includes the mental, social, and spiritual. Open systems then are not balanced in the typical sense of the word, as in possessing a stable or steady quality. On the contrary, they are unstable and this instability is precisely what leads to newer levels of existence. That is to say, open systems possess a certain amount of freedom to respond to it. Environment by giving and taking energy from it while in a state of non-equilibrium. Open structures interact with the environment, and in concert with its ebb and flow. Individual and societal choices are elements of open-systems. It is through our choices of action that we affect change and in a sense play an active role in the planning and design of our evolution.

**Attempting to Define Hope**

To provide a definition of hope that both scientists and philosophers can agree upon is a difficult task. Several thinkers and theorists have offered useful examples. Perhaps one of the more noteworthy is Viktor Frankl and while he does not provide a specific definition of hope, Frankl does imply that hope has a transcendent quality that is connected to one’s purpose and meaning (1984, p. 54). Extending beyond the discipline of psychology, Havel (2003), the former leader of the Czech Republic, states that hope is:

“...a dimension of the spirit, an orientation of the heart. It transcends the world that is immediately experienced and is anchored somewhere beyond its horizon. It is not the conviction that something will turn out well, but the certainty that something makes sense regardless of how it turns out” (Wheatley, 2003, p. 23).

A more poetic and artistic expression came from the French philosopher Gabriel Marcel more than a century ago:

“...The zone of hope is also that of prayer...It always has to do with the restoration of a certain living order in its integrity. But it also carries with it the affirmation of eternity and eternal goods...I was thinking this morning that hope is only possible in a world where there is room for miracles...hope is really a prophetic power. It has no bearing on what should be or even on what must be; it just says this will be. Reflecting on hope is perhaps our most direct means of apprehending the meaning of the word ‘transcendence’, for hope is a spring, it is the leaping of a gulf (Marcel, 1965, 75-9).”

Here, Marcel unveils a significant philosophical point that aligns with systems thinking; that hope has no bearing on the situational outcome, and he suggests it waits with openness for whatever life offers. As noted earlier imperfections and imbalances are as much a part of creating healthy life systems as are perfection and balance. In other words, we need life’s imperfections to move us toward deeper levels of meaning and upward toward more profound levels of evolution.

**Actions of Hope-Designing and Planning Our Future**

In this paper, the spirit of interdisciplinarity multiple perspectives have been integrated with systems theory. In the context of hope, the authors have tried to demonstrate that our actions of planning most certainly affect our future, our evolution, and our psychological well-being and can ultimately lead to a more hopeful, purposeful, intentional world. More importantly, hope is a natural part of the human condition and potentially stands to positively impact our future.
It seems fitting to conclude with a quote and an image discussed by Jantsch. He states that active planning and love are guiding principles of our evolution. Near the end of his book, he writes:

“Design, as I have said, is the interplay of planning and love, of fixing and flowing. Without love, we would lock ourselves into a solid cage; without planning, we cannot build a human world and play our proper active role in evolution. Without either, humanity would come to an end. Design implies centering and graceful motion; acting out and listening at the same time; letting subjective judgment and objective insight, subjective and objective will flow together. Design... is fluidity paired with precision—it is the recognition of imperfection as the inner most essence, the energizing principle, of human life (Jantsch, 1975, 296-7.)”

References


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Janette E. McDonald is an associate professor at Capital University. Her research areas are end-of-life systems thinking, and Buddhist psychology.

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The Application of Health and Behavior Codes in a Pain Management Center

By Gary J. Sipps, PhD, & Leon C. Howard, PhD, PCC-S

Abstract

The authors present information regarding the nature of the Health and Behavior Codes. The value and benefit of their application is delineated. Specific application of the Health and Behavior Assessment in a medical setting, a pain management center, is described. Other possible opportunities for the employment of these codes are considered. The authors encourage psychologists to consider the practice of Health and Behavior Assessments, Reassessments, and Interventions in a variety of settings and with a variety of populations.

Integrating Health and Behavior Assessments and Interventions within a medical setting contributes to the comprehensive biopsychosocial approach to patient assessment and treatment. The Health and Behavior Codes have been in effect for more than six years: they were first published in the Federal Register (Office of the Federal Register, 2001) in 2001 and were included in the Current Procedural Terminology (CPT) (American Medical Association, 2002) manual and the Medicare Fee Schedule in 2002 (Integrated Behavioral Health Project, 2007).

They afford psychologists the opportunity to provide services to those who do not necessarily present with a psychological condition. This extends the benefit that psychologists provide to those other than in traditional assessment and psychotherapy. They make it feasible for psychologists to offer medical professionals valuable services that can improve their treatment effectiveness. It also affords psychologists a referral source that can greatly expand their practices, by conducting assessments and interventions that are likely already within their professional repertoires. Although Medicare and many private insurance companies pay for these services, it appears that relatively few psychologists have pursued the opportunities provided by the introduction of these procedure codes.

“The health and behavior codes were developed to provide psychologists and other health care providers with a way to accurately capture services that focus on the biopsychosocial factors affecting physical health problems. Examples of the physical health issues that psychologists might address under the new codes include patient adherence to medical treatment, symptom management, health-promoting behaviors, health-related risk-taking behaviors and overall adjustment to physical illness. In almost all cases, a physician will already have diagnosed the patient’s physical health problem before a psychologist sees the patient.” (American Psychological Association Practice Directorate, 2008)

The specific procedures include:

- **96150** - the initial assessment of the patient to determine the biological, psychological, and social factors affecting the patient’s physical health and any treatment problems.

- **96151** - a re-assessment to evaluate the patient’s condition and determine the need for further treatment.

- **96152** - intervention services provided to an individual to modify the psychological, behavioral, cognitive, and social factors affecting the patient’s physical health and well being.

- **96153** - intervention service provided to a group.

- **96154** - intervention service provided to a family with the patient present.

- **96155** - intervention service provided to a family without the patient present. (American Psychological Association Practice Directorate, 2008)

In a compelling article in the *Ohio Psychological Association Review*, Ruddy, Borresen & Gunn (2009) encourage psychologists to establish collaborative relationships with medical professionals including primary care physicians. Although the Health and Behavior procedures would appear to be an appropriate means by which a psychologist may contribute to the care of a patient, these authors did not mention the possibility of offering these procedures. This indicates a relative lack of attention to what could be a very beneficial service.

The present authors have found the provision of Health and Behavior Assessments (HBA; 96150) to be a viable means for working with a medical patient population. We have been conducting HBA for patients seeking admission to Falls Pain Management Center (FPMC) at Summa Western Reserve Hospital of the Summa Health System. The focus of the assessment is on biopsychosocial factors that are related to the patient’s physical health status in order to optimize the benefit that the patient receives at the Pain Center. At FPMC, the focus is on the assessment of behavioral, social, biological, and psychological factors pertinent to the management of chronic pain related to the presence of a diagnosed medical condition. Current procedure at the Center includes having a potential patient complete a HBA prior to beginning medical and behavioral health interventions.

The protocol that has been developed for our needs includes the administration of the Pain Outcomes Profile (POP; Clark, Gironda, & Young, 2003); the Beck Depression Inventory-II (BDI-II; Beck, 1996); the Multiple Affect Adjective Check List-Revised (MAACL-R; Zuckerman & Lubin, 1985); and the Substance Abuse Subtle Screening Inventory-3 (SASSI-3; Miller, 1999). A structured interview is conducted
investigating the patient's status and level of functioning in the areas of focus outlined above. Given the degree to which patients require the prescription of narcotic medications, a urine drug screen is also required. The predictive validity of using these measures has been demonstrated repeatedly as subsequent disclosures and evaluations have yielded results consistent with HBA results. For example, a patient who does not present significant areas of concern during the HBA generally is not found subsequently to have difficulty participating in the pain management program. In addition, there is substantial evidence that subsequent administration of the measures obtained during the HBA can be used to assess successful treatment in the pain program (Faith, Sipps, Howard, & Waehler, 2009).

The report that is generated outlines an overall understanding of a potential patient's current mental status and gives an overview of how pain has affected his/her life. The medical staff members in FPMC use the results to assist in treatment planning. This includes the determination of the patient's strengths and weaknesses in regards to health behaviors. Such factors include social support, maladaptive behaviors such as addictions, involvement with salubrious regimen (e.g., exercise), current strategies for pain management, presence of depression/anxiety, etc. Recommendations address any factors that might prevent a potential patient from maximizing the treatment plan established with the medical provider. Patients are assigned into one of four categories related to the degree of preparedness that they present at the HBA for their constructive involvement in a comprehensive pain management program to assist the medical staff members in their determination of what is needed for “good patients to become better.” After the HBA assessment is completed, a potential patient is designated as currently ready for all treatment options if all of the administered assessments tools have yielded scores within clinically “normal” limits and the interview resulted in few if any problematic features hindering pain management treatment. When clinically significant issues that need to be addressed by the medical provider and/or a behavioral health staff professional appear during the HBA, this qualification is noted.

The most frequent specific recommendations of this sort include: 1) further investigating potential aberrant drug related behaviors by either obtaining an Ohio Automated Rx Reporting System (OARRS) report and/or the suggestion to conduct regular urine drug screens; 2) monitoring potential mental health issues or possible clinical defenses; 3) assessing the patient's ability to understand medical directives; 4) exploring specific pain management treatment modalities requested by patients during the HBA; and 5) addressing tobacco product use. A psychodiagnostic assessment may also be indicated. Patients who show features during the HBA that would obstruct pain management treatment offered by the medical provider may present with an untreated severe diagnosed mental health disorder (e.g., schizoaffective disorder) or substance use disorder (e.g., active alcohol dependence). The recommendations for patients with these concerns generally include instructing patients to seek a more extensive evaluation and/or treatment at a resource of his/her choosing. Ultimately, we ask patients to provide documentation of compliance that successful treatment has occurred when appropriate, or document that an assessment has been conducted indicating that no further treatment was required.

Finally, there are a small number of patients who are denied admission into the FPMC program due to such circumstances as 1) testing positive for cocaine metabolites during the urine drug screen, 2) previous discharge from the FPMC program, 3) refusal by the patient to complete any part the HBA, and 4) documented history (past 3-to-5 years) of convictions for offenses related to violent behaviors. Although there are limitations to having patients complete self-report assessments and patients might dissimulate during the process, the resulting information is clearly considered to be invaluable by professional staff of Falls Pain Management Center.

The employment of the HBA is also cost effective. Fees for the 96150 procedure are made in 15-minute units with a maximum of four units in one day. The diagnosis that is used for the procedure is the ICD-9 medical diagnosis for the medical condition that is related to the presence of chronic pain. For example, a patient presenting for treatment for chronic pain related to the presence of diabetic neuropathy would have a diagnosis of 250.6. This diagnostic determination is generally provided by the referring physician (e.g., primary care doctor). However, the psychologist providing the service can simply indicate the medical condition the patient reports in the course of conducting the HBA. This would be much the same as what most psychologists routinely do in regards to Axis III per DSM-IV-TR. In rare cases where an ICD-9 medical diagnosis is not provided by the referring physician we employ the diagnosis indicated by the medical provider of FPMC after he/she has conducted the initial medical evaluation.

We have completed over 1,600 HBAs over the past 19 months with individuals ranging in age from 18 to 92 years and we have found that Medicare and most private insurance companies do pay for the 96150 procedure. Noticeable exceptions include the Ohio Bureau of Workers’ Compensation and Buckeye (Medicaid HMO). It is of note that the Ohio Psychological Association has been involved in efforts with the former to change this status.

Although we have yet to conduct any Health and Behavior Reassessments or to provide Interventions, we do have plans in both regards. The latter would be conducted with individuals with diagnosed medical conditions to address health-related behaviors such as smoking cessation, improving dietary/eating habits, managing pain, increasing relaxation, and addressing sleep concerns. Again, these would be covered services provided by a psychologist without the need for a diagnosed psychological condition or the presence of mental health insurance benefits: these services are paid out of the medicine pool rather than the psychiatric pool. Thus, the provision of these services will not require the expenditures of limited mental health dollars. These services can be offered to patients in a wide variety of medical settings and for a wide variety of specialties: opportunity awaits.
References


About the Authors

Gary Sipps earned his PhD in counseling psychology at The University of Maryland in 1981. He completed a pre-doctoral internship on the staff of Student Counseling Services at Iowa State University. He entered a full-time, tenure-track faculty position in the psychology department at The University of Akron in 1981 and began seeing private psychotherapy clients in 1983. He entered private practice full-time in 1994. In November 2006, he joined the staff of Falls Pain Management Center at Summa Western Reserve Hospital/Summa Health System. He provides psychological consultation and evaluation, as well as pain management psychotherapy. Services include psychological counseling, cognitive imagery/ hypnosis, and psychological assessment.

Leon Howard, PhD, is a licensed professional clinical counselor-supervisor who has worked in the counseling field for the past 12 years. He earned his master of science in education degree from Youngstown State University and his PhD from The University of Akron. Currently, he splits his time between, working as a consultant, teaching at the University of Akron and working at the Falls Pain Management Center, located in Summa Western Reserve Hospital/Summa Health System in Cuyahoga Falls, Ohio.

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History
The protection of human participants is a huge issue in research. It was not always so.

One needs only look to the egregious use of Nazi concentration camp prisoners for biomedical “experiments” during World War II or to the poor African-American men with untreated syphilis recruited by the United States government for a study of the illness in the 1940s to understand that the rights of research participants have had a history of having been frequently and flagrantly ignored. The Nuremberg Code, written during the Nuremberg War Crimes trial, is considered the first code of ethics for research with human participants (Capron, 1989).

In 1974, Congress passed the National Research Act, which created the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. This group was charged with developing ethical principles and guidelines for research involving human participants. In 1978, the Commission produced the Belmont Report (1978) in which the principles of justice, beneficence, and respect for persons (autonomy) were set forth. Sherwin (2005, p.151) notes that the Belmont Report “cites the ‘flagrant injustice’ of the Nazi exploitation of unwilling prisoners and the Tuskegee syphilis study as evidence of the shameful history of research abuses.” According to Jonsen (2005, p. 7), “If research involving human persons as subjects is to be appraised as an ethical activity it must above all be an activity in to which persons freely enter.” Thus, the central importance of informed consent was established (Swenson, 2008).

The first APA Ethics Code was published in 1953. Throughout its 10 revisions, the goal has been to define the moral standards and values, which unite us as a profession and a discipline that both treats and studies behavior.

The Institutional Review Board (“IRB”) To protect the human participants in research, an institution that applies for federal research funds is required to set up an Institutional Review Board (“IRB”). (United States Department of Health and Human Services, 1991). The IRB must consist of at least five researchers/faculty from a variety of disciplines who can review research at the institution. At least one member must represent the public. Its mission is to ensure that human participants are dealt with in an ethical manner.

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Minimal risk to participants is usually thought of as the risk inherent in daily living. Although some minimal-risk pro forma class activities might be reviewed at the class or department level, the conservative approach is to obtain IRB approval for each project. Any research project with risks to participants or which deals with vulnerable individuals such as minors or incarcerated individuals must have a full IRB review before commencing the research. The IRB reviews the investigator’s proposal with special attention to the experimental procedure, the informed consent process, the description and recruitment of the participants to be used, the debriefing, the anonymity of the individuals, and the rationale

Protecting Human Participants in Research: What You Need to Know about the IRB
By Elizabeth V. Swenson, PhD, JD

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for the research. The IRB then approves or disapproves of the research or provides information that can be used to modify the procedures proposed to more fully protect the participants.

Examples
A student researcher’s senior thesis project is investigating how seeing a well dressed or casually-dressed individual while hearing happy or sad music might affect a person’s prediction of how well the pictured individual will do in a job interview. It would seem that this activity is minimally risky; people listen to music and make implicit predictions every day. Two members of the college’s IRB reviewed this proposal in an expedited manner. One member wondered what might happen if a participant recently broke-up with a partner and was reminded of this event by the sad music. The IRB then recommended a routine statement in the debriefing that if one is affected adversely by the experiment one might visit the University Counseling Center. This comment was accompanied by the telephone number and e-mail address of the Center along with the routine contact information of the principle investigator, the investigator’s faculty sponsor, and the IRB (Swenson, 2008).

A more difficult study might be the following scenario. Dr. Moore is interested in studying the origins and consequences of bullying. In his research, he plans to study children in middle school as well as adults. His lab consists of one graduate research assistant who is planning to use a piece of this study for her master’s thesis and an undergraduate who is obtaining independent study credit for her part in the work. In phase one of the project, students will be selected at random from two cooperating seventh grade classrooms. A questionnaire about bullying behavior as concerns each student is to be filled out by the teacher and one parent. The children will then be interviewed in focus-type groups of three by the graduate student. In order to obtain the parent’s informed consent and the children’s assent a description of the study is sent home from school with each child. The parent is to sign the parental consent form and then read the assent form to the child, who will then sign it. The children will bring the forms back to school in a sealed envelope. Each child participating would receive a book as a reward.

The IRB had several concerns about this study that did not occur to Dr. Moore. The parental consent form was written as if it were to be read by college graduates. Could the parents understand the study? And could they understand it well enough to explain it to their children? Each child receiving parental consent could conceivably have a different understanding of the procedure. With the consent form to be returned to school with the child, it would be only too apparent that some parents approved, others did not, and yet others did not receive the invitation at all. When reading over the interview questions, the IRB felt that some were quite invasive, especially asking students to describe the effect that bullying might have had on them. There was no indication that the children would know that they could refuse to answer one or more questions and still receive the reward. In addition, what kind of training did the graduate student receive in interviewing? How would she handle children who seemed distressed by the questions? How would the unselected students feel about the special attention and reward being given to the participant children? The IRB felt that Dr. Moore did not exhibit the appropriate sensitivity to give the special care needed to these vulnerable participants. Because of the relationship between the researcher and the two teachers involved, the IRB also did not feel that the teachers could freely decline to participate in the study, especially since it involved divulging sensitive personal information about the children.

Problems in Working with an IRB
Much has been written in recent years about problems that behavioral researchers have experienced with the IRBs in their institutions (e.g. Schwandt, 2007; Stark, 2007). In a national survey of individual researchers’ reactions to their own IRB submissions, Ashcraft and Krause (2007) found the most widespread complaint was the excessive amount of time needed to obtain IRB approval. A list of anecdotal problems with local IRBs contains more serious complaints including arrogant behavior, “demands for picky changes,” demands for consent exceeding those contained in federal guidelines, and arbitrary decisions (Keith-Spiegel and Koocher, 2005). Keith-Spiegel and Koocher explain that these problems with IRBs ironically lead researchers to cut corners so as not to be completely honest in their applications. Others have noticed “mission creep” leading IRBs to criticize aspects of methodology that are only vaguely related to the protection of participants (College of Law, University of Illinois, 2003). Some have complained that their IRB criticizes research that tends to clash with the mission of the institution.

Putting most of these problems in context, Denzin and Giardina conclude: “There seems to be widespread consensus that the current regulatory climate encourages a highly conservative approach on the part of IRBs in applying the Belmont Principles ... a strong tendency ... to interpret those principles in a manner most fitting high-risk biomedical clinical research (2007, 88).”

What is a researcher to do when needing to have a research project approved by an IRB? First one needs to note that a large number of researcher/IRB combinations experience no special problems, particularly if the research poses no risk or minimal risk to the participants. It is helpful to know that delays are not unusual; allow plenty of time for a response. It is also reasonable to assume that during vacation periods, many IRB members will be unavailable, causing even longer delays. Here are
some suggestions for minimizing the probability of IRB problems:

1. Carefully go over your application to be sure that all the “i”s are dotted and all the “t”s are crossed. Problems result when details are overlooked.

2. Find someone in your department who has had IRB experience, or a person in the IRB office, to informally look over your application.

3. Be sure of the difference between “anonymous” and “confidential,” often a sticking point.

4. Expect delays.

5. If you are a faculty advisor, be familiar with your students’ research. Be careful about signing off on the IRB application.

6. Educate the IRB about your perspective on the risks involved and the understanding of different cultures about issues such as confidentiality and informed consent (Pollick, 2007).

Overall, in any problem involving colleagues at an institution, being respectful, knowledgeable, and collegial goes a long way.

References


Author’s Note: The author wishes to thank John Carroll University Psychology major Vikki O’Keefe for assistance with this article and OPA Ethics Committee members for their comments.

Elizabeth V. Swenson is a professor of psychology at John Carroll University. She holds a PhD from Case Western Reserve University and a JD from Cleveland State University. Dr. Swenson teaches professional ethics, planning for graduate school, and legal issues in psychology to undergraduate students. She is chair of John Carroll University’s Institutional Review Board where she routinely reviews student and faculty research proposals for the safeguards to human participants. Dr. Swenson has been a member of the ethics committees of both the American Psychological Association and the Ohio Psychological Association. She practices law in Cleveland, Ohio, in the area of child protection and advocacy.
It has not been until the last 20 years that research has focused on sexual assault in the U.S. military. The goal of the current article is to provide a brief review of the research on military sexual assault (MSA) in relation to prevalence rates, psychological correlates of sexual assault, and factors that may increase sexual assault in the military. The strides that the military has made in implementing sexual assault training and prevention programs over the past several years, as well as recommendations for future improvements in the military’s prevention efforts and its response to sexual assault among its service members, are reviewed.

Studies show that 10.5% to 33% of women report an attempted or completed rape while in the military (Bostock & Daley, 2007; Murdoch, Pryor, Polusny, & Gackstetter, 2007; Suris, Lind, Kashner, & Borman, 2007), with 22% to 84% reporting some sort of sexual harassment (Kimerling, Gima, Smith, Street, & Frayne, 2007; Murdoch et al., 2007; Street, Gradus, Stafford, & Kelly, 2007). Fewer studies have examined male sexual assault in the military with the prevalence of reported sexual assault among men ranging from 1% to 12% (Kimerling et al., 2007; Martin, Rosen, Durand, Stretch, & Knudson, 1998; Murdoch et al., 2007), while rates of sexual harassment among men while in the military range from 36% to 74% (Bastian, Lancaster, & Reyst, 1996; Murdoch et al., 2007; Rosen & Martin, 1998; Street et al., 2007). Although women in the military are more likely to experience a sexual assault than men, the actual number of assaults is approximately equal (Kimerling et al., 2007). As noted by Bostock and Daley (2007), there is very little consistency in the methodology, sample, definitions of sexual assault, and surveys or questions used to measure military sexual assault (MSA), which likely accounts for the wide variation in prevalence rates across studies. Studies are often retrospective (sometimes asking participants about experiences that occurred over 20 years ago), are not Department of Defense (DoD) or servicewide, and do not analyze sexual assault rates by service, war era, or other characteristics.

Military Risk Factors

In order to prevent sexual violence, it is important to examine factors that may facilitate violence in the military. Some of these factors may be sociodemographic characteristics, substance use, prior sexual victimization and perpetration among recruits, military cultural and structural factors, emphasis on violence, current laws, and low reporting rates.

Sociodemographic characteristics of military personnel compared to the civilian population, such as being younger and being non-married, may contribute to increased rates (e.g., Kimerling et al., 2007). Young and single military recruits are often away from their parents for the first time and begin using alcohol and drugs for the first time, which may lead to an increased risk for sexual assault. A Department of Defense (DoD, 2005) report on sexual assault in military academies indicated that alcohol was involved in 58% of sexual assault cases from the Military Academy and 57% of cases reviewed from the Naval Academy. Military recruits come into the military with higher than usual rates of past victimization and perpetration (Rosen & Martin, 1996), which is related to increased risk of sexual victimization and perpetration in military samples (Merrill et al., 1999; Merrill, Thomsen, Gold, & Milner, 2001). In three samples of Navy men, Merrill et al. (2001) found that childhood sexual and physical abuse was related to greater rates of perpetration by these men.

There are many factors within the military that increase one’s risk of sexual victimization. Hunter (2007) identified several elements of military culture that may promote sexual violence, including sexualized and violent language, the acceptance of violence, the learned ability to objectify other people, obedience to the chain of command, and promotion of the belief that those outside the military will not understand what occurs in the military. Nicol, Charbonneau, and Boies (2007) found that rates of sociodominance (the extent to which an individual supports group-based dominance) increased over military training in a group of cadets, and that this change did not occur in a comparable...
sample of civilians. In another study, undergraduate men in military training were more likely to hold authoritarian beliefs and traditional sex-role attitudes than civilian undergraduate men (Kurpius & Lucart, 2000). Some aspects of the military legal system may discourage people from reporting sexual assault and some laws may promote rape myths (Houser, 2007). For instance, the current rape law does not acknowledge male victims, some sexual assault laws allow marriage to be a defense, and the military’s “Don’t Ask Don’t Tell” policy on homosexuality may discourage reporting because confusion may exist between homosexuality and same-sex rape, especially for men (Scarce, 1997).

Military Response and Implementations
In the past decade the DoD, the Department of Veterans Affairs, and the military branches have responded to criticism by changing laws, implementing a DoD office responsible for overseeing sexual assault education and treatment in the entire department, and providing more services to veterans who experienced sexual trauma in the Veterans Affairs (VA) system. In October, 2007, the Uniform Code of Military Justice (UCMJ) rape and sexual misconduct laws were amended by Congress after remaining relatively the same since its inception. The previous law stated “any person subject to this chapter who commits an act of sexual intercourse by force and without consent, is guilty of rape” [Joint Service Committee on Military Justice, 2005, p. 66 of Part IV, §45.a(a)]. The new law makes the use of force by the offender no longer necessary for the crime to be considered rape and the new law acknowledges substance-related assaults (Joint Service Committee on Military Justice, 2008). The new law also combines sexual acts that were previously described loosely under Article 134 and Article 120 and now encompasses 36 different sexual offenses with differing levels of offense and punishment.

The DoD implemented the Sexual Assault Prevention and Response Office (SAPRO) in 2005, which serves as a single point of accountability for sexual violence (DoD, 2007). Programs through this office are used to provide care and support to sexual assault victims, and prevent sexual assault through department-wide training, education, and prevention programming. The SAPRO has instituted a confidential restricted reporting system for sexual assault victims, which allows service members who have been assaulted to receive medical care and counseling without the notification of law enforcement or their commanders.

VA clinics are now required to screen all veterans (male and female) seeking care for military-related sexual trauma and designate someone who is in charge of sexual trauma screening, treatment, and personnel training (Department of Veterans Affairs, 2005). One study has evaluated the effects of these VA laws and mandates on screening for sexual trauma among veterans, finding that the majority of veterans are being screened for sexual trauma and that collecting this information is both feasible and valuable to treatment (Kimerling et al., 2007). Although these efforts will not prevent or reduce the number of sexual assaults in the military, they provide better services to those who have experienced sexual trauma within the military.

Recommendations
Although the military has taken steps to reduce and prevent sexual violence among its personnel, there needs to be continued efforts to address and prevent sexual assault. Further legal change must take place for widespread institutional change to occur, such as addressing laws concerning consensual sodomy, male victims, and sexual assault between spouses. The military’s stance on homosexuality should be reconsidered as it not only likely discourages reporting same-sex rape, but also promotes intolerance and discrimination (Taylor, 2004). Given that, those who hold intolerant belief systems (i.e., sexism, racism, homophobia) are more likely to accept rape myths (Aosved & Long, 2006), increasing tolerance among all groups within the military would be helpful in both the reduction of sexual violence and the increase of unity among service members.

A sizable portion of assaulted military personnel are unaware or unsure of how to report their assault (e.g., DoD, 2005; Government Accountability Office [GAO], 2008). It is likely that the reported instances are an underestimate of the actual occurrence of sexual assault (GAO, 2008). Therefore, it is imperative that all personnel receive training on reporting resources and the level of confidentiality afforded to each resource. An investigation by the Air Force found that there are a number of reporting barriers noted by victims, including fears of confidentiality breaches or retaliation, shame, not being granted advancement or clearances, betraying one’s group, being negatively judged by other personnel, and being re-victimized (U.S. Air Force, 2004). Many of these issues are still reported as barriers by service members (GAO, 2008).

There are many ways the military can change its policies or increase training in certain areas to aid in violence prevention. McSally (2007) recommended that, for women to achieve a more equal role in the military in relation to men, the military must make changes to polices (e.g., women not allowed in combat positions) that create differences. Another recommendation is to make personal safety and self-defense training accessible to all active-duty female personnel as well as to veterans at VAs. SAPRO and VA implementations, training, and screening procedures should be empirically evaluated. It is not clear how effective these changes have been in reducing sexual violence and decreasing negative outcomes (e.g., medical visits, unemployment, psychological difficulties). Although violence may be necessary for active duty combat, servicemembers need to be taught to discriminate between when the use of violence is appropriate and when it is not. The military must enforce its zero-tolerance policy on sexual violence to make the military a safer place for our servicemembers.
References


About the Author

Jessica A. Turchik, MS, is a fifth year doctoral clinical psychology student at Ohio University. Her research interests are sexual risk taking, sexual violence, and measure development and validation. She is currently doing a year-long internship at the Southwest Consortium in Albuquerque, New Mexico.
2009 Ohio Science Day Winners

The future is bright for the behavioral health profession, judging by the entries received at the 2009 State Science Day. For the 16th year, Ohio Psychological Association members judged the behavioral science projects and awarded fourteen Ohio students, grades 7–12, for their remarkable projects.

Science Day judges were broken into five different teams, corresponding with each different grade level. Fourteen judges reviewed 131 projects. Cash prizes, made possible by the Central Ohio Psychological Association (COPA), Cleveland Psychological Association, Toledo Area Academy of Professional Psychologists, Akron Area Professional Psychologists and the Dayton Area Psychological Association (DAPA), were awarded to the top finishers in each grade.

First place won $75, second place took home $50 and third place received $25. In addition to those taking home an award, there were many students in attendance who had presented in the preceding years.

Judges were Rose Mary Shaw, PsyD; Pam Deuser, PhD; Linda Siroskey-Sabdo, MA; Cathy McDaniels Wilson, PhD; Mary Miller Lewis, PhD; Michele Evans, PhD; Michael Ranney, MPA; Eric Butter, PhD; Esther Hampton, MA; David Hayes, PhD; Isaiah Jones; Michael Dwyer, PhD; and, Sara Austin, BS. A special thank you to the judges for donating their time to judge and for the donors for contributing award money!

Grade 7

1st: Sydney Schultz, Bellbrook Middle School, Bellbrook—Is multitasking efficient?
3rd: Declan McCord, St. Agatha, Columbus—Confirming the overconfidence effect

Grade 8

1st: David Irwin, Monroe JS, Monroe—Number sense – object recognition without counting
2nd: Hannah Littler, Bishop Flaget, Chillicothe—Color shape attraction
3rd: Audrey Rieger, Ottoville High School, Ottoville—Acceleration with age? The effects of age on speed perception

Grade 9

1st: Rachel Damato, Beaumont School, Cleveland Heights—Hang up and drive! Cell phone use and simulated driving
2nd: Katherine Dobscha, Beaumont School, Cleveland Heights—Shaping your thoughts: The effect of words on shape recognition

Grade 10

1st: Jeremiah Shaw, Archbishop Alter, Kettering—The relationship between exercise and memory across the age span
2nd: Andrew Favorito, Paulding High School, Paulding—Will incorporating music into the teaching methodology improve achievement in the classroom?

Grade 11

1st: Ajleeta Sangtani, Sylvania Southview High School, Sylvania—The effect of the olfactory sense and handedness on memory
2nd: Shaadee Samimy, Thomas Worthington High School, Worthington—The effects of socio-cultural factors on listeners’ perception of the accentedness of non-native speakers of English

Grade 12

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### Mindfulness in clinical practice: A basic overview

1. Which of the following are examples cited of mindfulness based treatments:
   - a. ACT, DBT, REBT
   - b. ACT, DBT, MBCT
   - c. REBT, MBCT, MBRP

2. Mindfulness is defined as awareness that emerges through paying attention on purpose.
   - a. True
   - b. False

3. The process of mindfulness may include all of the following EXCEPT:
   - a. Having awareness of physical sensations
   - b. Identifying means of changing a situation
   - c. Observing the thoughts

4. The author suggests that, in Ohio, how many individuals age 60 and older have at least one disability?
   - a. Over one-fourth
   - b. Over one-third
   - c. Over one-half

5. According to this article, which of the following is NOT one of the characteristics consistent with mercy killings?
   - a. Victim was suffering extreme pain
   - b. Female victim
   - c. Marital relationship is described as loving and caring
   - d. Firearm is used

6. The three categories of mercy killings are:
   - a. Assisted, non-assisted and unassisted euthanasia
   - b. Active, passive and non-resisted euthanasia
   - c. Voluntary, non-voluntary and involuntary euthanasia

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### Redefining the experience of informal care: Understanding the role of gender and the implications of technology in shaping caregiver outcomes in Ohio

7. The term informal caregiver refers to:
   - a. All of the care providers who are assisting in the provision of care
   - b. The individual in charge of making decisions about the individual
   - c. Those who are providing care with no financial provision

8. The author points out that gender differences in caregiver outcomes cannot be separated from differences in the types of tasks that male and female caregivers typically assume.
   - a. True
   - b. False

9. Which of the following was established by the State of California and adopted by Governor Strickland for Ohioans:
   - a. Network of Care
   - b. Care Network
   - c. Techcare

---

### Death in psychotherapy and Eastern wisdom traditions

10. In the Eastern traditions, the concept of death is dealt with during the final days of a person’s life.
    - a. True
    - b. False

11. In the Eastern traditions, death is mediated:
    - a. Upon systematically
    - b. When one feels depressed
    - c. As one of the four givens of existence

12. The purpose of meditating on death is to understand:
    - a. How one should live
    - b. The nature of when death will occur
    - c. To transcend death

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### Systems thinking and hope: Designing a transcendent future

13. Which of the following is NOT one of the systems theorists referenced in the article:
    - a. Schwartz
    - b. Jantsch
    - c. Prigogine

14. The author asserts which of the following is instrumental in effecting change and effectively planning and designing our evolution:
    - a. Hope
    - b. Systems
    - c. Choices of action

15. In order to move toward higher levels of evolution, we need to experience life’s imperfections.
    - a. True
    - b. False

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### The application of health and behavior codes in a pain management center

16. Which of the following is a reason to consider integrating health and behavior assessments in psychological practice?
    - a. They provide psychologists an opportunity to provide services to individuals who do not necessary present with a psychological condition
    - b. They help medical professionals improve treatment effectiveness
    - c. They provide a nice referral source
    - d. All of the above

17. Using the identified assessment protocol enables psychologists to identify which patients will benefit from medical treatment.
    - a. True
    - b. False

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### Protecting human participants in research: What you need to know about the IRB

19. The protection of human participants has always been a major priority in research.
    - a. True
    - b. False

20. Which of the following need to be included when providing information to an IRB:
    - a. Name and address of participants
    - b. What the research results will be used for (ie. Publication, presentation)
    - c. Process for debriefing participants
    - d. All of the above

21. The author points to which of the dilemmas in providing information to the IRB:
    - a. “Mission creep”
    - b. Researchers cutting corners so that their application is accepted
    - c. Research agenda may clash with the mission of the institution
    - d. All of the above

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### Sexual assault in the military: A review of the literature

22. Service members who experience an assault in the military have many of the same detrimental psychological effects as those associated with civilian assaults.
    - a. True
    - b. False

23. Which of the following is NOT a factor that may facilitate violence in the military:
    - a. Sociodemographic characteristics
    - b. Military cultural and structural factors
    - c. Lower prevalence of alcohol consumption
    - d. Past victimization and perpetration

24. The article stipulates that the Department of Defense has failed to respond to criticism by changing the laws and providing more services to veterans who have experienced sexual trauma.
    - a. True
    - b. False