Psychology in the Global Era: Embracing Career Development
Board of Directors
Executive Committee
President - Catherine A. Gaw, PsyD
Past President - Craig S. Travis, PhD
President-Elect - John R. Rudisill, PhD
Finance Officer - Jim R. Broyles, PhD
APA Council Representative - Cathy L. McDaniels Wilson, PhD

Standing Committee Directors & Regional Representatives
Robin Arthur, PsyD
Kathleen R. Ashton, PhD
Howard M. Bonem, PhD
Colin H. Christensen, PhD
Kenneth P. Drude, PhD
Priscilla Kingston, PhD
Dennis W. Kogut, PhD
Wanda McEntyre, PhD
Kimberly A. Metz, PhD
Margaret Richards Mosher, PhD
Steven D. Nichols, PhD
Trevor J. Petersen, BS
Lynne Rustad, PhD
Rose Mary Shaw, PsyD
Elizabeth V. Swenson, PhD, JD
Sally Wilson, PhD

Functional Committee Directors/Ad Hoc Task Forces/Liaisons/Affiliates
Christine E. Agaibi, MA
James J. Brush, PhD
Audrey E. Ellenwood, PhD
Robin Graff-Reed, PhD
David Hayes, PhD
Terry R. Imar, MA
Bradley K. Potts, PhD
Lynn S. Rapin, PhD
Helen D. Rodebaugh, PhD
David Schwartz, PhD
Gerald J. Strauss, PhD
Thomas P. Swales, PhD
Mary Ann Teitelbaum, PhD

President’s Club Members
2010-11
David L. Hayes, PhD, ABPP
Alice Randolph, EdD, MS Clinical Psychology
Richard C. Rynearson, PhD
Sandra L. Shullman, PhD
Thomas P. Swales, PhD, ABPP
Leon D. Vandreacreek, PhD
Jane Z. Woodrow, PhD

Sustaining Members
2010-11
James J. Brush, PhD
Robert F. Dallara, Jr., PhD
Kenneth A. DeLuca, PhD
Kenneth P. Drude, PhD
Nicolaas P. Dubbeling, PhD
Erhard O. Eimer, PhD
Barbara L. Fordyce, PhD
Sandra J. Forti, PhD
Sandra W. Foster, PhD
Catherine A. Gaw, PsyD
Carol S. Gee, PhD
Charles E. Gerlach, PhD
Wayne J. Graves, PhD
Thomas C. Kalin, PhD
Dennis W. Kogut, PhD
Carroll E. Lahniers, PhD
Kurt M. Malkoff, PhD
Jayne M. Malpede, PhD
Mary Anne Orcutt, PhD
Helen Davis Rodebaugh, PhD
Michael J. Russo, PhD
Paule A. Steichen Asch, PhD
Gerald J. Strauss, PhD
Jeffrey R. Wilbert, PhD
Willie S. Williams, PhD

The Foundation for Psychology in Ohio Donors (For the period September 1, 2010 – July 5, 2011)

COPA/PSYOHIO Fundraiser Supporters
Michael P. Brickey, PhD
Jim R. Broyles, PhD
Robbie L. Celeste, PhD
Elizabeth A. Cook, PhD, ABPP
Theresa Disenio, PhD
David L. Hayes, PhD, ABPP
Timothy M. Luis, PhD
Margaret Richards Mosher, PhD
Michael O. Ranney
Araceli Rivera, PsyD

PSYOHIO Change Fund Supporters
Christine E. Agaibi, MA
Kenneth P. Drude, PhD
Michele T. Evans, PhD
Wanda McEntyre, PhD
Elizabeth V. Swenson, PhD, JD
Mary Ann Teitelbaum, PhD

Silent Auction Supporters
Kristine Badurina
Tammie Biler
Mary C. Bricker, PhD
Phil Brock
Jim R. Broyles, PhD
Kenneth P. Drude, PhD
Michael D. Dwyer, PhD
William Ellis
Robin L. Graff-Reed, PhD
David T. Hellkamp, PhD
Sherry Knapp-Brown, PhD
Corinne Koneney
Janice McCloud
Cathy L. McDaniels Wilson, PhD
Jason Milligan
Margaret Richards Mosher, PhD
Christina Neumeier
Michael O. Ranney, MPA
Lynn S. Rapin, PhD
Meghan Real
John R. Rudisill, PhD

General Fund Supporters
Azania Akashi, PhD, MCC
Jane S. Allemang, PhD
Alissa M. Banyasz, BA
Darlene J. Barnes, PhD
Paul F. Becker, PhD
Mariana C. Belvedere, PhD
Joseph J. Bendo, PhD
Eugene A. Benedetto, MA
Maureen S. Black, PhD
Reginald C. Blue, PhD
Theodore G. Borkan, PhD
David R. Bousquet, MEd
Julie A. Brennan, PhD
Elaine J. Bruckner, PhD
Charles M. Buhman, Jr., PsyD
Edward N. Carrol, PhD
Bobbie L. Celeste, PhD
Christine Charyton, PhD
David L. Chiarella, PhD
Robert J. Cirino, PhD
Sarah L. Clark, PhD
Virginia B. Collings, PhD
William E. Collins, PhD
Judith A. Condit, PsyD
Elizabeth A. Cook, PhD, ABPP
Kathleen B. Corcoran, PhD
Antoinette S. Cordell, PhD
Christine M. Dacey, PhD
Cara Marker Daily, PhD
Robert F. Dallara, Jr., PhD
Daniel L. Davis, PhD
James R. Davis, MEd
Kenneth A. DeLuca, PhD
Paul L. Diamond, PhD
James A. Diehl, PhD
Marc B. Dielman, PhD
Janet E. Dix, PhD
Louise A. Douce, PhD
Michael G. Drown, PhD
Sue R. Dyrenforth, PhD
Laura W. Eckhardt, PhD
Erhard O. Eimer, PhD
Stephen W. Emerick, PhD
Frederick P. Ferri, PhD
James A. Fidelibus, PhD
Charles C. Fiumera, PhD
Donald K. Freedheim, PhD

State Science Day Supporters
Akron Area Professional Psychologists
Robin Arthur, PsyD
Central Ohio Psychological Association
Cleveland Psychological Association
Dayton Area Psychological Association
Michele T. Evans, PhD
Toledo Area Academy of Professional Psychologists

General Fund Supporters
Azania Akashi, PhD, MCC
Jane S. Allemang, PhD
Alissa M. Banyasz, BA
Darlene J. Barnes, PhD
Paul F. Becker, PhD
Mariana C. Belvedere, PhD
Joseph J. Bendo, PhD
Eugene A. Benedetto, MA
Maureen S. Black, PhD
Reginald C. Blue, PhD
Theodore G. Borkan, PhD
David R. Bousquet, MEd
Julie A. Brennan, PhD
Elaine J. Bruckner, PhD
Charles M. Buhman, Jr., PsyD
Edward N. Carrol, PhD
Bobbie L. Celeste, PhD
Christine Charyton, PhD
David L. Chiarella, PhD
Robert J. Cirino, PhD
Sarah L. Clark, PhD
Virginia B. Collings, PhD
William E. Collins, PhD
Judith A. Condit, PsyD
Elizabeth A. Cook, PhD, ABPP
Kathleen B. Corcoran, PhD
Antoinette S. Cordell, PhD
Christine M. Dacey, PhD
Cara Marker Daily, PhD
Robert F. Dallara, Jr., PhD
Daniel L. Davis, PhD
James R. Davis, MEd
Kenneth A. DeLuca, PhD
Paul L. Diamond, PhD
James A. Diehl, PhD
Marc B. Dielman, PhD
Janet E. Dix, PhD
Louise A. Douce, PhD
Michael G. Drown, PhD
Sue R. Dyrenforth, PhD
Laura W. Eckhardt, PhD
Erhard O. Eimer, PhD
Stephen W. Emerick, PhD
Frederick P. Ferri, PhD
James A. Fidelibus, PhD
Charles C. Fiumera, PhD
Donald K. Freedheim, PhD
2011 Political Action Committee (PAC) Donors
(Donations/pledges received for the period January 1, 2011 – July 5, 2011)

PAC Leader ($300-$599 donation)
Gregory S. Brigham, PhD
Bobbie L. Celeste, PhD
David L. Hayes, PhD, ABPP
John R. Rudisill, PhD

PAC Advocate ($120-$299 donation)
Bradley K. Potts, PhD
Michael O. Ranney, MPA
Bob Stinson, PsyD, JD, ABPP

PAC Supporter ($60 - $119 donation)
None reported

PAC Booster ($25-$59 donation)
Mary C. Bricker, PhD
Teresa A. Reinhard-West, PsyD
Linda D. Rhyne, PhD
Willie S. Williams, PhD

PAC Members ($10-$24 donation)
Theodore G. Borkan, PhD
Molly S. Martinez, MA

PAC Students ($5 donation)
None reported

Ohio Psychological Association
395 East Broad Street, Suite 310
Columbus, OH  43215
(614) 224-0034
(800) 783-1983
(614) 224-2059 fax

Michael O. Ranney, MPA, Executive Director
Heather N. Gilbert, BA, Managing Editor
Audrey E. Ellenwood, PhD, Editor

Staff
Michael O. Ranney, MPA, Executive Director
Denise Brenner, MBA, Director of Operations and Member Services
Bobbie L. Celeste, PhD, Director of Professional Affairs
Heather N. Gilbert, BA, Director of Communications and Education
Beth Wherley, BA, Director of Mandatory Continuing Education

Articles in The Ohio Psychologist represent the opinions of the writers and do not necessarily represent the opinion of
the society, member or the staff of OPA. Acceptance of advertising does not imply endorsement by OPA.

THE OHIO PSYCHOLOGIST AUGUST 2011  3
“Trust Sponsored Professional Liability Insurance provides the broad coverage and risk management resources I need.”

Sallie E. Hildebrandt, Ph.D.
Dr. Hildebrandt is in independent practice with a focus on the treatment of depression, sexual and marital therapy, and evaluation of bariatric surgery patients. She is also President of the California Psychological Association and Chair of the Committee of State Leaders.

Trust Sponsored Professional Liability Insurance

Insuring psychologists like me and you.

As an independent practitioner, I benefit from the professional liability coverage and risk management help I receive from The Trust. I believe the policy keeps pace with my evolving profession, and I have the assurance that when issues arise that might put me at risk of malpractice actions and disciplinary complaints, a free consultation with The Trust Advocate is just a phone call away.

With so much to do and so much at stake, it’s good to know The Trust has me covered. I can spend more time focusing on what matters — helping others to help themselves.

Call The Trust at 1-800-637-9700 or visit www.apait.org to learn what they can do for you.

www.apait.org • 1-877-637-9700

* Underwritten by ACE American Insurance Company, Philadelphia, PA (ACE), one of the ACE Group of Companies. ACE USA is the U.S. based retail operating division of the ACE Group of Companies, headed by ACE Limited (NYSE:ACE) and rated A+ (Superior) by A.M. Best and AA- (Very Strong) by Standard & Poor’s (ratings as of April 19, 2013). Administered by Trust Risk Management Services, Inc. Policy issuance is subject to underwriting.
# Table of Contents

**The Ohio Psychologist: Psychology in the Global Era: Embracing Career Development**

<table>
<thead>
<tr>
<th>Page</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>From the Editor, Audrey E. Ellenwood, PhD</td>
</tr>
<tr>
<td>7</td>
<td>Telepsychology Practices: Ohio Guidelines, OPA Communications and Technology Committee</td>
</tr>
<tr>
<td>13</td>
<td>Acceptance and Commitment Therapy for Children: A Review of the Literature, Julie A. Sell-Smith, MSW and Richard W. Sears, PsyD, ABPP</td>
</tr>
<tr>
<td>20</td>
<td>Utilizing Family-Focused Therapy to Reduce Frequency of Episodes in Adults with Bipolar Disorder, Allen McConnell, MS</td>
</tr>
<tr>
<td>24</td>
<td>Narratives of Young Women with Eating Disorders and Their Families: Stories of Illness and Recovery, Courtney J. Wudyka, MA, OPA Poster Session Graduate Empirical Winner</td>
</tr>
<tr>
<td>27</td>
<td>Romantic Involvement and Depressive Symptoms in Emerging Adults, Michael R. Bruner, BS, Amanda D. Kuryluk, BA and Sarah W. Whitten, PhD, University of Cincinnati, OPA Poster Session Undergraduate Winners, Empirical and People’s Choice Categories</td>
</tr>
<tr>
<td>30</td>
<td>The Worldwide Epidemic of Skin Bleaching: Prevalence, Predictors and Associated Problems, Irene López, Avril Ho and Analise Gonzalez, OPA Poster Session Undergraduate Non-Empirical Winners</td>
</tr>
<tr>
<td>33</td>
<td>Body Awareness and Empowerment Training for Abuse/Assault Survivors: An Adjunct to Psychotherapy, Paul Linden, PhD</td>
</tr>
<tr>
<td>36</td>
<td>Post-Traumatic Stress Disorder: A Case for Subtype Identification, Phillip R. Zoladz, PhD</td>
</tr>
<tr>
<td>41</td>
<td>2011 Ohio Science Day Winners</td>
</tr>
<tr>
<td>44</td>
<td>OP Continuing Education Quiz</td>
</tr>
</tbody>
</table>

**OPA 2010-2011 Editorial Board**

- Kerm Almos, PhD
- Paule Asche, PhD
- William Bauer, PhD
- Milton Becknell, PhD
- Charles Dolph, PhD
- Marc Dielman, PhD
- Ky Heinlen, PhD
- Jeanne Jenkins, PhD
- Andrea Karkowski, PhD
- Kathryn MacCluskie, PhD
- Janette McDonald, PhD
- Sabato Sagaria, PhD
- Carol Smith, PhD
- Elizabeth Swenson, PhD
- Richard VanVoorhis, PhD
“Psychology in the Global Era: Embracing Career Development” is the focus and theme of the Ohio Psychologist (OP). This theme is very optimistic as it provides a reminder to OPA members that with technology psychologists today are able to reach out and retrieve information as well as learn from a broader, more global perspective. The theme also reminds psychologists that as one enhances their careers the 2011 OP includes best practice approaches that can lead to the strengthening and shaping of the profession for years to come.

I hope that as you peruse the content within the Ohio Psychologist, you will find a written text that will (a) inspire you to use new therapeutic approaches that will enhance your career, (b) teach you about the most recent science of the profession and (c) learn how to research issues that are important to you. With that thought in mind, may you also be challenged to engage at some level in OPA in order to share your expertise, experience, and knowledge with those that will carry on and secure the future of psychology as it moves through the Global Era.

As you read this year’s OP’s publication, you will find that many of the enclosed articles extrapolate OPA’s 2010–2011 theme and three categories that evolve around advocacy, practice and science. The articles contained in the OP should help lead all of us into the Global Era of Psychology.

Advocacy
The Communication and Technology Committee (CTC) has certainly worked hard to help bring OPA members into the Global Era of Psychology by developing Technology Guidelines for OPA members. These guidelines have served as a base for development of telepsychology guidelines in other states and countries as well as current new telepsychology laws adopted by the Ohio State Board of Psychology. The CTC committee composed of Kenneth Drude, PhD, Audrey Ellenwood, PhD, Marc Dielman, PhD, Jeanne Jenkins, PhD, Kathleen (Ky) T. Heinlen, PhD, PCC-S, Michael Lichstein PhD, Paula S. Asch, PhD, Terry Imar, MA, and Mary Mills, MBA present in their article, “Telepsychology Practices: Ohio Guidelines” an overview of the OPA telepsychology guidelines and briefly discuss their application for practitioners in the field.

Practice
Julie Sell-Smith and Richard Sears, PhD, explored the adaptation of the evidence based modality of Acceptance and Commitment Therapy (ACT) to youth. These authors provide contextual information about basic ACT principles and how they might be adapted for children in their article, “Acceptance and commitment therapy for children: A review of the literature.” Richard Van Voorhis, PhD, Geoffrey Putt, PhD, and Kenneth Miller, PhD, in their article, “Training for Parents of Children with Disabilities: The Triple P Approach” provide clinicians with an overview of the Triple P Positive Parenting Program which is extremely beneficial for working with families who have children with a disability. Triple P is an evidence-based behavioral management program that focuses on teaching parenting skills. Allen McConnell, PhD focuses on adults diagnosed with Bipolar Disorder. In his article, “Utilizing Family-Focused Therapy to Reduce Frequency of Episodes in Adults with Bipolar,” a Family-Focused Therapy (FFT) approach is discussed that focuses on assessment, psychoeducation, communication and problem-solving strategies.

Science
The top graduate empirical OPA poster winner Courtney J. Wudyka from The Chicago School of Professional Psychology, presents an overview on her study entitled, “Narratives of Young Women with Eating Disorders and Their Families: Stories of Illness and Recovery.” In this article she and her advisors, Meghan Roekle, PsyD and Marcia Nickow, PsyD discuss the stories of four females with eating disorders. The top undergraduate empirical poster and People’s Choice winner Michael Bruner from the University of Cincinnati presents an article on “Depressive Symptoms and Romantic Involvement in Emerging Adulthood.” In his article, he discusses the unstudied links between romantic involvement and depressive symptoms in emerging adulthood (ages 18-25). Analise Gonzalez and Avril Ho from Kenyon College who captured the top prize in the undergraduate non-empirical poster session provide an article on “Cutting, Breaking, and Bleaching: Appearance Modification in Ethnic Minority Women.” In their manuscript they summarize the current literature on skin bleaching, including its prevalence, predictors and the problems associated with this practice. Paul Linden, PhD, combines psychotherapy, somatic education and martial art training in helping survivors of abuse or assault in his article, “Body awareness and empowerment training for abuse/assault survivors: An adjunct to psychotherapy.” Dr. Linden shares that through self-defense training abuse survivors learn to manage stress and pain and are able to developing assertiveness and self-protection. Philip Zoladz, PhD from Ohio Northern University presents a review of some of the inconsistent research findings in PTSD patients and emphasizes the possibility that several subtypes of PTSD, each with its own unique phenotypic fingerprint, could exist in his submission, “Post-Traumatic Stress Disorder: A Case for Subtype Identification.”

As many of you know, the Ohio Psychologist is a peer-reviewed publication. Each article submitted have been carefully reviewed by three peer reviewers, their feedback has been provided to every author and changes to each manuscript has been made before the acceptance was official. OPA is fortunate to have a core set of peer reviewers with a high level of expertise. I would like to extend my appreciation and thank you to the following who reviewed manuscripts for this issue of the Ohio Psychologist: Kerm Almos, PhD, Paule Asche, PhD, William Bauer, PhD, Milton Becknell, PhD, Charles Dolph, PhD, Marc Dielman, PhD, Ky Heinlen, PhD, Jeanne Jenkins, PhD, Andrea Karkowski, PhD, Kathryn MacCluskie, PhD, Janette McDonald, PhD, Sabato Sagaria, PhD, Carol Smith, PhD, Elizabeth Swenson, PhD and Richard VanVoorhis, PhD.

Also, Heather Gilbert, OPA’s Managing Editor, was highly instrumental in helping to publish the Ohio Psychologist. Her level of commitment and hours of work to produce this publication cannot be understated.

I would like to thank all who have contributed to making the Ohio Psychologist a reality. Your contributions are invaluable to both the organization and the profession.

Audrey E. Ellenwood, PhD
Editor, Ohio Psychologist
The use of communication technology in providing psychological services is increasingly a reality across the United States. As a result, more and more people are relying upon the Internet for connection, information, support and psychological services. Although the importance of having standards or guidelines for the use of technology in psychology (i.e. telepsychology) has been repeatedly identified (Barrett, 2005, Koocher & Morray, 2000, Midkiff & Wyatt., 2008, VandenBos & Williams, 2000), relatively little guidance has been provided by American professional psychological associations or state licensing boards. As a result “no clear professional consensus or detailed ethical national guidelines currently exist” (Koocher, 2009).

The state of Ohio’s psychology licensing law and regulations, similar to other states, include minimal references to telepsychology practices. This lack of clarity about telepsychology raises three concerns: (1) telepsychology clients are at risk for harm from substandard practices, (2) there exists an uncertainty and risk among psychologists about how to apply the American Psychological Association (APA) ethics code to telepsychology, and (3) psychologists are left waiting for legislative or case law to define for them telepsychology practices.

In order to provide guidance in the use of electronic communications for psychologists in Ohio and respond to the lack of telepsychology guidelines, the Ohio Psychological Association (OPA), through its Communications and Technology Committee (CTC), developed a set of telepsychology guidelines that were adopted by the organization in 2008 (OPA, 2008) and revised in 2010 (OPA, 2010). The purposes of this article are to present an overview of the OPA telepsychology guidelines and to briefly discuss their application for practitioners in the field.

**Abstract**

Communication technologies are increasingly being incorporated into the practice of psychology although there remains little guidance about their use. Unfortunately this places both clients and psychologists at risk for improper or questionable telepsychology practices. The Ohio Psychological Association (OPA) recently developed and adopted a set of telepsychology guidelines (2010) after an extensive review of telemental health standards and guidelines for its members. The purposes of this article are to present an overview of the OPA telepsychology guidelines and to briefly discuss their application for practitioners in the field.

**Historical Background**

During the mid 1990’s the APA’s Board of Professional Affairs appointed a task force for online psychotherapy and counseling with a mission to identify issues relevant to the practice of telepsychology. Before a final document or set of recommendations could be adopted by the APA the group discontinued. In 1997 the APA Ethics Committee issued a statement clarifying that the use of psychological services provided electronically were not prohibited and that the APA ethics code standards apply (APA, 1997). Years later, the APA Ethics Committee looked at possible separate standards for telepsychology practice but elected not to create specific standards for the use of technology. The 2002 revised APA ethics code (APA, 2002) did incorporate the phrase “electronic transmission” in a number of strategic sections of the standards, recognizing the need to clarify that the standards applied when using electronic communications. Since this addition to the ethics code, telecommunication practice standards or guidelines for psychologists have received little attention. In early 2011 the APA created a ten member telepsychology guidelines task force, composed of members from the APA, the Association of State and Provincial Psychology Boards (ASPPB) and the APA Insurance Trust, to begin to respond to the need for national telepsychology guidelines. The task force had not yet begun working at the time of this writing.

Other national or international health care organizations have proceeded in creating either telehealth standards or guidelines providing guidance in using technology in providing services. Two psychological organizations, the Australian Psychological Society (Australian Psychological Society, 2004) and the British Psychological Society (2009), have adopted telepsychology guidelines. The Canadian Psychological Association is in the process of revising a working draft of telepsychology guidelines (Canadian Psychological Association, 2006).

Since 1999 other mental health and health professional organizations have developed either standards or guidelines for providing services via electronic communications.
These include some interdisciplinary health groups (e.g. American Telemedicine Association (2009a, 2009b), International Society for Mental Health Online (2000)) that include psychologists and discipline specific organizations such as psychiatrists, physicians, social workers, and counselors. A list of relevant telehealth standards and guidelines reviewed by the OPA CTC in its developing telepsychology guidelines are included in Appendix A. Examination of these standards and guidelines show that there are numerous content and topic similarities (e.g. confidentiality, informed consent, provider competency, recordkeeping, appropriateness of services, etc.) due to underlying professional values shared across disciplines providing health or mental health services.

Guidelines and Standards
The term guidelines used in this article refers to statements that suggest or recommend specific professional behavior, endeavors, or conduct for psychologists in the state of Ohio. Guidelines differ from standards in that standards are mandatory and may be accompanied by an enforcement mechanism. Guidelines are more of an aspiration and are intended to facilitate the continued systematic development of the profession and to help assure a high level of professional practice by psychologists. In other words, guidelines are not mandatory or exhaustive and may not be applicable to every professional and clinical situation. Nor are guidelines intended to take precedence over the judgment of psychologists (APA, 2002b, p. 1050).

The OPA telepsychology guidelines are based upon and developed to be extensions of the 2002 APA Ethics Code and the 1997 Ethics Committee statement on electronic services. Although focused primarily upon clinical services, they are intended to be applicable to any psychological services which utilize communication technology. A more detailed description of the process of developing the OPA telepsychology guidelines is contained in the two OPA telepsychology guidelines documents (2008, 2010) available at http://www.ohpsych.org/professionalissues.aspx.

Why Telepsychology Guidelines?
The OPA CTC began its task with the assumption that psychology did not need separate or new telepsychology standards but rather guidelines about how to apply existing standards (i.e. APA Ethics Code). The guidelines serve as a basis for identifying what psychologists need to consider as recommended telepsychology practices for themselves and their clients. The guidelines are meant to be voluntary, evolutionary, based upon best practices and to take into account state and national laws and regulations that preempt other requirements or any voluntary guidelines. The guidelines were purposely focused to be general rather than technology specific.

Development of Guideline Considerations
Areas for the OPA telepsychology guidelines were modeled after major areas already identified in the APA Ethics Code and record keeping guidelines. These consist of (a) Appropriate Use of Telepsychology, (b) Legal and Ethical Requirements, (c) Informed Consent and Disclosure, (d) Secure Communications/Electronic Transfer of Client Information, (e) Access and Storage of Communications, (f) Fee and Financial Arrangements, (g) Supervision, (h) Assessment, and (i) Expiration and Review Date.

Telepsychology Guidelines
The Telepsychology guidelines which were adopted by the OPA and revised in 2010 are described below. A clarification on how the telepsychology guidelines can be implemented within psychological practices is also provided.

1. Appropriate Use of Telepsychology
Psychologists recognize that telepsychology is not appropriate for all problems and that the specific process of providing professional services varies across situation, setting, and time, and decisions regarding the appropriate delivery of telepsychology services are made on a case-by-case basis. Psychologists have the necessary training, experience, and skills to provide the type of telepsychology that they provide. They also adequately assess whether involved participants have the necessary knowledge and skills to benefit from those services. If the psychologist determines that telepsychology is not appropriate, they inform those involved of appropriate alternatives.

In order to develop the necessary skills and knowledge required to utilize telepsychology practices, psychologists need to obtain education, training, supervision and consultation (Koocher & Morray, 2001, Mallen, et. al 2005). Midkiff & Wyatt (2008) prudently advise “there must be no assumption that general therapeutic competence automatically translates to etherapy competence.” Opportunities for psychologists to learn about telepsychology are increasingly available in the form of online courses, journal articles, books, workshops, professional meetings and presentations. National organizations such as the ATA and APA and professional training programs offer educational and training programs useful to psychologists with an interest in telepsychology. In order to use telepsychology properly with clients, psychologists need to assure that their clients have sufficient knowledge, skills and physical capabilities to use and benefit from telepsychology services. It is incumbent that these be assessed prior to providing telepsychology services.

2. Legal and Ethical Requirements
Psychologists assure that the provision of telepsychology is not legally prohibited by local or state laws and regulations (supplements APA Ethics Code Sec. 1.02). Psychologists are aware of and in compliance with the Ohio psychology licensure
Psychologists are aware of and in compliance with the laws and standards of the particular state or country in which the client resides, including requirements for reporting individuals at risk to themselves or others (supplements APA Ethics Code Sec. 2.01). This step includes compliance with Section 508 of the Rehabilitation Act to make technology accessible to people with disabilities, as well as assuring that any advertising related to telepsychology services is non-deceptive (supplements APA Ethics Code Sec. 5.01).

When providing telepsychology procedures, psychologists employ reasonable efforts to assess a client’s level of functioning in order to select appropriate online assessment measures. (supplements 2002 APA Ethics Code Sec. 9.02)

Psychologists are separately licensed in each state in the United States with differences in the laws and regulations from state to state. Even though most states may not yet explicitly regulate telepsychology, it is considered wise for telepsychology providers to know what laws and regulations may apply to them in the jurisdiction where their client resides as well as the jurisdiction where the provider is located (Barrett, 2005, Zack 2008). Psychology licensing boards have slowly begun addressing and developing telepsychology regulations and will assuredly increasingly do so in the future. It is imperative that psychologists keep informed about those requirements and accompanying penalties for violations as they change.

In addition to being knowledgeable and abiding by legal aspects of telepsychology, psychologists are expected to comply with professional ethical requirements. The APA ethics code (APA, 2010) is the most obvious source for ethical considerations but there may be others such as licensing board ethical requirements. Guidelines such as the APA guidelines for recordkeeping (APA, 2007) have relevance to the practice of telepsychology and ought to also be considered.

3. Informed Consent and Disclosure
Psychologists using telepsychology provide information about their use of electronic communication technology and obtain the informed consent of the involved individual using language that is likely to be understood and consistent with accepted professional and legal requirements. In the event that a psychologist is providing services for someone who is unable to provide consent for him or herself (including minors), additional measures are taken to ensure that appropriate consent (and assent where applicable) are obtained as needed. Levels of experience and training in telepsychology, if any, are explained (though few opportunities for such training exist at this time) and the client’s informed consent is secured (supplements APA Ethics Code Sec. 3.10).

As part of an informed consent process, clients are provided sufficient information about the limitations of using technology, including potential risks to confidentiality of information due to technology, as well as any legally-required reporting, such as reporting clinical clients who may be suicidal or homicidal. This disclosure includes information identifying telepsychology as innovative treatment (supplements APA Ethical Principles 10.01b). Clients are expected to provide written acknowledgement of their awareness of these limitations. Psychologists do not provide telepsychology services without written client consent. Psychologists make reasonable attempts to verify the identity of clients and to help assure that the clients are capable of providing informed consent (supplements APA Ethics Code Sec. 3.10).

When providing clinical services, psychologists make reasonable attempts to obtain information about alternative means of contacting clients and provide clients with an alternative means of contacting them in emergency situations or when telepsychology is not available.

Psychologists need to inform clients about potential risks of disruption in the use telepsychology, and clearly state their policies as to when they will respond to routine electronic messages, and in what circumstances they will use alternative communications for emergency situations. Given the twenty-four-hour, seven-day-a-week availability of an online environment, as well as the inclination of increased disclosure online, clinical clients may be more likely to disclose suicidal intentions and assume that the psychologist will respond quickly (supplements APA Ethics Code Sec. 4.05).

The use of electronic communications is different enough from face-to-face communications to warrant psychologists to inform clients of the potential limitations these types of communications may pose to confidentiality. Additionally clients need to be informed about and provided with alternative ways to contact psychologists in an emergency if electronic communications are disrupted.
4. Secure Communications/Electronic Transfer of Client Information
Psychologists, whenever feasible, use secure communications with clinical clients, such as encrypted text messages via email or secure websites and obtain consent for use of non-secured communications.

Non-secure communications avoid using personal identifying information. Considering the available technology, psychologists make reasonable efforts to ensure the confidentiality of information electronically transmitted to other parties.

It is important that psychologists inform clients about who else may have access to communications with the psychologist, how communications can be directed to a specific psychologist, and if and how psychologists store information. Psychologists will need to take steps to ensure that confidential information obtained and or stored electronically cannot be recovered and accessed by unauthorized persons when they dispose of computers and other information storage devices. Clinical clients are informed of the types of information that will be maintained as part of the client’s record.

Since unsecured electronic communications are vulnerable to breaches of confidentiality it is advised that psychologists be cautious in their electronic communications with clients, especially if client identifiable information is used by the client or psychologist. Additionally it is imperative that psychologists keep informed regarding state and federal laws and regulations about mandatory patient health information security and privacy such as HIPAA and HITECH (DHHS, 2009). Federal penalties for “protected health information” being “breached” or accessed inappropriately can be very serious (DHHS, 2009). Encrypted data and communications however are exempt from mandated HIPAA/HITECH reporting.

Written electronic communications with clients using social media (e.g. Facebook, Twitter, and LinkedIn), email and texting needs to be done from the standpoint of maintaining client confidentiality and with the informed consent of clients.

5. Access to and Storage of Communications Psychologists inform clients about who else may have access to communications with the psychologist, how communications can be directed to a specific psychologist, and if and how psychologists store information. Psychologists take steps to ensure that confidential information obtained and or stored electronically cannot be recovered and accessed by unauthorized persons when they dispose of computers and other information storage devices. Clinical clients are informed of the types of information that will be maintained as part of the client’s record.

Psychologists have ethical and legal obligations to ensure that any electronic records of telepsychological services that they create and store are protected to assure client confidentiality. Disposal of such records also are expected to be done in a manner that assures confidentiality. The client is informed about what records are kept by the psychologist.

6. Fee and Financial Arrangements
As with other professional services, psychologists and clients reach an agreement specifying compensation, billing, and payment arrangements prior to providing telepsychology services (supplements APA Ethics Code Sec. 6.01).

Payment for telepsychology services may be different than face-to-face psychology services since at this time they are not billable to many health insurance plans. Whatever payment process is used, it needs to be clearly explained to prospective clients prior to delivering services.

7. Supervision
The type(s) of communications used for distance supervision is appropriate for the types of services being supervised, clients and supervisee needs. Distance supervision is provided in compliance with the supervision requirements of the psychology licensing board. Psychologists should review state board requirements specifically regarding face-to-face contact with supervisees as well as the need for having direct knowledge of all clients served by his or her supervisee. Distance supervision is usually intended to supplement rather than replace face-to-face supervision.

Most state psychology licensing boards at this time do not explicitly regulate distance supervision (APA 2010b). However, psychologists need to be aware of how their licensing board views distance supervision and to abide by any pertinent regulations that may exist.

8. Assessment
When employing psychological assessment procedures on the internet, psychologists familiarize themselves with the tests’ psychometric properties, construction, and norms in accordance with current research. Potential limitations of conclusions and recommendations that can be made from online assessment procedures are clarified with the client prior to administering online assessments (Supplements 2002 APA Ethics Code 9.06).

The assessment guidelines caution about differences which may exist between face-to-face assessment and online assessment. Four basic areas of concern with online assessment and testing have been identified: (a)


References


Kenneth Drude, PhD
Wright State University, School of Professional Psychology
Audrey E. Ellenwood, PhD
Youngstown State University, School Psychology
Marc Dielman, PhD
Bowling Green University, School Psychology
Jeanne Jenkins, PhD
John Carroll University, School Psychology
Kathleen (Ky) T. Heinlen, PhD, PCC-S
Cleveland State University
Michael Lichstein PhD
Cincinnati, Ohio
Paule S. Asch, PhD
Cincinnati, Ohio
Terry Imar, MA
Powell, Ohio
Mary Mills, MBA
Columbus, Ohio
Kenneth Drude received his PhD in counseling psychology from the University of Illinois. He is the Chairman of the Ohio Psychological Association’s Communication & Technology Committee.

Correspondence concerning this article should be addressed to Kenneth Drude, 723 Britton Avenue, Dayton, Ohio 45429. E-mail: Kenneth.Drude@wright.edu

---

**The Clinical Practice of Cognitive Therapy**

**October, 2011 - July, 2012**

**Intensive, Hands-on Training for Practicing Clinicians**

In-depth, practical training.
Lively, engaging faculty.
Live & video-taped demonstrations
Meets face-to-face 9 - 5 one day a month or Distance Education via Internet

**Sponsored by**
The Cleveland Center for Cognitive Therapy

**For more information** call (216) 831-2500 x 2 or visit www.BehavioralHealthAssoc.com
Introduction

Recently, there has been an explosion of literature on mindfulness-based treatments. Brown, Ryan & Creswell (2007) discovered more than 600 mindfulness-related manuscripts published as of 2006, with publications steadily increasing. However, the vast majority of these studies have focused on adult populations. Only recently have there been attempts to conceptualize children’s cases with mindfulness-based approaches, to establish guidelines for therapies with children, and to conduct feasibility and pilot studies examining the effectiveness of such adaptations.

Principles of Acceptance and Commitment Therapy

Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999) is a mindfulness-based intervention based on Relational Frame Theory (RFT; Hayes, Barnes-Holmes, & Roche, 2001). ACT focuses on the role that language plays in shaping cognitions. According to Hayes (2004), cognitive fusion occurs when language or verbal processes overshadow natural environmental functions. The mind begins to engage in a number of functions such as labeling, judging, comparing, etc., as opposed to maintaining an observational stance. As a result, children and adults begin to view private events such as thoughts, feelings, and sensations as factual information, rather than the passing experiences of their mind and bodies. Humans often engage in a number of strategies to attempt to control or avoid those experiences to which they are fused. Experiential avoidance, another concept outlined in ACT, refers to those attempts to control private events which ultimately result in prolonging or intensifying the pain and suffering associated with the experiences. Experiential avoidance and cognitive fusion narrow one’s repertoire of responses to suffering, which contribute to psychological inflexibility.

ACT may be used in conjunction with other behaviorally-oriented therapies, but differs from traditional cognitive behavioral therapy (CBT) in some significant ways. ACT acknowledges that pain and suffering are aspects of everyone’s life. ACT asks participants to willingly experience their negatively-valued private events rather than attempting to avoid or control them. Instead of relieving symptoms, ACT seeks to assist individuals in gaining greater acceptance of their pain and suffering. Acceptance facilitates greater psychological flexibility and diminished cognitive fusion and experiential avoidance. Rather than trying to eliminate all of the pain and suffering in life, or fighting one’s own thoughts and feelings, clients are taught to accept where they currently are. With increased psychological flexibility, clients can choose to commit to move toward what they value.

Six core clinical processes are identified within ACT: acceptance, defusion, self as context, contact with the present moment, values and committed action (Hayes, Strosahl, & Wilson, 1999; Twohig et al., 2008). The first four are considered mindfulness-based processes, while the last four are commitment/behavior change processes (self as context and contact with the present moment fall into both categories).

Adaptations to Child and Adolescent Therapy

Thompson & Gauntlett-Gilbert (2008) provide a discussion about modifications needed to apply mindfulness-based treatments such as ACT to child and adolescent populations. The authors first state that children and adolescents require greater explanations and rationales for using ACT methods than most adults. Youth may struggle to see the connection between engaging in a number of exercises, such as body scans and breathing spaces, and how they relate to everyday functioning, or to their specific reason for referral.

Twohig, Hayes, & Berlin (2008) use the analogy of ‘scratching an itch’ to explain the concept of acceptance and reasons for...
using an ACT approach. Children are asked to imagine that they have a mosquito bite. When asked what they will do about the bite, most children respond that they will scratch it. However, when questioned about whether or not the scratching helps, most youth indicate that it only temporarily works and the itch returns shortly after the scratching. This metaphor is extended into the realm of the identifying problem, outlining those methods that have temporarily worked and the need for greater acceptance of the “problem.”

Thompson & Gauntlett-Gilbert (2008) also stress the need for everyday generalizability of practice. The most beneficial tasks are those relevant to the child's/adolescent's life. The authors recommend engaging in mindfulness exercises while performing everyday tasks such as eating, brushing one's teeth, and making the bed. The authors also use a 'mindful texting' exercise in which youth are instructed on how to mindfully pay attention to thoughts, feelings, and sensations associated with receiving and sending a text. In addition, Semple & Lee (2008) recommend using a multi-sensory approach. Activities that engage all of the senses, i.e., mindful hearing, seeing, feeling, tasting, smelling, and moving, are recommended to assist children and adolescents in learning how to stay more fully present.

The ACT approach is heavily steeped in metaphors. Thompson and Gauntlett-Gilbert (2008) report using a puppy metaphor to discuss how the mind naturally wanders during mindfulness practice. Children are asked to think about training a puppy to sit still when it is inclined to wander off. Children are asked to notice where the puppy goes, to gently bring it back, and to attempt to have it sit down again. Greco et al. (2005) use the metaphor of a curious scientist who is attempting to observe an amoeba under a microscope to describe the curious, nonjudgmental stance needed to view thoughts, feelings, and sensations as they occur. Greco et al. (2008) use a 'loyal soldier' metaphor to assist adolescents in identifying self-protective strategies. In this situation, adolescents are read a story about Japanese soldiers in World War II who found themselves stranded on deserted islands after their ships capsized. Several months or even years later when the war had ended, the soldiers were discovered and they immediately took up their weapons to fight. Some of the soldiers refused to believe the war had ended and insisted on fighting those who had come to their assistance. Adolescents are asked to examine the ways in which they may metaphorically 'take up arms' and attempt to fight those who are attempting to assist them.

Semple and Lee (2008) also encourage practitioners to consider developmental adaptations, such as for the attentional capacity of children. Longer mindfulness practices such as body scans and breathing spaces should be replaced with shorter and frequently repeated practices. Eight group sessions lasting two hours each may be replaced with 12 hour and a half sessions.

Finally, Thompson & Gauntlett-Gilbert (2008) stress the importance of involving parents and caretakers. Caretakers can encourage children to engage in the exercises outside of therapy and may benefit from their own practice of mindfulness and acceptance-based techniques.

Caretakers can also become more aware of how they reinforce experiential avoidance. It is very difficult to see one's child hurting, so there can be a tendency to distract the child. Parents can be taught techniques such as accurate, empathic reflection, to help children turn toward their experiences, to internalize more functional ways of working with negative emotional states. For example, if a child is nervous about the first day of school, the caretaker can observe that the child appears anxious, ask the child to describe the physical sensations, then gently encourage the child to proceed toward the goal of getting to school even with the anxiety.

Murrell and Scherbarth (2006) completed a comprehensive literature review of all published ACT literature with children, adolescents and parents, and found a total of 13 studies. Four articles related to anorexia nervosa (Heffner et al., 2002; Hayes & Pankey, 2002; Onsillo & Batten, 2002; and Wilson & Roberts, 2002). Only one of the four articles described a published case study, while the other three provide theoretical responses to the application. Murrell & Scherbarth (2006) discovered one theoretical article related to the treatment of anxiety disorders (Greco et al., 2005) and two empirical case studies related to the treatment of chronic pain (Wicksell et al., 2005; Wicksell et al., 2006). The authors discovered a model describing how to integrate ACT into health care settings (Robinson, et al., 2005), and a case study describing the use of ACT methods with a child diagnosed with schizophrenia published in Spanish (Montes and Perez Alvarez, no reference provided). Three articles either described interventions or lay theoretical groundwork for treatment with parents (Blackledge & Hayes, 2006; Coyne & Wilson, 2004; Greco & Efert, 2004). Finally, one article was found utilizing a randomized clinical trial of ACT-like treatment with adolescents engaging in risky sexualized behaviors (Metzler et al., 2000).

Suggestions for Future Research

Few studies exist exploring the effectiveness of ACT treatments for youth, with the majority of publications being case studies. Even fewer studies employ experimental methods. Studies utilizing robust research methodologies, including large sample sizes, randomized clinical trials, and adequate comparison groups, are almost non-existent. In addition, more theoretical pieces are needed to address how to apply ACT methods to various subgroups of children and adolescents, such as for those with diagnoses of ADHD, depression, PTSD, and behavior disorders. Expanding our research and knowledge about such treatments could ultimately assist young clients in a more effective, time-efficient manner.

Summary

ACT is an evidence-based intervention which has thus far been studied mostly in adult populations. The principles appear to hold promise for children and adolescents, but significant adaptions will likely need to be made, which will need to be verified and honed by controlled research.

About the Authors

Julie Sell-Smith, MSW is a fourth year doctoral student at Union Institute & University. She is also a licensed independent social worker and has over 15 years of experience working with children, adolescents and their families in mental health settings.

Richard Sears, PsyD, ABPP is the Director of the Center for Clinical Mindfulness and Meditation and Core Faculty in the PsyD Program at Union Institute & University. He maintains a private psychology practice and regularly conducts mindfulness groups.
References


Training for Parents of Children with Disabilities: The Triple P Approach

Richard W. VanVoorhis, DEd, NCSP, Youngstown State University, Geoffrey E. Putt, PsyD, Akron Children’s Hospital, Kenneth L. Miller, PhD, PCC-S, Youngstown State University

Abstract:
This article is intended to give clinicians an overview of the Positive Parenting Program. Triple P is an evidence-based behavioral management program that focuses on teaching parenting skills necessary to successfully manage disruptive/externalizing behaviors. As children diagnosed with developmental disabilities are at significantly greater risk of presenting challenging behaviors, the article also describes a variant of Triple P called Stepping Stones Triple P (SSTP). SSTP is designed to increase parental competence and confidence in raising children with disabilities. In closing, the clinician’s role (as it relates to parent training) and Triple P resources are described.

Psychologists who work with children with disabilities and challenged families often build their clinical skills slowly over time and are generally in very high demand. Consequently, parents, educators, and others seeking behavior management services for parents and children often find it difficult to locate quality providers in their area. Clinicians (especially psychologists and school psychologists) are frequently expected to take a leadership role in designing treatment plans for children who exhibit disruptive behavior. These plans are often implemented through a collaborative process involving parents/caregivers, medical professionals, educators, and other individuals who comprise the intervention team. Integral to successful outcomes in this process is the identification of parent/caregiver responsibilities for reinforcing appropriate behaviors in the home environment. A solid parent training program is one type of treatment strategy designed to teach parents how to carry out these responsibilities in order to promote their child’s psychosocial, behavioral, and educational goals.

The Incredible Years Program) include such components, this article focuses on the Triple P approach.

Parent Training Programs
Benefits to families who participate in parent training are well documented. Dunst and Trivette (2001) reported that participation in parent support programs improves parental confidence and competence, and it encourages parents to understand that interactions initiated by the child are most important in child-parent communication. Parent support programs that produce more robust effects on social-emotional competence are characterized by a focus on specific needs of children, professional delivery of the program, and parent meetings that provide opportunities for peer support. Further, programs that target both parent support and direct early childhood education produce effects that are larger than average (Reynolds, Mavrogenes, Bezručzko, & Hagemann, 1996; Reynolds, Ou, & Topitzes, 2004). Finally, elements that have been consistently associated with larger effects in parent training programs have included increasing positive parent–child interactions and emotional communication skills, teaching parents to use time out and the importance of parenting consistency, and requiring parents to practice new skills with their children (Kaminski, Valle, Filene, & Boyle, 2008). While other high-quality and evidence-based programs (such as Parent-Child Interaction Therapy and

The Triple P Approach to Parent Training
Triple P (Positive Parenting Program) is an evidence-based behavior management program that focuses on teaching parents skills necessary to successfully manage disruptive/externalizing behaviors. Numerous studies have found the program to decrease disruptive behaviors in children, reduce parental stress, and decrease the use of coercive parenting. An example of this was seen in the large population-based trial of Triple P that was conducted in South Carolina. Participants were randomized by county (involving 18 different counties and well over 600 service providers). The study found large effect sizes related to reductions of substantiated child maltreatment, child out-of-home placements, and child maltreatment injuries (Prinz, Sanders, Shapiro, Whitaker, & Lutzker, 2009).

Triple P is not a new program. In fact, research on the program has been available for the last three decades. However, the “Triple P” name was not formally introduced until 1993. By April of 2009, there were almost 100 studies of Triple P as a program (Sanders, 2009). These included 46 efficacy trials, 27 effectiveness trials and several population trials and meta-analyses. Furthermore, the popularity of the program has spread across the globe (Triple P is widely disseminated in over two dozen countries and is the parenting program of choice for many of these countries). The popularity of the program in the United States is also growing in a steady fashion. This, in part, is due to the willingness of individual hospitals, mental health boards, agencies and other programs to fund the fairly significant training costs. Triple P is a program that is based on time-tested behavioral strategies and techniques. As Sanders (2009) reported, one of the strengths of the program is the myriad ways these evidence-based interventions can be presented to parents. These include small groups, large groups, through the internet, individually, on the telephone, via television, or in a self-directed manner. Finally, parent training as a clinical and evidence-based intervention can be offered as a stand alone service, or concurrent with other treatments.
Stepping Stones Triple P and Support for Parents of Children with Disabilities

Program objectives for Stepping Stones Triple P (SSTP) are designed to increase parental competence and confidence in raising children with disabilities (Sanders, Mazzucchelli, & Studman, 2003). Furthermore, the SSTP approach has been demonstrated to be particularly effective for pre-adolescent children with identified intellectual, physical and sensory disabilities, and pervasive developmental disorders (Harrold, Lutzker, Campbell & Touchette, 1992; Plant & Sanders, 2007; Roberts, Mazzucchelli, Studman & Sanders, 2002; Sanders & Plant, 1989; Whittingham, Sofronoff & Sheffield, 2006). Plant and Sanders (2007) reported that SSTP training was associated with lower levels of negative behaviors in children and a reduction in the number of settings in which problem behavior was displayed. In addition, gains made with SSTP were sustained after one year and parents who participated in SSTP training reported high levels of satisfaction.

It is noteworthy that children with diagnosed developmental disabilities are at significantly greater risk (compared to non-disabled peers) of presenting challenging behaviors including: aggression, destructiveness, non-compliance, self-injury, and stereotyped mannerisms (Dekker, Koot, Van der Ende, & Verhulst, 2003; Roberts, Mazzucchelli, Taylor & Reid, 2003). Furthermore, Sanders, Mazzucchelli, & Studman (2003), detailed the increased prevalence of certain types of challenging behaviors associated with specific syndromes and disorders. These behaviors often present challenges for caregivers, are disruptive to the family system, and can be objectionable in the school and other community settings. When dealing with these and other challenging behaviors, SSTP strategies are often preventative in nature and designed to complement other therapies and interventions. Although SSTP incorporates a variety of service modalities and levels of intervention, it targets a number of variables such as: general parenting and behavioral issues, discrete child behavior problems, multiple child behavior problems, developmental issues, parent-child communication, learning difficulties, and parent problems such as relationship conflict, depression, parenting stress, and adapting to having a child with a disability.

Support for Parents of Children with Disabilities

When a child presents with disabilities, parental/caregiver responsibilities often increase proportionally with the severity of the diagnosis and associated challenging behaviors. In more severe cases, parents and caregivers may be exposed to extreme levels of stress, fear, confusion, and hopelessness that can lead to significant problems in personal functioning as well as parenting effectiveness. The SSTP program helps parents learn to manage their emotional responses and accept their children as unique and special regardless of their disability. Through parenting programs such as SSTP, parents have the opportunity to improve parenting skills in order to reduce their child’s inappropriate behaviors and improve specific adaptive behaviors (including social and language skills, emotional skills, independence skills, and problem-solving skills). Also, parents are taught strategies to increase their own sense of parenting self-efficacy, which often leads to a reduction in parent depression, stress, and the use of coercive parenting strategies. Finally, according to Sanders, et al. (2003), parent training and support groups, such as SSTP, may provide multiple opportunities for parents to find support, friendship, and constructive feedback from other parents as well as opportunities for parents to normalize the parenting experience through peer interactions. Parents may also create social networks and share practical ideas to enhance parenting skills.

Triple P and the Role of the Clinician

When there is reasonable doubt about parents/caregivers' abilities to maintain progress in meeting treatment goals, a number of areas should be properly evaluated to determine need for assistance. Important variables may include perceived parental/caregiver effectiveness, parental stress, family environment, social support, access to/utilization of community resources, and parental mental health needs. Should clinicians determine that a parent/caregiver training referral is appropriate; referrals should be based upon unique client needs. In the event that a Triple P referral is provided, clinicians must provide a clear rationale for the referral and basic information about the program (i.e., content, time commitments, parent responsibilities, costs, and evidence of effectiveness). It is important to explain the potential program benefits to parents or caregivers, so they understand that this program is designed to improve skills in managing behavior, not to point out inadequate parenting skills. Finally, it may be helpful to explain to parents that involvement in a parenting program is one, of many, coordination of care options. As mentioned previously, the treatment team often involves a number of systems or agencies, so ongoing communication among service providers is especially important. For example, once parent permission is given, a clinician could gain valuable assessment information (obtained during Triple P sessions), which may be valuable in guiding individual/family therapy.

Resources for Ohio Clinicians

In order to provide practical and effective support to families who may benefit from parent training, clinicians should have knowledge of treatment options and resources. Trained Triple P providers are found throughout Ohio in locations such as Akron Children’s Hospital, Nationwide Children’s Hospital in Columbus, Cincinnati Children’s Hospital, and The Rich Center for Autism in Youngstown. Furthermore, The NeuroDevelopmental Science Center (NDSC) at Akron Children’s Hospital, in cooperation with Triple P America, has been identified as a regional training hub by Triple P America due to its diverse Triple P offerings (e.g., Standard, SSTP, Primary Care, and Teen Triple P) as well as its long term commitment of resources and personnel. For those clinicians who wish to learn more about the Triple P approach, review of its website is encouraged (http://www.triplep.net). In closing, findings presented in this paper indicate that high quality parent training programs, such as Triple P, should be viewed as a valuable clinical practice option for those who wish to assist parents in acquiring greater parenting confidence and competence. Additionally, tailored parenting supports, such as SSTP, appear to have a number of beneficial outcomes for both parents and their children with diagnosed disabilities.
References


About the Authors
Richard W. VanVoorhis, D.Ed. NCSP
Dr. VanVoorhis is an assistant professor in the Department of Counseling and Special Education at Youngstown State University. Dr. VanVoorhis provided a variety of school psychological services (including parent training) as a full time school psychologist for nearly two decades in the public school setting. His current research interests include: role and function of school psychologists, special education service delivery, disability assessment and identification issues, and career development topics. He is currently conducting research to determine the effectiveness of the Stepping Stones Triple P Program with parents and caregivers of children diagnosed with autism.

Geoffrey E. Putt, PsyD
Dr. Putt is a clinical psychologist and the Director of Parenting & Family Support Services in the NeuroDevelopmental Science Center at Akron Children’s Hospital. Dr. Putt is also the Director of The Center for Attention & Related Disorders at Akron Children’s Hospital. In addition to his clinical activities, Dr. Putt is also actively involved in community outreach, Resident and Fellow education, and multiple research endeavors. Dr. Putt has been interviewed as a parenting expert on all three of the major Cleveland television networks, and has been quoted in a variety of newspapers, on CNN.com, and in multiple national parenting magazines (such as Parents and Parenting).

Kenneth L. Miller, PhD, PCC-S
Dr. Miller is a professor in the Department of Counseling and Special Education at Youngstown State University and a Supervising Professional Clinical Counselor. He has collaborated in the development of a computer interface designed to collect assessment data regarding students diagnosed with autism, and he has developed online instructional modules on autism. His research interests include program evaluation, assessment of cultural bias and discrimination, and technology issues in clinical supervision. He is currently conducting research to determine the effectiveness of the Stepping Stones Triple P Program with parents and caregivers of children diagnosed with autism.
Abstract

Adults diagnosed with Bipolar Disorder often experience frequent relapses in symptoms due to non-compliance and/or lack of treatment options. Family-Focused Therapy (FFT) is a form of psychotherapy for individuals with Bipolar Disorder and their family members that focuses on assessment, psychoeducation, communication, and problem-solving strategies. The role of the family is emphasized throughout treatment as the individual and family members learn to recognize and manage the symptoms of Bipolar Disorder. Accumulating evidence indicates FFT is a cost-effective treatment option that significantly reduces the risk of relapse and inpatient hospitalizations. This article will review recent research on FFT and its utility in a variety of clinical settings throughout Ohio.

Bipolar Disorder is the most common primary diagnosis for adults hospitalized with a severe behavioral disorder in Ohio (Mental Health Advocacy Coalition, 2011). Upon discharge, most adults diagnosed with Bipolar Disorder have access to limited community resources and treatment options. As community resources and treatment options continue to be reduced due to the lack of funding, identifying and utilizing social support networks may be an important approach to assist adults with Bipolar Disorder.

Pharmacotherapy is often a frontline treatment for Bipolar Disorder; however, recent research is beginning to support the need for adjunct psychotherapy to aide in reducing a relapse of symptoms. Although a majority of individuals with Bipolar Disorder are prescribed medications, between 55-70% of individuals will experience a relapse in mood disorder symptoms that may or may not result in hospitalization (Geller et al., 2004). Stressors among social and family systems, in addition to non-compliance with medications, can account for the increased risk of relapse and hospitalizations (Morris, Miklowitz, & Waxmansky, 2007). Psychoeducational treatments, such as family-focused therapy (FFT), have been used to increase structure within stressful family environments, improve medication compliance, and delay and reduce the number of relapses (Morris et al., 2007). This article will review recent research on FFT reducing relapse and hospitalizations among individuals with Bipolar Disorder.

FFT was revised by Miklowitz and Goldstein (1997) as a form of psychoeducational treatment for individuals with Bipolar Disorder and their family members. FFT consists of 21 sessions over a nine month span with the four major components being (a) assessment, (b) psychoeducation, (c) communication enhancement training, and (d) problem-solving skills training (Morris et al., 2007; Rea et al., 2003). A functional assessment is completed prior to the first therapy session in order to individualize treatment based on the needs of the patient and family (Miklowitz & Goldstein, 1997; Morris et al., 2007). The first seven sessions focus on psychoeducation, where individuals and families are provided information on the symptoms, risk factors, and protective factors associated with Bipolar Disorder (Miklowitz et al., 2003; Rea et al., 2003). An important part of the psychoeducational component is teaching family members how to distinguish an individual’s personality traits from their mood disorder symptoms. Communication enhancement training accounts for the next seven to ten sessions as active listening skills and providing structured feedback are reviewed in role-playing exercises. The final four to five sessions of FFT teach problem-solving techniques with all families completing a “relapse drill” in which the family develops a strategy on how to respond if the patient’s symptoms return (Rae et al., 2003).

Because individuals diagnosed with Bipolar Disorder are at a high risk of hospitalization following a relapse in mood disorder symptoms due to a stressful family environment, Rea et al. (2003) compared whether FFT or an individualized psychoeducational program would reduce this risk. A total of 53 individuals recently hospitalized for manic episodes were randomly assigned into a FFT group (n = 28) or an individually focused treatment group (n = 25). Individuals in both groups were prescribed mood-regulating medications and were required to adhere to this medication regimen in order to participate in the study. The duration of treatment was one year in which 46% of the FFT group and 52% of the individually focused treatment group experienced at least one relapse of symptoms. However, those in the FFT group reported fewer relapse episodes than the individually focused group (28% vs. 60%, respectively) during the one-year follow-up after therapy was discontinued. In addition, members of the FFT group were less likely to be hospitalized during treatment and one-year after treatment was discontinued compared to the individually focused treatment group (12% vs. 60%, respectively). Rea et al. (2003) concluded that FFT is more effective in preventing rehospitalization compared to preventing a relapse in symptoms among individuals with Bipolar Disorder.

In a similar study, Miklowitz et al. (2003) randomly assigned 101 patients into a FFT group (n = 31) or a crisis management (CM) group (n = 70) to determine which type of outpatient treatment is more effective in relapse prevention. The FFT group adhered to the guidelines developed by Miklowitz and Goldstein (1997), whereas the crisis management group was offered two, one-hour home based sessions during the first two months, followed by crisis intervention sessions as needed for the remainder of the nine month study. Results indicated that a higher percentage of individuals in the CM group experienced relapse (n = 38) compared to the FFT group (n = 11), with the FFT group also reporting longer intervals between relapse episodes compared to the CM group. On average, the FFT group also reported a lower frequency of mood symptoms, particularly depression, compared to the CM group.
FFT has also been implemented with success in non-western cultures, such as Turkey. Turkey is a traditional collectivist culture where a strong level of interdependence is found among family members (Ozerdem et al., 2009). In fact, single members are expected to reside with their parents until they are married. Mental illness is still stigmatized within this culture as the family prefers that all problems remain within the family system. However, Turkish norms are supportive of pharmacotherapy and psychotherapy as forms of mental health treatments (Ozerdem et al., 2009). Nine patients diagnosed with Bipolar Disorder participated in FFT following a recent hospitalization. Mood episodes were significantly reduced from an average of 1.66 per year prior to treatment to 0.55 episodes per year following treatment. In addition, the pretreatment global assessment of functioning (GAF) scores ranged from 45-80, with the average GAF increasing to 75 after participating in FFT.

Additional cultural aspects of FFT were discovered within the Turkish sample. First, a higher number of family members participated in the FFT sessions compared to western cultures (Ozerdem et al., 2009). Between one to five members of the family, which include parents, spouse, siblings, or family friends, were present. The psychoeducational component of FFT was also successful in teaching families on how to differentiate symptoms of Bipolar Disorder from an individual’s personality, which is important given the stigma associated with mental illness. Furthermore, sessions reviewing communication enhancement skills resulted in parents and spouses learning to provide more positive feedback and requests compared to offering critical or stigmatizing attitudes towards the individual with Bipolar Disorder. Overall, FFT is a practical treatment for individuals with bipolar with only minimal changes needed to adapt treatment strategies for a particular culture (Ozerdem et al., 2009).

Given the increased risk of a relapse of mood disorder symptoms and/or hospitalization, FFT appears to be a successful psychoeducational treatment that minimizes stress and enhances structure within a family system. Family support appears to be a strong protective factor in relapse prevention among individuals with Bipolar Disorder with research supporting FFT as being more effective compared to other individually focused treatment strategies. Each study reviewed within this article examined individuals who were also required to adhere to their prescribed medication regimen. Only 30% of patients with Bipolar Disorder are known to comply with taking their medication (Morris et al., 2007); therefore, developing a family support system can serve as a level of accountability for a patient who otherwise would be non-compliant. FFT does exclude individuals without a supportive family or friends, as well as individuals who choose not to include relatives as part of their treatment plan.

Interestingly, Miklowitz et al. (2003) found FFT to be more influential in reducing depressive symptoms compared to manic symptoms. Therefore, it would follow that FFT can also benefit individuals with other mood disorders, such as major depression. A stronger focus on whether FFT is more effective in addressing major depressive episodes versus manic episodes is needed. Future research should also consider accounting for additional cultural and demographic factors (e.g., socioeconomic status, family structure, or attitudes towards mental disorders).

The cost of FFT may be a concern for an individual with Bipolar Disorder and the participating family members because of the 21 session commitment over a nine month span. In 2010, the national average cost of outpatient psychotherapy ranged from $94.59 to $122.80 per visit (Olfson & Marcus, 2010); therefore, a family should expect to pay from $1,986.39 to $2,578.80 of out of pocket expenses if health insurance coverage is not available. Although the cost of FFT might be perceived as expensive, it is a cost-effective treatment compared to emergency room visits and inpatient hospitalizations in Ohio. Recent estimates for emergency room visits in the state of Ohio indicate patients pay an average of $1,312 in costs to treat a severe behavioral health disorder (Mental Health Advocacy Coalition, 2011). Furthermore, an individual with Bipolar Disorder should expect to pay significantly more if inpatient hospitalization is necessary. In particular, an individual’s average length of stay is 6.5 days, resulting in an average cost of $13,006 per hospitalization (Mental Health Advocacy Coalition, 2011). If hospitalization is required for an individual participating in FFT, the individual is likely to have a reduced stay and save from 19% to 27% in hospitalization costs compared to a patient not receiving adjunct family therapy (Baker, McFall, & Shoham, 2009). Overall, FFT does contain short-term costs to the individual with Bipolar Disorder; however, it is a more attractive treatment option because of its success in reducing the frequency and duration of hospitalizations.

In summary, FFT can be an alternative approach to treating adults with Bipolar Disorder in Ohio. As mental health funding in Ohio continues to be reduced by the state and federal government (see Johnson & Candisky, 2010; Candisky, 2011), helping adults with Bipolar Disorder develop a supportive family system could be beneficial to their long-term prognosis. More importantly, the clinical utility of FFT in both western and non-western populations can be useful in providing needed psychological services to the culturally diverse population located throughout the state of Ohio.

---

**Effective • Efficient Empirically Supported**

**EMDR INSTITUTE**

**2011-2012 Training Schedule**

**COLUMBUS OHIO**

Weekend 1-September 9-11, 2011
Weekend 2-March 9-11, 2012

**CLEVELAND OHIO**

Weekend 1-March 16-18, 2012
Weekend 2-August 10-12, 2012

Eye Movement Desensitization and Reprocessing (EMDR) is a comprehensive, integrative psychotherapy approach proven effective for treatment of trauma-related disorders with adults and children.

“*The speed at which change occurs during EMDR contradicts the traditional notion of time as essential for psychological healing. Shapiro has integrated elements from many different schools of psychotherapy into her protocols, making EMDR applicable to a variety of clinical populations and accessible to clinicians from different orientations.*”

Bessel A. van der Kolk, MD

Visit www.emdr.com for US & International Training Schedules
PO Box 750 • Watsonville CA • 95077
831-761-1040 • registration@emdr.com
Narratives of Young Women with Eating Disorders and Their Families: Stories of Illness and Recovery

By Courtney J. Wudyka, MA, OPA Poster Session Empirical Winner, Chairperson: Meghan Roekle, PsyD, Committee Member: Marcia Nickow, PsyD, CADC, CGP

Abstract

Utilizing a social constructionist and narrative framework, this study explored narratives of young women with eating disorders and their families, how they understood the disorder and made meaning from it. A phenomenological qualitative research design was applied to examine the multiple stories people construct about their experiences of an eating disorder. Participants revealed many stories about their personal understandings of the eating disorder; some were consistent with society’s dominant narratives about eating disorders. Others were very different, even contradicting some of society’s dominant narratives, providing new insights into the lived experiences of individuals with eating disorders and their families.

The rates of diagnosed eating disorders among female adolescents and young adult women have been increasing in the United States and other Westernized countries throughout the last several decades (Hudson, Hiripi, Pope, & Kessler, 2007), perhaps as a result of increased awareness. The potential lethality of eating disorders has led to an upsurge in research seeking to understand this phenomenon. Few studies have examined from the perspectives of these young women their subjective experiences of having an eating disorder, and even fewer have explored the experiences of families who have a relative with an eating disorder. This research sought out those stories from young women and their families to provide their firsthand accounts of the phenomenon.
The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; American Psychiatric Association, 2000) includes three categories of eating disorders: Anorexia Nervosa (AN), Bulimia Nervosa (BN), and Eating Disorder Not Otherwise Specified (EDNOS). AN is characterized by a woman’s refusal to maintain a typical body weight, an intense fear of gaining weight, a perception that she is fat despite being emaciated, and amenorrhea. Women with BN exhibit cycles of binge-eating followed by purging behaviors, such as self-induced vomiting, laxative use, and excessive exercise. EDNOS is a heterogeneous category for women who clearly warrant an eating disorder diagnosis but do not meet all of the required criteria for AN or BN. Another atypical eating pattern currently housed under the EDNOS diagnosis is Binge Eating Disorder (BED). Although not yet an official diagnosis, BED has been preliminarily described as recurrent episodes of binge eating without any compensatory behaviors (American Psychiatric Association).

Historically, eating disorders have been understood from varying perspectives depending upon cultural context and the language used by the people in the culture to describe them. They were described as spiritual quests and miraculous feats of self-restraint. Fasting from food and drink has been a long-standing tradition in most Judeo-Christian religious denominations to remind followers that God, not food, sustains them (Foster, 1988). During the 14th and 15th centuries women utilized self-starvation to display their strict devotion to God; a particularly noble feat because during that time period the desirable female body type was curvaceous (Duran, Cashion, Gerber, & Mendez-Ybanean, 2000).

Though the attention paid to eating disorders has not changed, what has changed is how these behaviors are perceived. The medical community now labels these behaviors as “disordered” (Brumberg, 1988). The evolution of how we understand and describe atypical eating behaviors is an example of the transient nature of what is known and what is real depending on the language used by a particular culture. As a part of the social constructionist movement, narrative theory posits that no fact about the human experience is inherently determined by nature; rather, it is through a process of human interactions utilizing language to tell stories that what is real and meaningful is interpreted (Berger & Luckmann, 1967; Parry & Doan, 1994). Society’s current dominant narrative regarding eating disorders is that women who engage in these behaviors are mentally ill, take extreme measures to achieve the ideal thin body type portrayed in the media, and need intense interventions to normalize their eating behaviors. But certainly there are other subjugated stories about women’s experiences with eating disorders just waiting to be told, which may lead to a deeper understanding of the etiology, maintenance, and effective treatment of disordered eating behaviors.

Method

This study employed a qualitative phenomenological research methodology to understand a human problem through a process of inquiry in which the participants’ words are the data (Creswell, 1994). Specifically, it was hypothesized that young women with eating disorders and their family members would share their own idiosyncratic experiences with the eating disorder, how they made meaning from it and the stories they have constructed about it, which may or may not correspond to society’s story about eating disorders.

Following approval by the Institutional Review Board at the researcher’s academic institution, participants were recruited in a large Midwestern metropolitan city through the professional networks of the researcher’s dissertation committee members. Young women between the ages of 16 and 22 with a current or past diagnosis of an eating disorder, and one immediate family member, were invited to participate. This study had four participants: all were Caucasian, English-speaking, and of Upper-Middle class. One pair of participants consisted of a 20-year old young woman diagnosed with EDNOS (Participant A) and her biological mother (Participant B). The other pair consisted of a 17-year-old young woman diagnosed with EDNOS (Participant C) and her older sister (Participant D). Each participant was interviewed separately by the researcher, utilizing a semi-structured interview protocol. Interview questions were open-ended ("What is the story of food in your family?" and “Tell me the story of your (relative’s) treatment”). Questions were designed to elicit “thick and rich descriptions” of the participants’ lived experiences of an eating disorder (Rubin & Rubin, 1995).

The researcher tape recorded and transcribed the interviews. Each non-overlapping and non-repetitive statement, which described how the participant was experiencing the phenomenon, was listed. These statements were grouped into “meaning units,” across participants (Creswell, 1998). Meaning units were then grouped into larger themes across interviews to yield the results.

Results

All four participants shared stories echoing contemporary Western culture’s understanding of eating disorders. They all identified the role of intergenerational transmission of messages about food and appearances in their families, such as Participant D’s recollection of her younger sister (Participant C) portioning out her animal crackers as a child, emulating her mother’s habits of portioning food and counting calories. Participant B stated that her family-of-origin emphasized everyone looking “okay” because it meant the family was “okay.” She expressed a belief that this value was passed on to her family and “fueled” the eating disorder in her daughter (Participant A).

Regarding cultural stories, the participants described society’s expectations for women to achieve the “thin ideal” and demonstrate self-restraint regarding food consumption. Participant D noted mixed messages portrayed in many women's magazines, stating: “...half the magazine is like diet tricks and exercise tips and the other half is like recipes...it’s like this mixed message.” Interestingly, she also discussed advertisements geared toward women which label food as “sinful” or “heavenly,” implicating women’s morality in their denial or indulgence of food. When bombarded with these types of confusing stories, it seems no wonder that so many women struggle with disordered eating.

Participants also shared narratives highlighting their own idiosyncratic stories about how they came to understand the eating disorder aside from society’s conceptualizations. Both eating disordered patients identified symptoms of binge eating as the main component of their eating disorders and described this behavior as an addiction. They discussed their “abstinence” from “trigger foods,” including those with refined sugars and white flour. Consistent with the disease model and genetic heritability of addictions, several participants discussed family members’ substance addictions contributing to their genetic vulnerability to develop a food addiction. They identified participation in the 12-step model of Overeaters Anonymous as helpful in their recovery, a model very different from the current belief that individual and family therapy interventions are necessary for recovery from eating disorders. Society’s dominant narrative expects that eating disorders emerge from young women’s perceived lack of control (Kally & Cumella, 2008; Minuchin, Rosman, & Baker, 1978). Yet these women identified the importance of a structured meal plan to guide their food consumption during recovery, seemingly relinquishing that sense of control over their food choices.
They revealed stories which contradicted society’s belief that eating disorders are merely “issues with food.” After Participant A gained “the freshman 15,” her mother placed her on a strict 1,000 calorie diet and insisted she exercise daily. Participant A then began sneaking food behind her mother’s back, making her “feel like a badass” to rebel and assert her independence. Participant C described that food served her need for emotional regulation: “…food could be like everything. It’s a congratulatory thing, celebrate with a treat or something or like I’m sad, I need something to cheer me up, like I’ll have something.” From a strengths-based perspective, these women utilized food as a meaningful medium in order to communicate something about themselves.

Discussion

Overall, the participants revealed many stories about their experiences of eating disorders. They presented similar, well-known stories of family dysfunction, the tendency of eating disorders to run in a family, and the cultural pressure to be thin; all theories well supported by current research (Duran et al., 2000; Laliberte, Boland, & Leichner, 1999). However, they also voiced lesser known narratives about how they personally understand their eating disorder, including their belief that binge eating is an addiction, the utility of food as a tool to communicate feelings, and the importance of receiving addiction-focused treatment. Given that social support is helpful in recovering from eating disorders (Bloks, Spin honven, Callewaert, Willems-Koning, & Turksma, 2001; Bloks, Van Furth, Callewaert, & Hoek, 2004), therapists, families, and friends are recommended to consider the individual story of each young woman with an eating disorder rather than assume it corresponds to society’s dominant narrative.

A strength of this study was the small sample size (n=4). This enabled participants to utilize their own language to describe their experiences; the very crux of qualitative phenomenological research. However, there were also limitations. Both patients in the study were diagnosed with EDNOS; thus, it is difficult to draw any conclusions about the experiences of young women with other eating disorders. Future research should seek to address this limitation to further society’s knowledge about eating disorders and the role they serve for young women, and to inform best treatment practices within the mental health profession.

About the Author

Courtney J. Wudyka, MA is a fifth year Clinical PsyD student at The Chicago School of Professional Psychology. She is currently completing her pre-doctoral internship in the APA-accredited Internship program at the Wright State University School of Professional Psychology where she provides psychological assessments and individual, group, and family therapy to children, adolescents, and adults in two community-based mental health agencies. Courtney’s clinical interests include working with individuals with disordered eating behaviors and body image issues, as well as individuals who have survived traumatic experiences. Her clinical training experiences within military and community mental health settings have provided her with invaluable experiences working with socio-demographically and diagnostically diverse clients, and have afforded her the opportunity to draw from narrative theory when helping clients explore the many social contexts in which they are embedded while working towards an improved sense of well-being. Career goals include completing a year of post-doctoral work in a VA or community-based clinic, obtaining licensure, and finding employment in the Columbus area.

References


Romantic Involvement and Depressive Symptoms in Emerging Adults

By Michael R. Bruner, BS, Amanda D. Kuryluk, BA, and Sarah W. Whitton, PhD, University of Cincinnati, OPA Poster Session Winners, Empirical and People’s Choice Categories

Abstract

Involvement in romantic relationships has been linked with increased depressive symptoms in adolescents, but decreased depressive symptoms in adults. In this study, we explored the previously unstudied links between romantic involvement and depressive symptoms in emerging adulthood (ages 18-25). A sample of 1,002 undergraduate students completed self-report measures of depressive symptom level and several indicators of romantic involvement (relationship status, frequency of dating and sexual activity, and number of dating and sexual partners). Unexpectedly, depressive symptoms were unrelated to most romantic involvement variables. Symptom level was only associated with relationship status, and for women only, indicating that current involvement in a relationship was associated with lower depressive symptoms.

Introduction

It is well established that in adults, being in a committed romantic relationship is associated with better mental health than is being single (Umberson & Williams, 1999). However, recent research on adolescents has shown, unexpectedly, that involvement in romantic relationships is associated with increased levels of depressive symptoms. In two studies, adolescents who entered into a romantic relationship reported significantly greater levels of depressive symptoms than students who did not (Davila, Steinberg, Kachadourian, Cobb, & Fincham, 2004; Joyner & Udry, 2000). In addition, a growing body of research suggests that romantic activity frequency is significantly and positively associated with levels of depressive symptoms in adolescents (Quatman, Sampson, Robinson, & Watson (2001); Compian, Gowen, & Hayward, 2004).

Emerging adulthood, which encompasses ages 18 to 25, represents a distinct life stage that is unique to both adolescence and adulthood. Individuals first begin to explore the long-term potential for intimacy and happiness in romantic relationships in emerging adulthood (Arnett, 2000), so it is of particular importance to explore how romantic involvement relates to mental health during this period. The literature to date, however, has focused on adults and adolescents in middle or high-school, so it remains unknown how dating and romantic activities are associated with emotional wellbeing in emerging adulthood. The current study aims to address the current gap in the literature by exploring associations between romantic involvement and depressive symptoms in an undergraduate sample.

Due to the similarities of emerging adults to adolescents in terms of undeveloped identities and the tendency for their romantic relationships not to represent a primary attachment relationship (Arnett, 2000), it was hypothesized that, similarly to adolescents, higher depressive symptom levels would be associated with: 1) current involvement in a romantic relationship, 2) more frequent romantic and sexual activity, regardless of relationship status, and 3) a higher number of romantic and sexual partners, regardless of current relationship status. Because gender differences have been observed in how romantic involvement relates to depressive symptoms among adolescents (e.g., Joyner & Udry, 2000) and adults (Whisman, 2001), gender differences were assessed for each hypothesis.

Method

Participants

Participants were 1,002 introductory psychology students (n = 688 women) ages 18 to 25 at a large Midwestern university. Participants received research participation credit for participating in the study. The sample’s mean age was 19.12 (SD = 1.44). The ethnic distribution was 84.4% (n = 846) Caucasian, 7.5% (n = 75) African American, 4.1% (n = 41) multiracial, 2.0% Asian (n = 20), and 2.0% other (n = 20). Not surprisingly for a student sample, yearly income was below $10,000 for 90% (n = 885) of the sample. Approximately half (51.6%; n = 519) of the sample reported current involvement in a romantic relationship. Relationship length averaged 19 months (SD = 17 months). The mean rating for dating frequency and sexual activity frequency was “around once a week.” Participants had on average 1.9 romantic partners and 2.3 sexual partners in the past six months.

Measures

All measures were distributed using a password-protected online survey that participants could complete at their leisure.

Depressive symptoms were measured using the well validated Center for Epidemiological Studies – Depression Scale (CES-D; Radloff, 1977). Scores reflect summed ratings of how often 20 depressive symptoms were experienced in the past week on a 4 point scale (0 = rarely or none of the time; 3 = most or all of the time). Internal consistency in this sample was excellent (α = .90).

Current relationship status was assessed by asking: “Are you currently in a romantic relationship?”

Romantic and sexual activity level: Participants rated the frequency of their romantic activity (e.g., going on a date, “hanging out” where it was clear it was romantic) and sexual activity (e.g., kissing, sexual touching, intercourse, etc.), each on a 6-point Likert-type scale (0 = never to 5 = every day or nearly every day). Participants also reported the number of romantic and sexual partners they had in the past six months.
Results
To evaluate whether depressive symptoms were associated with participation in a current romantic relationship, and if this association differed by gender, a 2 (Gender) x 2 (Relationship Status) ANCOVA was performed with depressive symptoms as the dependent variable. There was a significant gender by relationship status interaction, F(1, 998) = 4.66, p = .03. To discover the nature of the interaction, t-tests were performed separately for men and women. As displayed in Figure 1, depressive symptom levels did not differ between men in a relationship (M = 14.76, SD = 10.15) and men not in a relationship (M = 14.00, SD = 8.33), t(310) = -0.72, p = .47. For women, however, depressive symptom levels differed significantly, such that women who were in a current romantic relationship (M = 15.78, SD = 10.18) reported lower levels of depressive symptoms than women not in a relationship (M = 17.94, SD = 10.01), t(688) = 2.79, p = .005. There was also a significant main effect of gender on depressive symptom level, with women having higher levels of depressive symptoms than men, F(1, 998) = 13.50, p < .001.

To test whether depressive symptoms were negatively associated with participation in a current romantic relationship, and if this association differed by gender, a 2 (Gender) x 2 (Relationship Status) ANCOVA was performed with depressive symptoms as the dependent variable. There was a significant gender by relationship status interaction, F(1, 998) = 4.66, p = .03. To discover the nature of the interaction, t-tests were performed separately for men and women. As displayed in Figure 1, depressive symptom levels did not differ between men in a relationship (M = 14.76, SD = 10.15) and men not in a relationship (M = 14.00, SD = 8.33), t(310) = -0.72, p = .47. For women, however, depressive symptom levels differed significantly, such that women who were in a current romantic relationship (M = 15.78, SD = 10.18) reported lower levels of depressive symptoms than women not in a relationship (M = 17.94, SD = 10.01), t(688) = 2.79, p = .005. There was also a significant main effect of gender on depressive symptom level, with women having higher levels of depressive symptoms than men, F(1, 998) = 13.50, p < .001.

To test whether depressive symptoms were negatively associated with participation in a current romantic relationship, and if this association differed by gender, a 2 (Gender) x 2 (Relationship Status) ANCOVA was performed with depressive symptoms as the dependent variable. There was a significant gender by relationship status interaction, F(1, 998) = 4.66, p = .03. To discover the nature of the interaction, t-tests were performed separately for men and women. As displayed in Figure 1, depressive symptom levels did not differ between men in a relationship (M = 14.76, SD = 10.15) and men not in a relationship (M = 14.00, SD = 8.33), t(310) = -0.72, p = .47. For women, however, depressive symptom levels differed significantly, such that women who were in a current romantic relationship (M = 15.78, SD = 10.18) reported lower levels of depressive symptoms than women not in a relationship (M = 17.94, SD = 10.01), t(688) = 2.79, p = .005. There was also a significant main effect of gender on depressive symptom level, with women having higher levels of depressive symptoms than men, F(1, 998) = 13.50, p < .001.

Discussion
The present findings suggest that emerging adult men are dissimilar to both adolescents and adults in that involvement in a romantic relationship is neither a risk nor a protective factor for depressive symptoms. Other studies of emerging adults have also reported an unexpected lack of associations between depression and romantic relationship constructs (e.g., relationship satisfaction; Dorf-Caine, 2008). It is possible that in this unique life stage, at least among male college students, romantic relationships are simply not as important in individuals' evaluations of self, life satisfaction, and emotional wellbeing. Evidence suggesting that emerging adult men are less committed in romantic relationships than women (Frisén & Wängqvist, 2011) raises the possibility that romantic involvement may not affect the emotional wellbeing of young men as it does young women because the romantic involvement is not as important to them. Future research should assess whether commitment level moderates the association between romantic involvement and depressive symptoms.

Unexpectedly, level of romantic and sexual activity and number of romantic and sexual partners were not related to level of depressive symptoms for either men or women in our sample. Among adolescents, the link between romantic involvement and depressive symptoms may be present because at these ages individuals uniformly lack sufficient emotional resources for coping with the intrinsic challenges of romantic activities (Davila, 2008). In contrast, during emerging adulthood, there may be relatively more variability between individuals in level of coping skills. Roberts, Caspi, and Moffitt (2001) found that between the ages of 18 and 26, some individuals displayed significant levels of personality maturation (defined as increased self-control, well-being, and social closeness, and decreased aggression), whereas others were already highly matured and displayed little further change during the same time period. The cross-sectional nature of the current study cannot account for such individual differences, and any meaningful correlations between romantic or sexual activity and depressive symptoms might have been obscured by mixing emerging adults who resemble adolescents (with lower coping skills and maturity) and those who resemble adults (with higher coping skills and maturity) in the same sample. It may be that a positive association exists for emerging adults with low coping skills and maturity, and a negative association for those with high coping skills and maturity. Future research should assess potential moderating effects of coping skills and emotional maturity to explore this possibility.

There are some limitations to the current study that should be noted. The cross-sectional design precludes any conclusions regarding directionality of effects. Because undergraduate students typically have a higher socio-economic status relative to the general population, the present findings may not generalize to non-college populations. Finally, participants were not assessed for a formal diagnosis of depression; romantic involvement may relate differently in those with clinical depression. Nevertheless, romantic involvement does not appear to put emerging adults at risk for depressive symptoms as it does adolescents; rather, for women in this age group it may actually be associated with lower depressive symptoms.

Table 1. Correlations among Variables

<table>
<thead>
<tr>
<th>Variables</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Dating Frequency</td>
<td>--</td>
<td>.09</td>
<td>.69**</td>
<td>-.01</td>
<td>-.11</td>
</tr>
<tr>
<td>2. Dating Partners</td>
<td>.03</td>
<td>--</td>
<td>.07</td>
<td>.54**</td>
<td>.04</td>
</tr>
<tr>
<td>3. Sex Frequency</td>
<td>-.72**</td>
<td>.04</td>
<td>--</td>
<td>.11</td>
<td>-.05</td>
</tr>
<tr>
<td>4. Sex Partners</td>
<td>-.03</td>
<td>.47**</td>
<td>.07</td>
<td>--</td>
<td>.07</td>
</tr>
<tr>
<td>5. CES-D</td>
<td>-.06</td>
<td>.02</td>
<td>-.01</td>
<td>.04</td>
<td>--</td>
</tr>
</tbody>
</table>

Note: *p < .05; **p < .01. Correlations for men are above the diagonal, and those for women are below.
References


Dorf-Caine, R. (2009). The moderating effect of masculine-typed characteristics on the association between dating relationship satisfaction and depressive symptomatology in undergraduate women. Unpublished manuscript, Boston University, Boston, MA.


About the Author

Michael Bruner, BS, is currently taking psychology courses and doing research at the University of Cincinnati while seeking admission to a graduate program in clinical psychology. Before deciding to pursue psychology he received his baccalaureate degree in biology from the University of Cincinnati in 2008. His research interests include couples and family psychology, with a particular focus on young adults. Mr. Bruner can be contacted via e-mail at brunermr@mail.uc.edu.
The Worldwide Epidemic of Skin Bleaching: Prevalence, Predictors and Associated Problems

By Irene López, PhD, Avril Ho and Analise Gonzalez, OPA Poster Session Undergraduate Non-Empirical Winners

Abstract
Practiced all over the world, skin bleaching is a worldwide, multi-billion dollar phenomenon, which is associated with a host of medical problems. In this report, we summarize the current literature on skin bleaching, including its prevalence, predictors, and the problems associated with this practice. We then conclude with considerations for future research.

Prevalence and Practice of Skin Bleaching
Skin bleaching, defined as the practice of lightening one’s skin, is a universal phenomenon that occurs throughout the world. Although estimates vary depending on the sampling frame and recruitment method used, it appears to be most prevalent in Western and Central Africa, as well as in Asia (Ly et al., 2007). Skin bleaching involves the use of various mass produced and/or homemade products, used either in isolation or in conjunction with one another. Bleaching products may include specialized creams, soaps, lotions, serums, pills, capsules, and gels, or even everyday household toiletries that are infused with skin lightening ingredients. Although less common, sheep placenta masks, laser surgery and injections may also be used. Depending on the context, other substances or foods may be used to augment the bleaching effect, such as Vitamin C, yogurt or papaya. In more extreme cases, toothpastes, peroxides, hair dye chemicals or straighteners, camphor balls, sand, cement, battery fluid, and even actual bleach may be used. Different products may be used concurrently or sequentially, and instructions for making these homemade combinations can easily be found on the Internet.

The process of skin bleaching also varies greatly. For example, for some bleaching may begin with a total body bath, upon which supplemental treatments are typically given once or twice daily, or only specific parts of the body may be bleached. Overall, research indicates that while virtually every part of the body can be bleached, the neck and face are by far the most common areas, followed by arms, underarms and legs.

Problems Associated with Bleaching
Many skin bleaching products typically bleach through the use of three main ingredients: hydroquinone, mercury and corticosteroids, which deactivate enzymes that produce melanin. These ingredients are known to have a number of health risks and problems. The net effect is an array of skin disturbances and disorders, ranging from skin burns, uneven and patchy skin, thinning and wrinkling of skin and contagious fungal infections. Additionally, bleaching may lead to the loss of skin elasticity and impaired wound healing.

Yet, despite these well-documented risks, users are often unaware of their effects. This lack of knowledge may be because skin bleaching companies often fail to list or mislabel their ingredients, fail to list the percentage of chemicals in their compounds and do not list warnings of adverse effects or contraindications. However, even with appropriate labeling, bleaching may still continue in less developed countries, due to, among other reasons, high rates of illiteracy. Finally, some users continue to use, or increase their use of products, because hyperpigmentation can sometimes occur upon their discontinuation. Additionally, some users hold the belief that in order to avoid or eradicate these effects they must either continue or increase their bleaching.

Predictors of Skin Bleaching
While these beliefs may explain the maintenance of skin bleaching, reasons given for the initiation of bleaching include a host of sociodemographic, interpersonal and social factors, as well as actual or perceived medical concerns, and more macro level forces, such as Westernization/acculturation and the media (See figure 1).

Sociodemographic Factors: Women constitute three-quarters of the skin bleaching market, although it is increasing among men, especially in Ghana, Zambia, India, and the UK. With regards to age, while the average age of onset is typically in early adulthood, the range of onset varies.

Additionally, skin bleaching occurs throughout various levels of social class, although it has been studied in predominately poorer and less developed countries. However, in some countries, such as in India, skin bleaching products are specifically targeted towards the middle class and users do acknowledge that part of the perceived benefit of bleaching is the ascribed social status that comes with having lighter skin.

Interpersonal and Social Factors: Apart from these demographic indicators, the most obvious reason for skin bleaching is the desire for lighter skin, and this has been documented both among those who are light and dark skin (Ajose, 2005). Often there is the perception that lighter skin is more beautiful, healthier, softer and pleasing (Asia Market Intelligence; cited in Schwartz, 2002). For example, in a study among various Asian subgroups, Malaysian men were the most likely to want their partners to have a pale complexion (74%), followed by men in Hong Kong (68%) and Taiwan (55%). Furthermore, lighter skin was valued because it made the user feel more attractive and because they found this more attractive in others.
Because of this desire for lighter skin, many non-bleachers claim that users lighten their skin because users hate themselves and/or their racial group. However, participants themselves rarely cite this as a reason. Instead, overwhelmingly participants mention that they bleach because of the pressure or influence of others. For example, in a study in South Africa, users indicate that they were first introduced to bleaching by friends or family, followed by people in the medical professions, such as chemists or pharmacists. Contact with others therefore normalizes this experience. Finally, while white skin may be idealized among many Asians, this desire for whiteness may not always reflect a yearning to be white per se, but instead a culturally specific ideal of beauty as exemplified by the white face of the Japanese Geisha which predates Western imperialism (Ashikari, 1005).

Thus, for some bleaching may not be a way to erase one’s “Asianness” but a way to heighten it.

**Macro Level Forces**

Still, acculturation, or more specifically Westernization, has been noted as one possible reason for the increase in skin bleaching. Increasingly, this practice has not only been documented within native born populations, but also among immigrant and diasporic groups. However, it is still unclear whether bleaching is an imported cultural practice that immigrants bring with them when they migrate, or a practice initiated upon entry to a new place of residence. Nevertheless, one of the first studies to assess bleaching found that among Kenyans, bleachers had a greater likelihood of speaking English as compared to other non-bleaching Kenyans, suggesting that exposure to Western ideals was an important factor (Barr et al., 1972).

Exposure to Western ideals can evidently be seen in the sheer amount of advertising given to skin bleaching. For example, a study in Hong Kong found that 30% of advertisements on television on a Saturday night were devoted to whitening products (Leong, 2006). There has also been a proliferation of websites and videos dedicated to skin bleaching that often promise outlandish and false health claims regarding their products. In particular, these advertisements promise a transformative and personally empowering experience that can be achieved in a matter of days or weeks. Lighter-skinned models are as healthier, happier and more successful with love and careers. It is therefore not surprising that bleachers cite the media as one of the primary reasons they chose to bleach.

**Medical Concerns and Perceived Health Benefits**

Finally, apart from these concerns, approximately 30% of those who use skin bleaching products wish to alleviate abnormal hyper skin pigmentation, such as melasma, eczema or acne. Others, such as some users in Ghana, may bleach to “correct” the skin damage cause by other health problems, such as AIDS (Olumide et al., 2008). Yet, apart from this group, many report that they bleach in order to appear healthier, and to tone or cleanse their face and/or body, which is ironic since darker skin provides a number of protections against skin disorders.

**Discussion**

Skin bleaching is a worldwide epidemic. However, despite its profitability, prevalence and adverse health effects, psychological research on skin color is limited. This is unfortunate as psychology can help us understand the contextual meanings ascribed to skin color and to see how macro forces interact with interpersonal variables to explain the feelings associated with skin color. In addition to more research, we need more sophisticated prediction models to ascertain the reasons and its association to mental health. Finally, we should also identify how skin bleaching works in conjunction with other appearance modification procedures such as ethnic cosmetic surgery, which is also becoming disturbingly high (Sturm-O’Brien, Brissett, & Brissett, 2010).

**References**


![Figure 1. Reasons for Skin Bleaching. This chart demonstrates the common reasons for skin bleaching.](image)
About the Authors

Irene López, PhD
Email: lopezi@kenyon.edu

Irene López is an assistant professor of psychology and the Harvey F. Lodish Junior Faculty Development Professor in the Natural Sciences. Dr. López is a clinical psychologist who studies psychopathology using a cross-cultural and feminist lens. In particular, she is interested in the impact of acculturation on mental health, cross-cultural psychopathology, and socioeconomic status. Other areas of interest are phenotype, racial and ethnic identity, LGBT, and women’s issues in ethnic minority communities, which she seeks to understand within the tradition of liberation psychology. Dr. López has received a number of awards for her teaching and research, including a faculty fellowship by the American Association of Hispanics in Higher Education and a High Flyer Excellence in Teaching Award from the University of Missouri-Columbia. Currently, she is a Task Force member of the American Psychology Association Committee on Socioeconomic Status.

Avril Ho
Email: hoaw@kenyon.edu

Avril Ho hails from Singapore and is a senior psychology major and Japanese minor at Kenyon College. Broadly speaking, she is primarily interested in multicultural psychology and psychopathology. Specifically, she is interested in autism and appearance modification issues in ethnic minority women. Her research has been presented and accepted for presentation at several conferences, including the American Psychological Association annual conference in August 2011.

Analise Gonzalez
Email: gonzaleza@kenyon.edu

Analise Gonzalez is a senior comparative global identities major at Kenyon College. She is particularly interested in ethnic, gender, and socioeconomic identity and social experiences of minorities. She has just completed research on representations of Muslim identity in United States and French news media. Broadly, her research has been presented and accepted for presentation at several conferences, including the American Psychological Association annual conference in August 2011.

A New Beginning...
A New Way of Life

Substance Abuse and Behavioral Health Services

- Detoxification
- Adult & Adolescent Residential Treatment
- Residential Partial Hospitalization
- Half Way Houses
- Out Patient Programs
- Special Populations
  - Pregnant Females
  - Narcotic Replacement Therapies
  - Dual Diagnosis (MISA)

Features

- 12-Step Model
- Easy Access to Treatment-24/7
- Transportation to and from Treatment
- Clinically Driven Variable Length
- Covered by Most Insurance Plans
- Relapse Prevention & Aftercare Planning
- JCAHO National Accreditation
- Licensed by the State of Pennsylvania

24-Hour Call Center
866-769-6822

www.whitedeerun.com | www.bowlinggreenbrandywine.com
Body Awareness and Empowerment Training for Abuse/Assault Survivors: An Adjunct to Psychotherapy

By Paul Linden, PhD, Columbus Center For Movement Studies

Abstract

Combining psychotherapy, somatic education, and martial art training is effective in helping survivors of abuse or assault. Somatic education focuses on teaching body awareness as a foundation for improving efficiency and effectiveness in action. An element that is a particular focus of my work is the distress response. When people are abused or assaulted, they typically contract or collapse their breathing, posture, movement and attention. This distress response starts as a natural result of shock and often becomes a coping strategy to reduce awareness of physical and emotional pain and of the environment. The contraction/collapse usually stays stuck in the body until it is deliberately unlearned and replaced. Through opening and stabilizing the body, clients can develop a state of calm alertness and compassionate power. Self-defense training provides abuse survivors the opportunity to practice utilizing this new state as a foundation for managing stress and pain, staying present under pressure, maintaining good boundaries, and developing assertiveness and self-protection. This work requires the skills of a psychotherapist, a somatic educator, and a martial artist, and most often that would require a team of three individuals.

As a somatic educator and martial artist, I teach a broad variety of clients, from musicians, athletes, computer users, and children with ADHD, to sexual abuse or assault survivors. My work focuses on processes for developing body awareness, calm alertness, and compassionate power as a foundation for effective action. The two modalities I use most are Being In Movement® mindbody education and Aikido, a non-violent martial art.

Distress response

A key element in all my teaching is helping people overcome the body’s distress response. When people feel threatened or challenged, they typically make their breathing, posture, movement and attention small. This may take the form of tensing and bracing as preparation for exerting effort. It may take the similar form of tensing and hardening in anger. It may show up as constricting in fear. It may take the form of collapsing and becoming limp in defeat and resignation. It may manifest in numbing of specific areas of the body or in an overall state of dissociation. Or elements of these can combine.

All this can be summarized as the fight/flight/freeze/collapse response. However, contracting or collapsing the body reduces ease and efficacy, and this reinforces feelings that the challenges or threats being faced are indeed difficult or overwhelming. Action is much more efficient and effective when the body is free and expansive, and how to develop this new body state and apply it in daily life is the focus of my teaching.

Abuse/Assault

I focus on two intertwined elements in teaching survivors of abuse and assault. The first is the persistence in the body of the distress response. Having internalized a sense of helplessness, abuse/assault survivors experience much of life as overwhelming, which reinforces and maintains the distress response.

The second element is a learning process. Victims of abuse or assault learned in the moment of their abuse that they were powerless to control their environment and create safety. Since they lacked the reality of safety, trauma survivors often developed coping strategies based on ways of creating the feeling of safety by deflecting or reducing awareness of the self and/or the environment. A key part of this reduction of awareness is the contraction or collapse of the body, which is a withdrawal of attention from the body and the environment. Once adopted, this coping strategy becomes self-maintaining.

The solution to the distress response is to lead survivors through a carefully graded series of challenges (with their informed permission at each stage). At each step, the process is to replace the distress response with a stronger, calmer, and more effective physical organization, and then on that basis succeed in defeating the challenge.
Somatic Education
My first step in work with trauma survivors is body awareness training. From my perspective, emotions are constellations of events in the body. For example, anger might for a given individual include clenching the fists, tightening the jaw, and raising the voice. What we normally mean by the word “anger” is what those body actions feel like to the person who is doing them. By learning to notice the physical underpinnings of feelings, survivors will find it easier to become aware of and understand what their feelings are. By working with breathing, posture and movement, survivors will be able create a state of calm alertness and compassionate power and use that to antidote the distress response. Learning how to anchor awareness in the core of the body while reaching awareness out into the environment in a radiant and expansive pattern is crucial. It is the exact opposite of the distress response, and it is the foundation for effective self-protection.

Self-Defense Training
Once people can maintain the state of relaxed alertness and stability as they talk about their trauma, it is important to practice speech and movement exercises for boundary management and assertiveness. This naturally segues into self-defense instruction.

Teaching self-defense as an adjunct to psychotherapy is different from ordinary self-defense instruction. I teach a client only the defenses against the specific attacks they experienced. I emphasize that for greatest effectiveness, the defense techniques must be executed in the somatic state of calm alertness and compassionate power. Power which is brutal rather than compassionate would be rejected by many survivors, and many would be retraumatized.

By succeeding with the self-defense techniques that would be effective in the present if they were to be attacked in the same way as they had been in the past, abuse or assault survivors create for themselves a feeling of safety based on real, effective skills. Without that, the process of empowerment would be seriously incomplete.

Example
Managing emotions is important in learning self-protection. Two feelings that come up very frequently in work with abuse or assault are defensiveness and hypervigilance. Defensiveness is the emotional stance of readiness to identify invasive and hurtful things and push back against them. Hypervigilance is the emotional/perceptual stance of constant, anxious scanning of the world based on the expectation of threats and dangers. The purpose of both defensiveness and hypervigilance is safety. However, these states are uncomfortable and don’t really work well.

Working with the issue of defensiveness, my first question would be, “Where in your body do you feel the defensiveness?” Then I might ask, “What are you doing there which produces the feeling of defensiveness? What movements does that part of your body want to do?” If I ask the client to do the movements, most often the client will cross their arms and hold them against the chest or stomach, while stiffening the breathing and tensing muscles throughout the body. Similarly, the action of hypervigilance is anxious glancing in all different directions. It’s a focused and narrow directing of attention, constantly shifting to take in a broad view of the surroundings.

One of my somatic teaching strategies is to examine movements as expressing testable strategies. Reframing the action of defensiveness as an hypothesis, we would get the statement: Creating a physical barrier is an effective way to keep from being penetrated. And that makes it obvious how to evaluate or test that strategy. I have people stand with their arms crossed over their belly to prevent me from poking them in the belly. When they rely on stiffness, it makes them so immobile that they are unable to block a poke, and so of course I can poke them easily.

Reframing the actions of hypervigilance as a hypothesis, we would get the statement: Narrow, sharp focus is the most effective way of perceiving incoming threats. Going back to the belly poking, it’s easy for people to experience that the narrowness of hypervigilance is stiff and immobile, which makes them so disconnected from their surroundings that again I can poke them easily.

Next I have people stand with their arms held up about shoulder height and wide open, while relaxing and paying almost casual attention in all directions. Then from that position, I have them try to block me when I attempt to poke them in the belly. It always comes as a great surprise to them that when their arms are relaxed and held wide and their attention is wide open, they can move swiftly and effectively to block me when I try to poke them. (It often helps people avoid needless guilt to remind them that they could not have done this as a child.)

As it turns out, the hypothesis that being wide open allows one to prevent being penetrated can be verified with tests involving a number of varied threats, anything from an actual physical punch to an insult. The commonality in all aspects of self-regulation and boundary management is that being open is necessary for effective action about what to let in.

Even more counterintuitive, it is easy to demonstrate physically that kindness and considerate regard for the opponent sharpen perception, increase physical stability, and create the
physiological state which is most conducive to effectively keeping people out.

Conclusions
By reclaiming their bodies and their power, abuse or assault survivors become better able to use psychotherapy to work on their emotional issues.

I should comment on a major difference between psychotherapy on the one hand and somatics or self-defense on the other hand: the two body disciplines make extensive use of touch (though I have developed ways of teaching much of the material without using touch). Work with touch and self-defense is not inherently unsafe or retraumatizing. It is not being touched which is traumatizing, but through inappropriate, overpowering touch being made to feel powerless. Experiencing one’s capacity for effective action is healing. Done in a gradual, stepwise manner, paced to the individual’s learning requirements, alongside psychotherapy, such work is strengthening. Because the outcome of appropriate work with touch and self-defense is an enhanced sense of personal boundaries and efficacy, work with these modalities contributes to trauma recovery.

Somatic work is appropriate at different stages of recovery. For example, trauma survivors may be so out of touch with their feelings as to make psychotherapy difficult, and body awareness training could be helpful as a means of giving felt content to the words which name feelings. On the other hand, trauma survivors are often not ready for the immediacy of body-centered sensory work, and psychotherapy could be helpful as a means of building strength for somatic work.

Somatic education, self-defense and psychotherapy address different areas of human functioning, use different methods, and require extensive, specific training. Psychotherapists could find somatic educators and martial artists with whom to create treatment teams. Including both somatic education and self-defense alongside psychotherapy is very effective in recovery from abuse or assault.

About the Author
Paul Linden is a somatic educator, a martial artist, and an author. He is the founder of the Columbus Center for Movement Studies and the developer of Being In Movement® mindbody education. He holds a BA in Philosophy and a PhD in Physical Education. He is a sixth degree black belt in Aikido, a first degree black belt in Karate, and a certified practitioner of the Feldenkrais Method® of somatic education. His work focuses on body awareness training as a way of learning skills of self-regulation and performance improvement. He has worked with a broad variety of populations and issues, including: ergonomic safety for computer users; reduction of performance anxiety and improvement of movement efficiency for musicians and athletes; self-regulation for children with Attention Deficit disorders; and boundary management and reduction of dissociation for survivors of trauma. You can contact him at Aikido of Columbus, Columbus Center For Movement Studies.

www.being-in-movement.com
3003 Silver Drive, Columbus, OH 43224.
614-262-3355 or 263-1111
PaulLinden@aol.com

Most of his articles and books are downloadable at www.being-in-movement.com. Among them are the e-books:

• Winning is Healing: Body Awareness and Empowerment for Abuse Survivors
• Winning is Healing—Basics: An Introduction to Body Awareness and Empowerment for Abuse Survivors. Also available in German as Das Lächeln der Freiheit
• Embodied Peacemaking: Body Awareness, Self-Regulation and Conflict Resolution
• Teaching Children Embodied Peacemaking: Body Awareness, Self-Regulation and Conflict Resolution
• Reach Out: Body Awareness Training for Peacemaking – Five Easy Lessons (A free download. Also available in German, Spanish & Portuguese.)
Post-Traumatic Stress Disorder: A Case for Subtype Identification

By Phillip R. Zoladz, PhD, Ohio Northern University

Abstract

Over the past few decades, extensive work has attempted to elucidate the psychobiological mechanisms underlying post-traumatic stress disorder (PTSD). Although PTSD is reportedly characterized by heightened autonomic activity, exaggerated startle, hypocortisolism and cognitive impairments, empirical assessments of these measures in PTSD patients have produced inconsistent findings. As a result, it has become difficult to understand the precise biological and behavioral sequelae that are induced by this disorder. The present review highlights some of the inconsistent research findings in PTSD patients and emphasizes the possibility that several subtypes of PTSD, each with its own unique phenotypic fingerprint, could exist.

Individuals who are exposed to intense trauma that threatens physical injury or death are at significant risk for developing post-traumatic stress disorder (PTSD). People who develop PTSD respond to a traumatic experience with intense fear, helplessness or horror (American Psychiatric Association, 1994) and subsequently endure chronic psychological distress by repeatedly reliving their trauma through intrusive, flashback memories (Ehlers, Hackmann, & Michael, 2004; Holmes, Grey, & Young, 2005; Reynolds & Brewin, 1998, 1999; Speckens, Ehlers, Hackmann, Ruths, & Clark, 2007). These intrusions are frequently precipitated by the presence of cues associated with the traumatic event; therefore, PTSD patients make great efforts to avoid stimuli that remind them of their trauma. The re-experiencing and avoidance symptoms of the disorder significantly hinder PTSD patients' ability to function normally in everyday life and foster the development of several additional debilitating symptoms (Elzinga & Bremner, 2002; Nemeroff et al., 2006).

Research over the past 30 years has documented several physiological and behavioral abnormalities associated with PTSD, including, but not limited to, heightened autonomic arousal, exaggerated startle, abnormal hypothalamus-pituitary-adrenal (HPA) axis function, structural alterations of several cortical brain regions (e.g., amygdala, hippocampus, prefrontal cortex) and cognitive impairments (Elzinga & Bremner, 2002; Nemeroff et al., 2006). However, a thorough assessment of the PTSD research literature reveals numerous findings that are inconsistent with the typical phenotype of the PTSD patient, suggesting that there are great individual differences in how the disorder manifests itself. Because the treatment of a disorder like PTSD depends heavily on understanding the symptoms that are specific to it, such a vast difference in symptomatology only hinders the development of more successful therapeutic approaches for individuals with the illness. This problem is further exacerbated by the fact that PTSD is a mental illness that commonly presents itself with at least one comorbid diagnosis. This makes research, diagnosis and treatment more difficult because it forces researchers and clinicians to speculate as to which disorder is causing the observed symptoms, PTSD or the comorbid disorder. The goal of psychologists is to predict behavior, and they often go about attaining this goal by developing law-like generalizations that apply to entire groups of individuals – in this case, PTSD patients. A problem with this approach arises, however, when a group of individuals displays inconsistent behaviors or characteristics in the same situation, such as when some PTSD patients exhibit impaired learning and memory in a laboratory setting, and others do not (Verfaellie & Vasterling, 2009). Thus, the abundance of inconsistent findings in the area of PTSD symptomatology has led researchers to speculate that multiple forms of PTSD could exist, each with its own unique phenotypic fingerprint. If this is the case, developing a better understanding of the different forms of PTSD could facilitate the development of more targeted treatment options for PTSD patients, as well as enhance clinical and preclinical research into the etiology of the disorder. The purpose of this commentary is to simply highlight some of the discrepancies in the PTSD research literature and to discuss what implications they could have for researchers and clinicians. Since an exhaustive review of such discrepancies would be lengthy, the present discussion addresses only those discrepancies found in the cardiovascular and HPA axis research that has been conducted on people with PTSD.
(de Kloet, Otitz, & Joels, 1999). Given the role of cortisol as a stress hormone, investigators initially speculated that people with PTSD would exhibit abnormally high levels of cortisol. Quite unexpectedly, however, initial investigations revealed that individuals diagnosed with PTSD demonstrated abnormally low levels of baseline cortisol, relative to traumatized individuals who did not develop PTSD. Subsequent research also showed that abnormally low cortisol levels could be a risk factor for developing PTSD rather than a by-product of the disorder. These studies indicated that traumatized individuals who developed PTSD exhibited significantly lower cortisol levels following the traumatic event than those traumatized individuals who did not develop PTSD (Delahanty, Raimonde, & Spoonster, 2000; McFarlane, Atchison, & Yehuda, 1997; Resnick, Yehuda, Pitman, & Foy, 1995). This finding was supported by additional work demonstrating that hydrocortisone treatment significantly reduced the development of PTSD in patients who had just experienced cardiac surgery or septic shock (Schelling, 2002; Schelling et al., 2004; Schelling et al., 1999). Despite these findings, ensuing research on cortisol levels in people with PTSD both at baseline and following the initial traumatic event produced mixed, and often contradictory, results (Yehuda, 2002, 2005, 2009). Some of these studies, like the initial investigations, reported that individuals with PTSD exhibited significantly lower levels of cortisol than controls; others, however, reported that these levels were either greater than or no different from controls. This discrepancy in cortisol findings continues to abound and has become perhaps one of the most widely debated issues regarding the neurobiological basis of PTSD.

Another unforeseen discovery related to HPA axis functioning in people with PTSD was that they appear to exhibit significantly greater baseline levels of CRH than controls (Baker et al., 1999; Brenner et al., 1997). Such a finding created a paradox in that if most people with PTSD exhibit abnormally low levels of cortisol, how could they possibly exhibit significantly greater levels of CRH, a precursor to cortisol? This potential biological signature of PTSD is quite different from that which is frequently observed in people with major depression, who often present with abnormally elevated levels of both CRH and cortisol, a pattern of symptoms that intuitively makes more sense (Kasckow, Baker, & Geraciotti, 2001). Subsequent work did reveal that in pharmacological challenge paradigms, PTSD patients produced significantly less ACTH than healthy control subjects (Kellner et al., 2000; Smith et al., 1989). In addition, several studies reported no differences in baseline ACTH levels between PTSD patients and controls, despite the presence of greater baseline CRH levels in people with PTSD (Duval et al., 2004; Kanter et al., 2001; Libezon, Abelson, Fligel, Raz, & Young, 1999; Neylan et al., 2003; Otte et al., 2007; Otte et al., 2006; Yehuda, Giller, Halligan, Meaney, & Bierer, 2004; Yehuda et al., 1996). Thus, it is possible that persistent elevations of CRH desensitize CRH receptors in the anterior pituitary gland, leading to a blunted release of ACTH upon CRH receptor stimulation. Of course, many of these findings have not gone unscrutinized, and several studies have produced results inconsistent with the initial findings (see Yehuda, 2002 and Yehuda, 2005 for excellent reviews). Therefore, another interpretation of these findings is that different subsets of PTSD patients exhibit different alterations of these hormonal precursors to cortisol.

As can be seen, one must be cautious not to describe heightened baseline cardiovascular activity and hypocortisolism, and perhaps several other physiological and behavioral symptoms that have not been discussed here, as well-accepted characteristics of PTSD, because such findings have not been consistently demonstrated in the research literature. While meta-analyses have oftentimes supported the broad claims made about PTSD, it may be useful to consider what the vast individual differences in this patient population are trying to tell researchers and clinicians about the disorder. It may be that only certain subsets of individuals who develop PTSD display greater baseline HR and BP or have lower baseline levels of cortisol, depending on several factors (e.g., age, sex, type of trauma, intensity of trauma) and their interactions with one another. As one investigator has speculated in regards to HPA axis-related findings, “the absence of cortisol alterations in some [PTSD patients] implies that alterations associated with low cortisol and enhanced negative feedback are only present in a biologic subtype of PTSD” (Yehuda, 2005, p. 373, italics added for emphasis). If this is the case, it becomes ever more important to understand what subtypes of the disorder exist; by knowing what subtypes exist, more finely-tuned treatment options could be developed for individuals suffering from this stress-related psychological illness.

References


The Ohio Psychological Association continued its tradition of supporting the Ohio Academy of Science's State Science Day by providing the judges for the Behavioral Health Projects. The 2011 Science Day was held on Saturday, May 7 at French Field House on the campus of The Ohio State University. This year the entire Science Day involved 1,166 students and their 1,085 projects. The Behavioral Health project category is defined as “relevance, creativity and understanding of human behavior as demonstrated by the project. A project with animals may be considered if it is relevant to human behavior. Projects referencing psychological science will be given preference.”

Eight teams of judges assembled by OPA judged 136 projects in grades five to 12. Judging of fifth and sixth graders was added this year. The breakdown of projects was as follows:

- Grade 5: 4
- Grade 6: 8
- Grade 7: 45
- Grade 8: 32
- Grade 9: 16
- Grade 10: 16
- Grade 11: 16
- Grade 12: 2

Thanks to our outstanding judges this year: Rosemary Shaw, Brigette Beale, Cathy McDaniels Wilson, Christy Tinch, David Hayes, Gregory Alfred, Janice Vidic, Jeff Markino-Shrivers, Jim Broyles, Kendea Oliver, Linda Sirosky-Sabado, Mary Miller Lewis, Mary Mills, Michele Evans, Pam Deuser, Peg Mosher, Rachael Kaufman and Michael Ranney. Judging of all of these projects was completed in a two and a half hour time span! Great job, judges!

Awards are given based on merit. If projects meet high standards set for behavioral health science projects prizes are given as follows: for grades five and six; first $50 second $25; for grades seven and eight; first $75; second $50; third $25; and for grades nine through twelve; first $75; second $50.

Prizes were funded by the Foundation for Psychology in Ohio, with support from Akron Area Professional Psychologists, Central Ohio Psychological Association, Cleveland Psychological Association, Toledo Area Academy of Professional Psychologists and OPA member donations.

Thanks to the donors who made the awards possible and for our tremendous judges who did such a great job of selecting our winners this year. Thanks also to all of the students who participated and did such a great job of presenting their research.

---

### About the Author

Dr. Phillip Zoladz is an assistant professor of psychology at Ohio Northern University. He obtained his Bachelor of Arts in psychology from Wheeling Jesuit University in 2004 and his Masters of Arts and Doctor of Philosophy in behavioral neuroscience from the University of South Florida in 2006 and 2008, respectively. In addition to instructing courses related to the physiological basis of behavior, Dr. Zoladz continues an active research agenda, which aims to develop a better understanding of the neurobiology of stress-induced alterations of cognition and stress-related psychological disorders.

Correspondence: Phillip R. Zoladz, Department of Psychology & Sociology, Ohio Northern University, 525 South Main Street, Ada, Ohio, 45810 Email: p-zoladz@onu.edu; Phone: 419-772-2142; Fax: 419-772-2746

---

### 2011 Ohio Science Day

#### Behavioral Health Project Winners

The 2011 State Science Day Behavioral Health winners are:

<table>
<thead>
<tr>
<th>Grade</th>
<th>1st</th>
<th>2nd</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade 6</td>
<td>Avery G. Warner - Driver distractions</td>
<td>Sean C. Maynor - Color effects Dayton Christian School, Waynesville</td>
<td>from texting? Springfield HS, Springfield</td>
</tr>
<tr>
<td>Grade 7</td>
<td>David A. Dixon - How does brain lateralization affect tail-wagging in dogs? St. Mary, Delaware, Lewis Center</td>
<td>Adam G. Ben-Porath - To share or not to share opinions: The effects of post-event information on eyewitness testimony National Inventor's Hall of Fame School, Akron, Copley</td>
<td></td>
</tr>
<tr>
<td>Grade 8</td>
<td>Kirstin N. Boni - Perception: Our view of the world around us West Geauga MS, Chesterland, Novelty</td>
<td>Christian J. Kellamis - Is online reading comprehension as good as reading comprehension from print media? Oakwood MS, Canton</td>
<td></td>
</tr>
<tr>
<td>Grade 9</td>
<td>Nadia A. Syed - Can a simulation deter drivers from texting? Springfield HS, Springfield</td>
<td>Josephine G. Benson - Learning to hear: Developing a double-phoneme boundary Bowling Green HS, Bowling Green</td>
<td></td>
</tr>
<tr>
<td>Grade 10</td>
<td>Sean C. Maynor - Color effects Dayton Christian School, Miamisburg, Waynesville</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grade 11</td>
<td>Sheila Shahri - The effect of age of acquisition of bilingualism on the performance on the alternate uses test Sylvania Southview HS, Sylvania, Toledo</td>
<td>Anisha S. Basu - Multitasking: Friend or foe? Hudson HS, Hudson, Hudson</td>
<td></td>
</tr>
</tbody>
</table>

---


---


The 2011 OP Quiz for Continuing Education

The articles selected in this issue are sponsored by the Ohio Psychological Association. OPA is approved by the American Psychological Association to provide CE for this home study. Complete this form in its entirety. A total of 80% of responses must be correct to receive 1.0 CE credit. Submit this form and payment (OPA members: $20; Non-Members: $30) to OPA OP Home Study, 395 East Broad Street, #310, Columbus, OH 43215. Pending successful completion of this test, you will receive a certificate of completion within 20 business days of receipt.

<table>
<thead>
<tr>
<th>Name:</th>
<th>License Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>City:</td>
</tr>
<tr>
<td>Email:</td>
<td></td>
</tr>
<tr>
<td>Payment: Check (made payable to OPA)</td>
<td>VISA/MC</td>
</tr>
<tr>
<td>Card Number:</td>
<td>3 digit code:</td>
</tr>
<tr>
<td>Signature:</td>
<td>Date:</td>
</tr>
</tbody>
</table>
| By signing this form, I am stating that I have taken this test myself, without help from any outside sources.

For each question, there is only one possible choice. Please select the correct letter for each question.

1. Multiple Choice
   Select the best answer from each question below:
   1. All of the following are true about ACT except:
      a. ACT acknowledges that pain and suffering are aspects of everyone’s life.
      b. ACT asks participants to avoid all negative experiences.
      c. ACT asks participants to willingly experience their negatively-valued private events rather than attempting to avoid or control them.
      d. ACT seeks to assist individuals in gaining greater acceptance of their pain and suffering.

2. Elements related to teaching survivors of abuse and assault are:
   a. The persistence in the body of the distress response.
   b. A learning process.
   c. A only
   d. A and B

3. Areas for the OPA telepsychology guidelines were modeled after major areas already identified in the APA Ethics Code and record keeping guidelines. These areas consist of all except:
   a. Appropriate Use of Telepsychology
   b. Legal and Ethical Requirements
   c. Informed Consent and Disclosure
   d. Secure Communications/Electronic Transfer of Client Information
   e. Access and Storage of Communications
   f. Client Welfare
   g. Supervision
   h. Assessment
   i. Expriation and Review Date

4. EDNOS is:
   a. A category in the DSM-IV for individuals with emotional disorders.
   b. The name of a group of women who participated in an eating disorder study.
   c. A only
   d. A and B

5. PTSD research, diagnosis and treatment are difficult because:
   a. The illness forces researchers and clinicians to speculate as to which disorder is causing the observed symptoms.
   b. There are no symptoms associated with the illness.
   c. The illness does not address comorbid issues.
   d. People refuse to participate in studies for fear of redeveloping symptoms.

6. A recent study on Depressive symptoms revealed:
   a. There was a significant difference in depression levels between men in a relationship and men not in a relationship.
   b. Depression levels did not differ between men in a relationship and men not in a relationship.
   c. For women depressive symptom levels did not differ significantly for women who were in a current romantic relationship versus women not in a relationship.
   d. No differences were found in depression for men and women whether in a relationship or not.

7. Skin bleaching has resulted in:
   a. Creating a healthier appearance for people with problem skin.
   b. Helping to decrease depression in people with chronic skin problems.
   c. Minor skin irritation that is easily corrected by over the counter drugs.
   d. Skin disturbances and disorders, ranging from skin burns, uneven and patchy skin, thinning and wrinkling of skin, and contagious fungal infections.

8. Psychoeducative (2001) reported that participation in parent support programs improves:
   a. Parental confidence
   b. Parental understanding that interactions initiated by the child are most important in child-parent communication.
   c. Parental competence
   d. All of the above

9. Which component is part of the Family Focused Therapy process:
   a. Assessment
   b. Intervention
   c. Consultation mentoring
   d. Problem-solving skills

10. Skin bleaching occurs:
    a. mainly in lower SES levels
    b. only in upper SES levels
    c. throughout various levels of social class
    d. only in the middle SES level

II. True or False:
   Answer the following statements as True or False:
   1. The ACT approach is heavily steeped in metaphors.
   2. Self-defense instruction is the first step in teaching interventions how to deal with abuse and assault.
   3. Guidelines differ from standards in that standards are mandatory and may be accompanied by an enforcement mechanism.
   4. Recent research on adolescents has shown, unexpectedly, that involvement in romantic relationships is associated with increased levels of depressive symptoms.
   5. Participants in an eating disorder study revealed stories that supported society’s belief that eating disorders are merely “issues with food.”
   6. Individuals first begin to explore the long-term potential for intimacy and happiness in romantic relationships in adulthood.
   7. Triple P (Positive Parenting Program) is an evidence-based behavior management program that focuses on teaching parents skills necessary to successfully manage disruptive/externalizing behaviors of children.
   8. The cost of FFT may be a concern for an individual with lower SES levels.
   9. The Telepsychology guidelines will expire seven years after that date.
   10. Children with diagnosed developmental disabilities are at less risk (compared to non-disabled peers) of presenting challenging behaviors.
Bring Harmony to Your Practice

At CPH & Associates, our dedicated consultants are committed to providing the most comprehensive, accessible Professional Liability Insurance featuring NEW HIGHER LIMITS* to protect your most important asset, your peace of mind.

Unlimited Defense Coverage
Covers you for legal fees and court costs involving claims or allegations at no additional cost.

State Licensing Board Defense
Automatically receive limits of $35,000 with options to increase up to $100,000 available.

Deposition Expense Coverage
Pays up to $10,000 per deposition.

Medical Expense Coverage
Pays up to $5,000 per incident regardless of fault.

Enhance Your Benefits with
- First Aid Coverage
- Assault Coverage
- Defendant’s Reimbursements
- Portable Coverage
- Professional Liability
- Supplemental Liability

Ask About Our Discounts**

• Newly Licensed
Receive up to 50% off your professional liability premium if you have been licensed within 24 months.

For Licensed Clinical Psychologist Only —
Receive 15% off if licensed within 36 months.

• Risk Management Discount
Save 10% off your professional liability premium for completing your states Legal and Ethical CEU requirement for licensure renewal. Only applicable to fully licensed professionals.

CPH & Associates only provides Occurrence Insurance, protecting you from claims and damages made during the life of the policy, even after it expires. Plus, your premium stays the same year-to-year.

Trust CPH & Associates, leaders in insurance and risk management solutions for healthcare and social service fields.

APPLY ONLINE: www.cphins.com
Save 5% off your Professional Liability Insurance Premium and get your proof of coverage in minutes!

CPH & Associates
711 South Dearborn Street, Suite 205
Chicago, IL 60605

Call Toll Free: 800-875-1911 / Fax: 312-987-0902
For more information, visit us online at www.cphins.com.

* Higher limits not applicable to all coverage benefits listed. **A combination of discounts cannot exceed 50% off the premium.
Great workshops. Great people. Great time.

OPA’s 2011 Convention
“Psychology in the Global Era: Embracing Career Development”

October 26-28, 2011
Cherry Valley Lodge, Newark

More than 20 workshops on
billing, diversity, insurance, ethics, technology, mindfulness, autism spectrum disorders, Ohio psychology law, retirement, forensic psychology and more!

Registration begins online in late August at www.ohpsych.org

Classified

Psychologist – Ohio licensed psychologist needed to conduct independent evaluations of Social Security disability claimants on referral by the Ohio Division of Disability Determination. One-time evaluation requiring no treatment of examinees. Opportunities are available throughout Ohio. Use your own office or location and make your own hours. Fees are set by Social Security Administration. Most evaluations include a clinical evaluation and report. Some evaluations require intelligence and memory testing. Bilingual psychologists (preferably Spanish speaking) are needed and are compensated at a higher rate when translation services are used. Opportunities also available for independent psychological consultants to work in our Columbus office reviewing disability claims. Hours are flexible. For more information, please contact Heidi Block, Professional Relations Officer at 614-438.1967.

Office Space – Dr. Margaret Zerba (216-973-9756) has a third floor office in The Medical Heights Building on Fairmount Boulevard in Cleveland Heights.

This unfurnished suite consists of 750 sqft. with three offices, a waiting room, a closet, and a small room for appliances, fax machine, etc. There is no running water or lavatory in the suite but the lavatories on the second and third floors are conveniently located and clean. Dr. Zerba replaced the floor and had the suite repainted when she moved in over a year ago. It is beautiful in neutral but cheerful color and simplicity. Dr. Zerba is interested in transferring her lease to a new leaseholder(s) or subletting to one or more professionals. This building leases to professionals, and many are mental health professionals. If you cannot reach Dr. Zerba for more information or to see the office, Suite 326, you could call Dawn Jordan, Building Manager, at 216-791-4990.

Office Space - Dr. Pamela Deuser (614-481-2101) has a second floor private practice office available at her Grandview/Marble Cliff area location; a former residence commercially upgraded to provide a comfortable, professional setting. The office (160 sq. ft. plus closet) leases for $430/month and includes utilities, cleaning and common area access. Office equipment use is available for additional fees.