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"Psychology’s Role in Integrated Health Care" is the focus and theme of the 2013 Ohio Psychologist (OP). This theme helps to remind all practitioners that the role of psychologists has expanded and is an integral part of health care. Integrated health care is not only fostered in the state of Ohio and the United States, but also around the world. The theme prompts psychologists in practice to reflect upon how they can expand their practice and effectively serve clients in a number of settings. The theme further helps to remind us of the OPA’s mission to advance the creation, communication and application of psychological knowledge to benefit society and to improve people’s lives in Ohio. What better way is there to advance psychology then through integrated health care? The ten articles contained within this year’s OP serve as a means to strengthen and lead the profession into the ever expanding health care arena.

I hope as you read the content within the Ohio Psychologist, you will find an article that will:

• Inspire you to reflect upon how you might expand your practice into an integrated healthcare setting

• Teach you about the most recent science of the profession as it relates to integrated health care

• Learn about current research being conducted by students in the field of psychology.

As you reflect upon the enclosed content, keep an open mind and allow yourself to be challenged to actively participate at some level in OPA in order to carry on, influence and secure the future of psychology as it analyzes, grapples with, and embraces the role of psychologists in integrated health care. In particular, integrated health care is the wave of the future and will influence the way we think, act and respond in a number of personal and professional ways. The 2013 OP addresses how to expand the field of psychology into the health care arena through the avenues of advocacy, practice and science.

Advocacy
In her article, “Integrated Health Care on College Campuses: The Call for Collaboration,” Christine F. Muller-Held, PsyD presents the need for collaborative health and mental health relationships by providing a brief, relevant literature review and describing current practice experiences at the University of Cincinnati’s student health clinic. Historical trends and current public policy shifts suggest a need to continue development of collaborative relationships in the general population, as well as on college campuses. The health and behavior codes (H&B codes) allow psychologists to bill for services rendered to individuals with medical conditions when services are directly related to optimizing medical functioning. Kristine Woods, PsyD and Bobbie Celeste, PhD in their article, “Advocating for Medical Reimbursement of Health and Behavior Codes,” share how Ohio Medicaid does not reimburse these codes, despite Medicare and several private insurance companies who do reimburse services billed under the codes. As a result these authors encourage psychologists to advocate for Medicaid reimbursement of the H&B codes and specific recommendations are made for how psychologists across the state can become involved in the effort. Allison Fernander, PhD and Ashley Murray, BA explain in their article, “Development and Implementation of Doctoral Training Sites in Pediatric Primary Care Settings,” that there are numerous benefits and challenges of integrating psychological services in a pediatric primary care setting; therefore a greater emphasis has been placed on training graduate students interested in pediatric psychology. Students need to gain clinical experiences of working in interdisciplinary teams and conceptualizing patients from a biopsychosocial perspective prior to their predoctoral or postdoctoral internship. Necessary steps needed to create a successful training site by identifying the needs of psychology in a pediatric setting, using consultation models to guide practice in training sites, and assessing the benefits and challenges of psychologist-physician collaboration are reviewed.

Practice
There is an increase in the identification of individuals with behavioral, cognitive and physiological factors resulting from sleep deprivation. Leah Gonzales, PhD, Richard Van Voorhis, DED, Sally Lewis, PhD and Carrie Fiol present in their article, “Use of Comprehensive Treatment Teams for Students with Developmental Disabilities and Emotional and Behavioral Needs” a paradigm shift in which professionals through comprehensive treatment teams can draw on the knowledge and skills of parents and professionals to develop evidence-based treatment plans for students with developmental disabilities and dual mental health needs. Joan Lawrence, PhD and I present in our article, “Evaluation of Competency and Standard of Care Compliance for Hospital-Based Psychologists,” a structured evaluation form that allows for objective assessment of competency and compliance of a neuropsychologist in a rural area by a peer reviewer. Gary J. Sipps, PhD, Jon Thomas, PhD, Erin Farrer, PhD, Shannon Perkins, PhD, Rod Myerscough, PhD, Leon C. Howard, PhD and David Brinkman-Sull, PhD discuss how there has been a substantive number of recent developments pertinent to the delivery of mental and behavioral health services, such as the new CPT codes (American Psychological Association Practice Directorate, 2013) and the institution of PQRS standards (Centers for Medicare and Medicaid Services, 2012). These changes, however, are part of a larger process. Through their article, “The Integration of Psychology and Medicine in a Health System,” they provide a number of medical specialties who speak in their own voice, outlining salient aspects of their job description, services provided, interaction with other professionals and relevant competence/training/ experience needed.

Science
Students who won awards from OPA at this year’s Student Poster Session at Convention submitted articles describing an overview of their research. In their article, “Using Mouse Tracking to Examine the Time Course of an Auditory Lexical Decision Task,” graduate empirical poster award winners Maura Krestar, MA, Sara Incer, MS and Connor McLenann, PhD describe how they implemented mouse tracking studies to demonstrate that hand movements reveal the progression of responses over time during psychological tasks. Results are described as being related to cognitive processing during an auditory lexical decision task. Sara Incera, MS, Teresa Markis, MA and Connor McLenann, PhD were also selected graduate empirical poster award winners. They further expanded in their article, “Mouse-Tracking Reveals When Stroop Effect Happens,” how mouse tracking reaction
times revealed significant differences in spatial attraction and velocity of participants in their study through use of the Stroop task. Ali Clark-MacKeown and September Staley, winners of the top undergraduate poster award, present a study that sought to explore the social and cognitive foundations of social mimicry during a one-on-one interaction with preschoolers in order to explore the developmental roots of mimicry in their article, “Exploring the Social and Developmental Roots of Social Mimicry in Preschool Children.” Brittan Davis, MEd, Sneha Pitre, MA, Tiffany Williams, MEd, Keelan Quinn, MA and Joshua Bagaka’s, PhD, winners for the graduate non-empirical category, overview their article, Importance of “Peer Relationships in Doctoral Programs,” speak of doctoral student attrition and the need for mutually supportive peer relationships in order to promote resilience, success, emotional stability and decrease the attrition rate of students in doctoral programs.

The 2013 Ohio Psychologist
The Ohio Psychologist is a peer-reviewed publication. Each article submitted has 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 of the article was official. This process takes time and the volunteer hours of many individuals. OPA is fortunate to have a core set of peer reviewers with a high level of expertise. I would like to extend my appreciation to the following who reviewed the 2013 manuscripts for this issue of the Ohio Psychologist:

William Askren, PhD, Kerm Almos, PhD, Paule S. Asch, PhD, William Bauer, PhD, Milton Becknell, PhD, Charles Dolph, PhD, Marc Dielman, PhD, Jeanne Jenkins, PhD, Ky Heinlen, PhD, Andrea Karkowski, PhD, Kathryn MacCluskie, PhD, Janette McDonald, PhD, Sabato D. Sagaria, PhD, Elizabeth Swenson and Richard VanVoorhis, PhD.

Furthermore, 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. We at OPA are very thankful for the expertise that she brings to this year’s publication.

I would like to end by thanking our authors who have contributed to the 2013 Ohio Psychologist. Your contributions are an invaluable contribution to both the Ohio Psychological Association and the profession.

Audrey E. Ellenwood, PhD
Editor, Ohio Psychologist

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Integrated Health Care on College Campuses: The Call For Collaboration
Christine F. Muller-Held, PsyD, University of Cincinnati

Abstract
The need for collaborative health and mental health relationships was explored by providing a brief, relevant literature review and describing current practice experiences at University of Cincinnati’s student health clinic. Historical trends and current public policy shifts suggest a need to continue development of collaborative relationships in the general population, as well as on college campuses. Examining an established, integrated college health relationship can highlight the feasibility of medical and mental health integration in this unique setting.

Background
As a society, we are long past the time where mental health can be divorced from physical health. The Cartesian view of a mind-body dichotomy has been rejected time and again through studies and anecdotal data that suggest our physical health is connected to our mental health. The push for collaborative care has been ongoing for more than 35 years (Russell, et al., 2003), and has recently taken the shape of the drive toward development of Patient-Centered Medical Homes. This model situates primary care as a part of a collaborative team that works toward “personalized, coordinated, effective and efficient care” (National Committee for Quality Assurance [NCQA], 2011). It is difficult to argue against better patient care, better outcomes, and better efficiency of our medical system.

College Student Mental Health
The need for integrated health care extends beyond the general community, and on to college campuses. A controversial and conflicted thread of literature exists that explores trends in college student mental health over time. Benton and colleagues (2003) suggest that there have been clinically meaningful increases in mental health problems within the college student population over a 13 year span, whereas Hoeppner and colleagues (2009) found no such trend. Jenks Kettmann and colleagues (2007) suggest that the severity increase may be perceptual in nature—a small number of students with more severe difficulties may utilize resources at a greater rate or strain insufficient systems, creating the perception that the severity of mental health problems has surged in the population as a whole. Combined with low base-rate but highly salient behaviors like suicides on campus and spree killings, the perception has developed that college students have more severe mental health problems, at higher rates of occurrence, now more than ever before. Community-based studies suggest that primary care physicians are first-line providers for mental health concerns in more than 50 percent of cases, and prescribe more antidepressants than any other medical field (Loeb, Bayliss, Binswanger, Candrian, & deGruy, 2012; Mojtabi & Olsson, 2008). If this pattern holds true in college campus health centers, collaborating and integrating with psychologists and psychiatrists should be a natural fit, and one that benefits everyone involved—students, primary care physicians, mental health providers, and the college community as a whole.

A review of the Spring 2012 American College Health Association-National College Health Assessment (ACHA-NCHA) suggests that common concerns of surveyed college students span both physical and mental health. The top ten reported circumstances that impact academic functioning range from stress, sleep problems, and common colds, to anxiety and depression (ACHA, 2012). Psychologists and supervised psychology trainees are uniquely qualified to work with physicians and psychiatrists to develop and carry out treatment plans for students who present with these common stressors, as well as more complex psychiatric diagnoses and personality disorders.

Evidence-based psychological treatments exist for depression, various anxiety disorders (i.e. PTSD, OCD, Specific Phobias), and insomnia. These treatments do not come in the form of a pill, nor can they be disseminated in the 15 minute patient encounter. Being able to refer to an in-house mental health clinic is likely a relief to the college health physician, and may reduce the stigma a student feels and who may, otherwise, not initiate treatment. In some cases, including eating disorders, diabetes, and hypertension, the need for a treatment team approach is imperative to ensure the physical health of the client. Neither physicians nor psychologists can do it all, and an integrated approach to physical and psychological treatment ensures that nobody has to.
Putting Theory into Practice: Integration in Action at University of Cincinnati’s Campus-Based Student Health Service

It is much easier to write about collaboration than to make it work. There must be reasons why more medical practices are not employing psychologists—and it turns out, there are. Logistical barriers (i.e., time, office space, billing procedures), professional factors (i.e., adhering rigidly to professional roles, protecting “turf”), and interpersonal factors (i.e., personality style, communication skills, willingness) all can contribute to the difficulties of establishing a stable collaborative practice (Anderson & Lovejoy, 2000; Bray & Rogers, 1995; McDaniel, 1995; Perrin, 1999; Russell, et al., 2003). Feierabend and Bartee (2004) identified a continuum of collaborative practice, ranging from “Level 1,” which involves limited contact and is primarily referral-based, to “Level 5” which is fully integrated at all levels, including billing and record-keeping, and has a shared mission and vision. Feierabend and Bartee’s “Level 5” is very similar to Drotar’s “independent functions model” (1995), which is characterized as referral-based collaboration at different practice locations, and with limited communication. Communication is usually carried out by phone or mail. These models are rife with the professional and interpersonal barriers previously mentioned, yet are the most commonly developed forms of collaboration since they sidestep the challenging logistical barriers.

When “Level 5” collaboration works, it is a boon to patients and providers alike. The University Health Service at University of Cincinnati, a campus-based health clinic, is a prime example of integrated health care in the college setting that incorporates co-location, collaboration, use of emerging technologies, and fully integrating office services like billing and insurance processing. This on-campus student health clinic utilizes the expertise of general physicians, specialty physicians, counselors, psychiatrists, psychologists, nurses, and nurse practitioners to meet student needs in an expeditious fashion. On any given weekday, a student can walk in to see a physician for a mental health referral, and be scheduled with one of the many on-site mental health providers, including psychologists, licensed counselors, psychology trainees, or psychiatry staff. Often appointments are available within a week, if not in the same week. Consistent with the findings of the ACHA-NCHA survey, common referrals for mental health services include stress, depression, and anxiety, in addition to academic problems/psychoeducational assessment for ADHD, management of chronic mental health concerns, and relationship concerns. Many referred clients may also have continued contact with the primary care clinic for medication management, or be referred to psychiatry for more complex medication treatment. To ensure cohesive treatment and the best outcomes for the patient in question, collaboration is a necessity, not an option.

Co-location is a key feature of higher-level collaborative relationships. The specialty services provided at University Health Services are all co-located within one campus-based clinic, allowing physicians to obtain immediate consultation services for patients that may be at risk for self-harm, harm to others, or who are in severe distress. Likewise, the mental health clinic staff is able to immediately consult with physicians and psychiatrists if a patient appears ill, needs a medication consultation, or is otherwise generating concern related to physical health issues. This form of “curbside consultation” occurs frequently out in the clinic, in the staff lunch room, and by secure messages. In addition to these informal collaborative contacts, formal treatment team meetings between psychiatry and mental health providers convene on a regular basis with the goal of protecting time for collaboration. At times, patients are identified whose needs can create stress in the broader clinic system. The inclusion of the primary care and nursing staff in case conferences, as needed, can aid in developing a consistent approach to managing the needs of clients who are high-utilizers of clinic resources, or who may test boundaries. The use of treatment teams also helps reduce the tendency for providers to focus on “protecting their turf.” It becomes easier to see colleagues as working toward the same end goal: better care for the patient.

The proliferation of electronic medical record technology adds ways in which clinic staff can collaborate. At University Health Services, clinical staff is able to view all clinical contact notes—medical and mental health. This access, used sensitively and in HIPAA-compliant fashion, provides a well-rounded, holistic view of the patient in the exam room. Simply being able to see that the distressed patient usually sees Therapist X or Doctor Y may be enough to help a treatment provider make a gentle suggestion to the patient to get back in touch with his therapist, or to have a walk-in visit with her preferred physician. These opportunities for collaboration and coordinated care are lost if records are physically split or electronically blocked. This level of appropriate access to records is consistent with the principles of “Level 5” collaboration and allows for the minimization of logistical barriers like dual record keeping. The EMR utilized by University Health Services also incorporates billing functions and pulls all information needed for insurance claims, resulting in fully integrated billing for both medical and mental health services.

Conclusion

The American College Health Association (2010) developed a white paper that sought to define and explore how collaboration is being carried out in a sampling of college counseling and college student health centers. They identified that many surveyed colleges and universities have “merged” services, but that does not necessarily suggest “integrated” or “collaborative” services, as records, billing, office spaces, and policies often remain separate. There is ample evidence to suggest that integration of medical and mental health services is necessary for addressing complex mind-body interactions, and for providing holistic care for patients. College and university settings are no different than the broader community. Collaboration in this setting may even be more important, given the concern that college students experience more severe mental health symptoms now than ever before, and that so many stressors impacting college student health and wellness are psychosocial in nature. While fully-integrated collaboration is rife with challenges, careful planning and consideration of barriers (ACHA, 2010) can result in successful implementation, to the benefit of all involved.

References


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About the Author

Christine Muller-Held, PsyD is a clinical psychologist at the University of Cincinnati, working as Senior Staff Psychologist and the coordinator of mental health services at UC’s University Health Services clinic. Beginning in graduate school, Dr. Muller-Held has maintained an active professional interest in the intersection between medical and mental health, specifically related to collaborative relationships between physicians and mental health providers. Outside of her clinical and administrative duties, Dr. Muller-Held enjoys cooking and baking, reading and spending time with her husband and family.

Author Note

Correspondence regarding this article should be directed to Christine Muller-Held, University Health Services, University of Cincinnati, P.O. Box 210010 Cincinnati, Ohio 45221-0010. E-mail: mullerce@ucmail.uc.edu
Advocating for Medicaid Reimbursement of Health and Behavior Codes

Kristine Woods, PsyD and Bobbie Celeste, PhD

Abstract
The health and behavior codes (H&B codes) allow psychologists to bill for services rendered to individuals with medical conditions when services are directly related to optimizing medical functioning. Currently, Ohio Medicaid does not reimburse these codes, despite Medicare and several private insurance companies who do reimburse services billed under the codes. However, there is potential for Ohio Medicaid to open reimbursement of the H&B codes particularly as their nature is consistent with the integrated health care model. Advocating for Medicaid reimbursement of the H&B codes is crucial for changes to be made, and specific recommendations are made for how psychologists across the state can become involved in the effort.

Introduction
With the passage of the Affordable Care Act in 2010 and the focus on patient-centered health homes, the future of psychology will exist within an integrated care model alongside physicians, nurses, case managers and others providers. Integrated physical and mental health services have the potential to allow psychologists to focus on prevention of mental health disorders, particularly with individuals who have chronic medical conditions. Increasingly, psychologists are also being called upon to assist professionals and their patients as they deal with medical diagnoses. Within behavioral medicine, psychologists often work with individuals to provide services such as assisting with adjustment to diagnosis and treatment, pain management, and improving adherence to the medical regimen. These individuals often do not meet full criteria for a mental health (DSM) diagnosis which is required to bill insurance companies for reimbursement under the traditional Current Procedural Terminology (CPT) psychotherapy codes.

In 2002, the Center for Medicaid and Medicare Services (CMS) approved and activated the health and behavior codes (H&B codes) for use by licensed clinical psychologists, with the purpose of improving services delivered to patients within the medical system (Foxhall, 2000). The CPT manual describes that the purpose of these codes is to improve the patient’s physical health by attending to the psychological, behavioral, emotional, cognitive, and social factors that may be negatively impacting their acute or chronic illness (Schmidt, Yowell, and Jaffe, 2011). Billing under the H&B codes allows psychologists to bill for their services under the medical diagnosis, greatly expanding the opportunity for psychologists to provide services to individuals with acute and chronic medical conditions (Noll & Fischer, 2004). Because psychologists’ services within the medical setting are thought to optimize the individual’s medical functioning, reimbursement for the H&B codes are generally drawn from the medical care funds rather than the mental health funds. However, successful reimbursement for services rendered under the H&B codes varies from state to state and across insurance carriers.

Effectiveness of H & B Codes
Services appropriately billed under the H&B codes include assessment and intervention for a wide variety of physical conditions. Pediatric headache, obesity, and cardiology programs have found the use of health and behavior services useful and effective (Drotar, 2012). Pain management programs use health and behavior services to assess the biopsychosocial barriers to successful treatment of injury and chronic pain in patients within the Summa Health System in Northeastern Ohio (Sipps, 2011). Psychologist Sam Knapp, Director of Professional Affairs for the Pennsylvania Psychological Association, reviewed the research data on cost savings using behavioral treatments billed under the H&B codes. In his letter and fact sheet, Knapp cited effectiveness and cost savings obtained in a variety of settings and patient types. Hospital savings of $1,500 per patient were found when treating hip fracture pain and $500 per patient was saved in a coronary disease program (Brooks, Titler, Ardery, & Herr, 2008). Patients with hypertension who received behavior treatment saved an average of $1,300, mostly in decreased use of pain medication (Fahrion, Norris, Green, Green, & Snarr, 1986). One study of women with diabetes and excess weight found a $12,600 cost reduction by using a program that included diet, exercise, and behavior modification (Roux, Kuntz, Donaldson, & Goldie, 2006).

Current Status of H&B Codes
In a 2004 national web-based survey on use of the H&B codes, Delamater reported limited use of the codes (44 percent of the respondents) and even more limited success with reimbursement (most respondents reported less than 50 percent reimbursement). Despite, the American Psychological Association’s (APA) continued advocacy for reimbursement of the H&B codes and the fact that Medicare and many private insurance companies do pay for the use of H&B codes, many state Medicaid agencies do not. Ohio Medicaid is currently one of the states that does not reimburse for services billed under the H&B codes (Nordal, 2012).

Roughly one in five Americans, approximately 60 million people, are estimated to currently be enrolled in the national Medicaid program (Kaiser Family Foundation, 2011a). Statistics from June 2010 indicate that total Medicaid enrollment in Ohio was just under two million people (Kaiser Family Foundation, 2011b). As the state of Ohio begins to reorganize and change the structure of current health care coverage to be consistent with the Affordable Care Act, the number of individuals covered under Medicaid is expected to significantly increase. It is expected that the Affordable Care Act will allow psychologists to function within a multidisciplinary care system where there will be opportunities to focus on prevention (Clay, 2011). Therefore, an appropriate billing mechanism needs to be in place to allow for psychologists to sustain provision of services to the individuals who do not meet criteria for traditional mental health diagnoses.

What Can You Do?
Now is the perfect time for psychologists to advocate for Medicaid reimbursement of the H&B codes as the state of Ohio prepares for the healthcare changes under the Affordable Care Act. Psychologists, particularly those providers who work directly with individuals who have medical conditions, are encouraged to get involved. The Ohio Psychological Association (OPA) has an advocacy committee that is actively working toward Medicaid reimbursement of the H&B codes. At the state level, an important first step is to work with Ohio’s Medicaid program to provide education about the purpose and benefit of the H&B codes. This step was initiated by OPA executive director, Michael Ranney and this author (Bobbie Celeste) in February of 2013. Efforts highlighted the consistency between the nature of the H&B codes and a model of integrated health care currently being promoted by the Ohio Governor’s Office of Health Transformation and national policy makers.

Additionally, advocacy efforts in other states suggest that demonstration of cost-savings benefits from psychology involvement with individuals with complex medical conditions is a viable strategy to achieve reimbursement (Duke, Guion, Freeman, Wilson, & Harris, 2012). Psychologists who have data of this nature are strongly encouraged to join the OPA’s advocacy campaign to strengthen the argument for the
advantages of the H&B codes. Nationally, psychologists are encouraged to get involved with the APA Practice Organization to advocate for reimbursement of the H&B codes (Woods & Gillaspy, 2012). The APA Practice Organization’s website, Practice Central has information on the H&B codes as well as a letter that psychologists can use to advocate for reimbursement from insurance companies.

For psychologists working in an integrated care setting, recruiting other medical providers, families and individuals receiving the psychological services, and individuals from various nonprofit advocacy organizations (e.g., Muscular Dystrophy Association, American Diabetes Association) to advocate on behalf of psychologists is recommended (Duke, et al., 2012). These individuals may be encouraged to write letters or emails to the state Medicaid office, or to request formal meetings to discuss the direct benefits of services provided under the H&B codes. Advocacy from individuals outside of the profession is likely to provide additional credibility to the value of the services provided by psychologists (Woods & Gillaspy, 2012).

Conclusions

As we prepare for the future of integrated health care, we need to ensure that the role of psychologists is not overlooked. We have a unique skill set that has demonstrated effectiveness in treating complex medical conditions. As such, in order to sustain our services, an appropriate and efficient billing mechanism needs to be in place. The CMS recognized this need in 2002 when they approved and activated the H&B codes, allowing psychologists to bill for health psychology-focused services using the individual’s medical diagnosis. Unfortunately, the Ohio Medicaid program has not followed the CMS lead, and the H&B codes remain inactive for reimbursement in Ohio. Advocating for the H&B codes is essential, and a necessary step in allowing psychologists to bill for health maintenance and prevention services. Advocacy for our patients requires more than assisting in the hospital or clinic. Professionals must also provide scientific evidence that contributes to public policy decisions. As scientists and practitioners, psychologists can contribute significantly to major health policy changes. Conducting and publishing research, assessing and treating patients is laudable. At the same time, if we do not communicate our findings to policy makers, the more significant changes we seek, to provide better health care to all, will not be realized.

References


About the Authors

Kristine Woods, PsyD is a pediatric psychologist in the NeuroDevelopmental Science Center at Akron Children’s Hospital. She works primarily with children and adolescents with headaches, migraines, and other pain disorders. Dr. Woods earned her doctorate in 2010 at Indiana University of Pennsylvania and completed a two-year fellowship in pediatric psychology at the University of Oklahoma Health Sciences Center. She is a member of the Ohio Psychological Association, the American Psychological Association, the Society of Pediatric Psychology, the Society of Clinical Child and Adolescent Psychology, and the American Headache Society.

Bobbie Celeste, PhD is a licensed psychologist and Director of Professional Affairs for OPA. She has a long time interest in religion and spirituality and has explored various traditions and practices, often using them in her clinical practice. As the Director of Professional Affairs, Dr. Celeste Bobbie Celeste advocates for psychologists at the state and national level. She also trains psychologists and students to promote public policies that create psychologically healthy communities. Her private practice draws on her training as a PhD from The Ohio State University in counseling psychology.
Development and Implementation of Doctoral Training Sites in Pediatric Primary Care Settings

Allison Fernander, PhD & Ashley Murray, BA

Abstract
There are numerous benefits and challenges involved in integrating psychological services into pediatric primary care settings; therefore a greater emphasis has been placed on training graduate students interested in pediatric psychology. This specialized training allows students to gain the clinical experience of working in interdisciplinary teams and conceptualizing patients from a biopsychosocial perspective prior to their predoctoral or postdoctoral internship. Wright State University’s School of Professional Psychology is working to create this training opportunity. Due to the complex nature of creating training sites in a pediatric primary care setting, the purpose of this article is to discuss the necessary steps needed to create a successful training site by identifying the needs for psychology in pediatric primary care settings, using consultation models to guide practice in training sites, and assessing the benefits and challenges of psychologist-physician collaboration. This research can then be used as a foundation for future training sites within pediatric primary care settings.

Introduction
Pediatricians are often the first health care provider consulted when a child exhibits symptoms of a developmental or behavioral problem. While referrals to psychological services are one solution, families often do not follow through with accessing these services or may experience barriers to receiving treatment such as difficulties with transportation, financial resources and stigma (Clay & Stern, 2005). Based on these difficulties, there is an increasing call for the integration of psychological services into pediatric primary care offices so that children and families are able to access these services in one setting.

Benefits to combining both medical and psychological services include providing developmentally appropriate information and education to children and families, facilitating crisis intervention, providing brief motivational and behavioral interventions, providing psychological and neuropsychological assessment, enhancing communication between patients and their medical team, coordinating family resources, and providing support for medical professionals working with special populations (Drotar, Spirito & Stancin, 2003; Stancin, Perrin, & Ramirez, 2009).

Developing a strong working relationship between psychologists and physicians can take a considerable amount of time and effort due to differences in patient conceptualization, clinical experience, time and communication demands, and training requirements (Muse, Brown, & Cothran-Ross, 2011). As the strength of this partnership grows, the benefits of collaboration are significant allowing both professionals to utilize their knowledge set to develop a more comprehensive conceptualization of the child and current concerns. At the same time this collaboration process can create a variety of unique challenges such as delegating duties performed, managing insurance and reimbursement, and time constraints (Perrin, 1999).

Due to the benefits and challenges of integrating psychology in a pediatric primary care setting, a greater emphasis is placed on training graduate students interested in pediatric psychology. It becomes critical that they gain the clinical experience of working in interdisciplinary teams and conceptualizing patients from a biopsychosocial perspective prior to their predoctoral internship or postdoctoral fellowship. The current research study focused on the initial phase of a three phase process that included identifying the behavioral and mental health needs of the pediatric population in physician offices in and around Dayton, Ohio (Montgomery County). Findings will be used to inform the development of a training site within a pediatric primary care setting.

Method
Pediatric Behavioral Health Needs Questionnaire (PBHNQ)
The PBHNQ is a physician-completed (or other qualified medical professional) self-report measure intended to assess the perceived behavioral/mental health service needs for the pediatric population in their practice. Participants are asked to rank the perceived frequency of specific behavioral/mental health concerns present within their patient population. The survey provides 15 potential behavioral/mental health concerns. The physician or other qualified medical professional is asked to rank the three most frequently noted behavioral/mental health concerns that are present in the pediatric population at their practice on a scale from “1 to 3,” with a ranking of “1” indicating the most frequently presenting concern. The PBHNQ was developed for the purpose of this study, and item selection was based on the literature of current behavioral/mental health concerns in the pediatric population.
Participants Used
To identify the needs of the pediatric primary care population, the PBHNQ questionnaire was administered to outpatient physicians or qualified health care providers who had regular contact with this population in Montgomery County and the seven surrounding counties. Outpatient physicians/providers included in this study were limited to those who treated patients in family practice, pediatric, and gynecology settings. In total, 200 physician offices were contacted, and 11 completed questionnaires were returned. Out of the surveys returned, eight were completed by pediatric offices and three were completed by family practice offices.

Procedure
Physician offices were contacted by telephone to briefly describe the purpose of the study and to determine their level of interest. A script was recited to the office staff briefly describing the nature of the study and requesting their participation. When verbal consent was granted from the office staff, an appointment was set and physicians were approached for participation in this study. An informed consent letter was given to provide a more detailed description of the study and their rights. In instances where the physician was unavailable to meet for an appointment, the questionnaire was faxed to the physician for completion.

After verbal consent from the physician was obtained, he or she was asked to complete the questionnaire. The questionnaire sought to identify demographics of the pediatric population receiving medical services, as well as the top three behavioral and mental health concerns the pediatricians or family health physicians felt were most prevalent in their work. In instances where the physician was unavailable, a nurse that had direct contact with the pediatric population in the setting completed the questionnaire.

Data Analysis
Due to the low response rate, quantitative analysis was limited. As a result, percentiles were computed to identify the most frequently reported behavioral and mental health concerns, patient and physician office demographics, and physician offices that expressed an interest in consulting with psychologists in the future.

Results
The participating physician offices ranged in patient size from 225 to 45,000 (M = 9,984.55) based on the number of patients seen annually. All of the physician offices had a relatively even distribution in female and male patients. In addition, the physician offices identified their patients as primarily Caucasian (75%) and their payment methods varied (No Insurance = 3.86%; Medicaid = 38%; Private Insurance = 56.5%; Private Pay = 1.35%). The four most prevalent behavioral and mental health needs (see Figure 1) were identified as Behavior Problems (73%), Anxiety (55%), Obesity (45%), and Depression (45%). Of the 11 participating offices, 82% reported a desire to work with a mental health consultant to address these needs.

Discussion
Phase one of this research study provided an assessment of the mental health and behavioral needs of the pediatric population, and this data will be used for establishing training relationships and future research collaboration between pediatricians and the School of Professional Psychology at Wright State University. In an environment of pressure from managed care to find cost-effective treatments, there is increased need for outcome-based research that provides empirical support for treatment interventions and improved health outcomes for pediatric patients using a holistic approach that combines psychosocial and medical services. Phase one provided a foundation for the current perceived needs, and created a starting point for integrating medical and psychological services.

Due to the need for the integration of psychological and medical services, and the scarce opportunities students have in integrated settings, developing training opportunities for doctoral psychology students is critical. Unique challenges with developing training opportunities in a primary care setting frequently exist due to the considerable effort it can take to address concerns regarding appropriate identification of the need and formulating collaborative relationships. Many training opportunities focus heavily on brief behavioral health checks, brief consultations with providers, and psycho-education for families when needed (Pisani et al., 2005).

Research indicates training sites need to be flexible and willing to explore concerns the pediatricians have, work to develop a contract for the roles and responsibilities of the doctoral trainee, and allow the pediatrics to still maintain and refer patients to community psychologists (Raggi, 2010; Dortar, 1995). By engaging in these practices, outcomes may be mutually beneficial for psychology trainees, the medical team with whom they are working, and patients.

Future Research
The researchers aim to utilize the results obtained from phase one, previous research on the integration of psychology in primary care settings, and consultation models to implement phase two of this research study by developing a training site within a local pediatric primary care office. While this process will vary depending on the particular primary care office with which one is collaborating, an external supervisor will likely monitor the doctoral trainee through in vivo training within the primary care setting. Trainees will also receive face-to-face supervision. This model of consultation is consistent with the collaborative team model, within which responsibilities and decision making power are shared between psychology and medical staff. The interdisciplinary team will then meet regularly to discuss patient care and treatment planning. This model is more commonly used in teaching centers (Clay & Stern, 2005; Dortar, 1995; Roberts, 1986). Specialized training will include use of anticipatory guidance and brief behavioral/mental health intervention and assessment within an interdisciplinary framework, and place additional emphasis on the most frequently reported behavioral health needs identified in this study (behavior problems, anxiety, obesity, and depression). The responsibilities of the doctoral trainee will be to provide patients with anticipatory guidance regarding child development, brief interventions and assessment, and basic psychoeducational services when minor concerns arise. The trainee will also communicate with the medical team regarding referrals, patient concerns, treatment planning, and patient progress. Once the training site has been fully developed, research will be conducted to assess the effectiveness of the collaborative relationship as measured by decreased time spent by medical professionals addressing psychosocial/mental health concerns and decreased mental health/behavioral symptoms present in referred patients over time. This research can then be used as a foundation for future training sites within pediatric primary care settings.

Continued on page 14
References


About the Authors

Allison Fernander, PsyD is an Assistant Professor at Wright State University's School of Professional Psychology in Dayton, Ohio. In addition, she currently serves as the Director of the Ellis Human Development Institute Assessment Clinic and Child Anxiety and Biofeedback Clinic. Dr. Fernander received her PsyD from Spalding University. She completed her internship in pediatric psychology at the University of Miami Miller School of Medicine and post-doctoral fellowship at Columbus Children's Hospital. Dr. Fernander’s clinical and teaching interests include pediatric psychology, child clinical psychology, health psychology, lifespan development, child assessment, and consultation-lesion. She has presented extensively on pediatric psychology and child mental health concerns.

Ashley Murray, BA is a third year clinical psychology doctoral student at Wright State University. She obtained her BA in psychology, graduating with cum laude and departmental honors from the University of Cincinnati. Ashley’s interests include chronic illness, treatment adherence, neuropsychological disorders, and developmental disorders in children. Her dissertation will be looking at the effectiveness of Group Theraplay on caregiver-child interactions in children diagnosed with autism spectrum disorder. She has had experience conducting early interventions for young children identified as at risk for developing conduct disorders, conducting neuropsychological assessments in a hospital setting, and providing individual and group therapy at a community mental health center. In addition, she has worked on several research projects at Wright State University which include evaluating a therapeutic model at a juvenile detention center, determining common factors within suicides in Dayton, Ohio, and conducting research on the behavioral and mental health needs of children in a primary care setting.
Use of Comprehensive Treatment Teams for Students with Developmental Disabilities and Emotional and Behavioral Needs

Leah Gongola, PhD, BCBA-D, Carrie Fiol, Sally Lewis, PhD and Richard Van Voorhis, DEd, NCSP

Abstract

Professionals have had a relatively recent “epiphany” in understanding that it is unrealistic for one individual to hold all of the answers (Osborn, Dean, & Petruzzi, 2004). Rather, the time has come for a paradigm shift in which professionals capitalize on each other’s strengths and expertise by blending and collaborating. Comprehensive treatment teams draw on the knowledge and skills of team members to inform the development of evidence-based treatment plans for students with developmental disabilities and dual mental health needs. This article will discuss the composition and use of treatment teams and the application of dynamic, collaborative services to enhance positive treatment outcomes for students across settings.

Introduction

Recently in the United States, autism prevalence has been reported to impact every 1 in 88 children (Centers for Disease Control, 2012) with statistics suggesting that a ten-fold increase in autism has occurred within the past half-century (Johnson, Myers, & the Council on Children with Disabilities, 2007). Further, research signifies that one in six children has a developmental disorder (Boyle et al., 2011) and also, that children with developmental disabilities are at a significantly increased risk of having dual diagnoses. As a result of increasing prevalence, the incidence of students in public schools with dual diagnoses such as developmental disabilities or autism in conjunction with emotional and behavioral needs to include anxiety, attention deficit hyperactivity, oppositional defiant, and bipolar disorder has amplified.

Behavioral concerns frequently coexist with developmental disabilities, particularly when paired with co-morbid mental health disorders. These problem behaviors are often among the most demanding and stressful issues faced by schools and parents during educational programming. Research suggests that the needs of individuals with developmental disabilities and dual mental health needs can be particularly challenging; resulting in delays in response to treatment (Singh et al., 2002). There are many implications pertaining to the education of these students given the fact that behavioral concerns often inhibit academic and social growth.

Because of the complexities that dual diagnoses can often present, one individual is not able to singly handle the depth of treatment needs for each student with challenging behavior; thus, many students receive services from a variety of practitioners. The traditional framework often results in practitioners across separate settings applying interventions and strategies in an isolated fashion. This framework is contradictory to best practice which instead, supports a collaborative and systematic combination of treatments by way of varying professionals with diverse skill sets. Multimodal treatment plans are designed to treat the student with dual diagnoses holistically across settings; as opposed to using a fragmented approach with variations in each setting (Singh et al., 2002). Best practice suggests that professionals should merge to create comprehensive treatment teams; an essential ingredient to facilitate positive treatment outcomes. This paper will discuss the composition and work of the treatment team with specific consideration given to the development of student case histories, use of data for decision making, and team member responsibilities.

Composition of the Treatment Team

Synthesizing Professional Disciplines

To address the challenging behavioral needs of students with developmental disabilities and dual diagnoses, several professional disciplines have come to the forefront in developing research-based interventions to include clinical psychologists, school psychologists, counselors, speech pathologists, and behavior analysts. Services for students can be provided through school-based teams, community-based mental health clinics, or home-based teams. In practice, when student behavior is observed as significantly aggressive, impulsive, or anxious, school teams need to merge and collaborate with community-based professionals such as clinical psychologists and home-based professionals such as behavior analysts to support the student and to develop a more detailed System of Care (SOC). The integration of school, community, and home-based supports allows for all team members to obtain a solid understanding of student functionality across environments in addition to attaining information about how all parties are treating the challenging behavior. Considerable content shared about the student increases the likelihood that important information will be synthesized and used in the development of an effective, individualized plan (Osborn, Dean, & Petruzzi, 2004).

Work of the Treatment Team

Developing Case Histories

Assuming that appropriate consent is given from all parties, comprehensive teaming begins with a case history in which team members share written evaluations and reports such as the Evaluation Team Report (ETR), Independent Educational Evaluation (IEE), and Behavior Intervention Plan (BIP). During this initial phase in the process, the team discusses the student’s current and previous responsiveness to interventions and operationally defines specific behaviors of concern. This information helps to ground the team and in moving forward,
ensures that all team members fully understand the prioritized treatment objectives for the student.

Presenting Single Subject Data
At the initial meeting and throughout the process, team members share single-subject data to inform decision making and also, to prevent and minimize emotionally-tainted treatment decisions. Single-subject data serves as a strong tool in determining the frequency of problem behavior while functional behavior assessments should be completed to determine behavioral function. When treating individuals with developmental disabilities and co-existing mental health needs, numerous and complex factors can impact the success of the treatment plan. For example, the most commonly occurring triggers for problem behavior are medical conditions, environmental variables, and psychiatric illness (Pyles et al., 1997). For this reason, there must be an integration of professionals from both mental health and behavioral backgrounds when determining the cause of problem behavior and when developing appropriate, function-based interventions to support positive behavior change.

Assigning Responsibilities and Timelines
Responsibilities and timelines should be assigned to team members to ensure accountability in follow-through. For instance, if the school team needs to gather additional information related to the timing and frequency of problem behavior, the educator and behavior analyst might be assigned this component. Parents may also need to gather data so that the team has a representative sample of the student’s behavior across settings. This data can drive development of the Individualized Education Program (IEP) and annual goal setting. In addition, the home team can refer to the data when delivering home-based behavioral interventions and when determining priorities for parent training.

Identifying the Team Leader
Osborn and colleagues (2004) discuss that while treatment teams originated in the medical profession, there is a current shift and more flexibility when determining team players and their roles and responsibilities. The comprehensive treatment team should include one individual that coordinates the efforts of all team members to include designing interventions and progress monitoring. Most importantly, the team leader should actively initiate and emphasize the need for strong communication and feedback loops so that all members feel a sense of inclusiveness; allowing for continued visibility with the student’s challenges and progress along the way.

Establishing Frequent Communication
In using frequent communication, team members are encouraged to develop a weekly or monthly template in which they share critical information. Realistically, because of cost and scheduling conflicts, most teams will sustain communication via distance modalities and will include a general update on the student’s functioning, status of the treatment plan, and emerging issues (Singh et al., 2002).

Conclusion
Comprehensive treatment teams provide many benefits when programming for students with developmental disabilities and emotional and behavioral needs. The shared expertise and problem solving between team members supports the design and implementation of evidence-based treatment plans; resulting in maximized therapeutic gains for individual students (Pyles et al., 1997). Teams using data and a multimodal treatment approach have proven to be most effective for students with decreasing anxiety and oppositional behavior while simultaneously increasing academic performance (U.S. Department of Education, 2002).

The collaborative spirit of treatment teams benefits not only the student, but also, the varied professionals involved. The facilitation of relationships from a variety of backgrounds exposes each professional to a broader array of best practices, a clear advantage to all team members. When considering the provision of care for students with developmental disabilities and coexisting mental health needs, it is our professional and ethical responsibility to ensure a consistent and strong integration of interventions on an ongoing, flexible, and evolving basis. In order to make this happen, we must value and commit to professional collaboration.

References


About the Authors
Leah Gongola, PhD, BCBA-D was a general and special educator and Medicaid provider. She now is an Associate Professor in the Counseling, Special Education and School Psychology Department at Youngstown State University. Dr. Gongola also directs Proactive Behavior Services, in which she works with individuals with behavioral needs. In addition, she is the director of Camp Sunshine of Aurora, a nonprofit summer camp designed to meet individualized needs for students with disabilities.

Carrie Fiol is an Intervention Specialist certified to teach grades K-12. Carrie is also a Graduate Assistant in the Special Education Department at Youngstown State University continuing her education to receive her Master's in Autism and Related Disabilities in August 2013. She works as an in-home ABA Tutor for students with behavioral needs. In addition, Carrie is a lead teacher at Camp Sunshine of Aurora, a summer camp to meet the individualized needs of students with disabilities. Currently, Carrie is
under BCBA Supervision in order to become board certified in the next year.

Sally A. Lewis, PhD is an Associate Professor in the Department of Counseling, Special Education, and School Psychology at Youngstown State University. Dr. Lewis has experience training pre-service candidates in special and gifted education leadership, collaboration, and assessment. Also, she has worked extensively with children with disabilities, communication disorders, and gifts and talents and their families in school and community agency settings to assess and address student academic and behavioral needs.

Richard W. VanVoorhis, DEd, NCSP is an Assistant Professor in the Department of Counseling, Special Education, and School Psychology at Youngstown State University. As a practicing school psychologist Dr. VanVoorhis has nearly two decades of experience in the public schools. He also has experience working in a community mental health clinic. Dr. VanVoorhis’s research interests include: role and function of school psychologists, special education service delivery, disability assessment and identification issues, parent training, and career development topics.

Evaluation of Competency and Standard of Care Compliance for Hospital-Based Psychologists
Audrey E. Ellenwood, PhD, Youngstown State University and Joan Lawrence, PhD
Community Hospitals and Wellness Centers

Special Acknowledgement goes to Community Hospitals and Wellness Centers
Bryan, Ohio

Abstract
Compliance with standard of care is a process ensuring that clients receive reasonable, sensible, and ethical quality of care in accordance with the usual and customary mental health standard practices for the profession and within a particular community. Compliance is typically established based on the judgment of a peer in the field. A tenuous position is created when a reviewer lacks specific knowledge related to standards of care for an employment setting of a psychologist such as in rural areas. To date there does not seem to be: (a) consensus among psychologists as to what standard of care entails, (b) rules that clearly define standard of care; and, (c) a set standard of uniform evaluation criteria. To circumvent these issues a structured evaluation form was developed that allows for objective assessment of competency and compliance. The form can be adapted for use in a variety of general and specialty psychology practices.

Have you ever been asked, “Did a psychologist administer valid and reliable instruments or provide appropriate care for a particular client’s concern?” If so, you have been asked to respond to a competency and standard of care inquiry. Competency is a fundamental part of meeting standard of care, for a professional cannot meet standard of care if they are not competent (in terms education, training, skills, and continuing education) to practice. Standard of care is a medical or psychological treatment guideline that specifies appropriate diagnostic, testing, and/or treatment based on scientific evidence and collaboration between medical and/or psychological professionals involved in the care of a given condition for a particular client (Zur, 2010). Compliance with standard of care is a process in which a psychologist engages to ensure that clients receive reasonable, sensible, and ethical quality of care in accordance with the usual and customary mental health standard practices for the profession as a whole and also within a particular community. As a result, professionals within a particular community are held to the same standard as others of the same profession or discipline with comparable qualification in similar type localities (Zur, 2007; Caudill, 2004; Doverspike, 1999; Woody, 1998).

Why Standard of Care?
Assuming that a psychologist has been judged competent by achieving licensure, the standard of care is set of standards established so that psychologists can have a guideline from which to ensure and maintain quality care for their clients. One must remember that a guideline is not a law, but provides a minimum platform from which a psychologist should operate in order to maintain quality of care for clients.

For the psychologist, the focus for the standard care of service delivery is on the process of decision-making in diagnosis, test choices, interpretation, and treatment paradigms. The client, the payer, the psychologist’s employer, and regulating or accrediting agencies may be more focused on outcomes such as resolution of the presenting problem, revenue generation and cost effectiveness, and documentation of competence and compliance. Ideally, a psychologist’s adherence to the standard of care meets the goals of everyone involved and, in the event of a conflict, assists to protect the psychologist (and, often, the client) in disputes ranging from payment for services to lawsuits.

First and foremost, standards of care are in place for the benefits and protection of clients. The American Psychological Association Ethical Principles of Psychologists and Code of Conduct (APA, 2010) is the original standard of care for our profession, with the Preamble and Principle A stressing the importance of improving the conditions at the individual and organizational/societal levels, benefit to persons with whom psychologists work, doing no harm, and welfare of persons. Day to day adherence in clinical practice involves operationalizing these ideas into clearly delineated measurable professional behaviors that allow psychologists to make well-reasoned, scientifically sound judgments about diagnoses, assessment, and treatment that are optimal for client wellbeing. While the...
outcomes may not always be what is desired or expected (e.g., the
cient may want to be ‘fixed,’ the payer may grumble about additional
sessions, the employer might rail about cost effectiveness), adherence
to standards of care demonstrates a good faith effort to providing the
best service possible.

At a more pragmatic level, documentation of competence and
adherence to standards of care allows payers to get what they pay
for, employers to know that their psychologists are doing a good job
and to conduct meaningful performance reviews, and regulation or
accreditation agencies to judge the quality of services in the hospitals
they oversee. This has widespread positive impact which includes;
respect for and trust in the profession, containment of health care
costs, secure employment of psychologists, and maintenance of
institutional quality. In the event of a complaint, conflict about
expected outcomes, or institutional review, failure to adhere to
standards of care could result in a psychologist losing a job, they and/or
their employing hospital being sued by a client, loss of license, or
sanctions from federal and/or state regulating and accrediting
agencies. Because successful pursuit of complaints, lawsuits, and
adverse accreditation reviews requires the complaining party to prove
reckless or intentional negligence or professional behavior below the
standard of care (Woddy, 1998) and because psychologists are not
expected to be textbook perfect and clients cannot be guaranteed
positive or expected outcome results (Caudill, 2004), documented
adherence can help to protect the psychologist and employing hospital
from adverse outcome.

Evaluating Competence
and Compliance

Competence means that psychologists have received the proper
education and training to engage in clinical practice, and that
they maintain their level of skill through continuing education,
and is inherent in meeting standards of care. Compliance with
the standard of care means that psychologists have acted in a prudent
and reasonable manner and followed established professional and
community standards as have others of the same profession with
comparable qualification in similar localities with similar clients.
Demonstrating compliance with the standard of care is done primarily
via documentation in the clinical records (Zur, 2010). However this
is not as straightforward as it would seem, as currently there is no
uniform assessment which is used from one locality to the next.
Compliance is typically established based on the judgment of a peer
in the field, co-workers in allied health professions (physicians, social
workers, nurses, etc.), or administrative personnel within the agency
or hospital. Such process puts everyone involved in a tenuous position
when the reviewer lacks specific knowledge of what a psychologist
should be doing according to standards of care, and this is a particular
problem when a psychologist (especially in a specialty field) is ‘one of
a kind’ in their employment setting. Even when reviews are conducted
by professional colleagues in larger settings, it is noteworthy that
there is little to no consensus within the profession, as each reviewer
has their own definition for determining level of quality care and
compliance. While it might be argued that board certification is the
solution, passing that test does not guarantee that the professional
is actively and consistently adhering to standards of care a day to day
basis. Review of clinical records certainly provides a crucial part of
the picture in the process of job performance evaluation and in the
legal arena (Zur, 2010), but we would also argue that an interview
by the reviewer is invaluable to understanding and assessment of
the how the psychologist’s rationale for diagnosis, assessment, and
intervention maintains compliance with standard of care. That said,
for the evaluation to be valid and meaningful in meeting the goals of
standard of care, much like a scientific research study, there must be
performance measurement criteria whose assessment results would be
objective and reproducible.

The basis for defining standards of care involves incorporating the
clinical, ethical and legal guidelines for psychologists integrated into
one to form the final standard of care and the basis for evaluation
of compliance. In order to conduct a fair and reasonable evaluation
of a colleague’s compliance to a standard of care a reviewer needs
to be familiar with the following mandates within the profession
and professional organization codes, (4) Consensus in the community,
(5) Consensus among professionals within psychology; and, (6) HIPPA
Federal Guidelines (Caudill, 2004), Williams (2003,1997), Doverspike

When assessing competence and compliance with standard of care,
to date there do not seem to be: (a) a consensus among professional
psychologists as to what standard of care entails; (b) there are no
textbooks or set of rules that clearly define standard of care; and,
(c) a set standard of uniform evaluation criteria is unavailable.
Depending on the reviewer’s professional history, interests, and biases,
a performance assessment may idiosyncratically define the standards
which will be applied for the review a peer’s compliance and may focus
on one, some, or all of (a) definition of the clinical process that should
be implemented in a certain setting, (b) quality of in-take procedures;
(c) process for the identification of client psychological history (d)
choice of assessment instruments for the presenting problems; (e)
interpretation of psychometric data; (f) quality of report and follow-
up; (g) adequacy of clinical treatment and interventions; (h) adequacy
of recommendations; (i) adequacy of follow-up care; and, (j) degree
to which a psychologist has been compliant to the state’s ethical, legal
laws, and HIPPA federal guidelines. We propose the necessity for a
standardized form of evaluation of adherence with standards of care
by psychologists.

A Case in Point: How do we evaluate
our rural Neuropsychologist?

Rural and urban locations differ significantly from each other (Latta,
2006), and demographic, economic, structural, and cultural make-up
of the rural communities around a rural hospital often dictate health
care delivery to a greater degree than they do in larger population
centers. Rural health care facilities and practitioners face unique
challenges in regard to lower population, larger geographic catchment
areas, greater reliance on Medicare and Medicaid than on higher paying
commercial insurance, limited availability of cutting-edge technology,
fewer general and specialty healthcare providers, and maintaining objectivity in service provision. Furthermore, there is a

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widely held misperception that, because of these challenges, rural healthcare is somehow substandard to that of city hospitals (Latta, 2006). Nothing could be further from the truth! Rural hospitals, and the health professionals who work there, are subject to the same accreditation and regulation standards as are urban facilities. That poses dilemma for competency, standard of care, and performance evaluation of specialists who may be “one of a kind” in a rural hospital; while allied health professionals, patients, and administrators can rely on their impressions that the specialist is doing a good job, their subjective impressions do not hold water with regulating and accrediting agencies like JCAHO, which require documentation of routine review of clinical competency and compliance with standards of care. In the case of a hospital-based psychologist in a rural facility, there are no peers with the necessary knowledge base available in the hospital to conduct a competency and compliance evaluation, and a rural facility recently confronted the dilemma of how to evaluate their neuropsychologist in order to comply with JCAHO regulations. In consultation with the neuropsychologist, administration decided to go outside the facility to obtain a peer evaluation of competency that would comply with requirements of JCAHO and professional standards of care for the field and the specialty, yet still take into account the unique aspects and challenges of practicing in a rural area. The authors developed a structured evaluation form that we argue allows for objective assessment of competency and compliance, will create reproducible results, and may be adapted for use in a variety of general and specialty psychology practices.

Competency and Standard of Care Compliance Evaluation Form for a Neuropsychologist

The following Competency and Standard of Care Compliance Form (Appendix; Competency and Standard of Care Compliance in Neuropsychology) was developed for a rural hospital in Northwest Ohio. To date, review of the literature does not produce a standardized competency and standard of care form for the evaluation of a neuropsychologist’s duty of care, therefore this form was developed to aid with the peer review for competency and standard of care through review of clinical records and neuropsychological procedures and to serve as a final written evaluation report for a hospital. The form was designed to assess: (1) Level of Training; (2) Clarification of Neurological Diagnostic Concern and Clinical Interview Procedures; (3) Neuropsychological Assessment Selection; (4) Administration and Scoring of Neuropsychological Assessments; (5) Interpretation of Neuropsychological Test Results; (6) Recommendations; (7) Follow-Up Care; (8) Supervision Activities; (9) APA Ethical Guidelines for Practice in Psychology; and, (10) On-going Professional Development. This form could be utilized by peers within the neuropsychological field if requested to evaluate a colleague whom they have not met. This form was designed to be utilized in two ways: (1) Review of clinical records and (2) Interview of Neuropsychologist to clarify record keeping. The developer of the form believes that an interview with the neuropsychologist would be pertinent in assessing the neuropsychologist’s clinical judgment as well as for clarification of the clinical record. If you would like to view the full form, please contact Heather Gilbert at the OPA office, hgilbert@ohpsych.org.

References


About the Authors

Audrey E. Ellenwood, PhD is Co-chair of the OPA Communications & Technology Committee and Coordinator of the School Psychology program at Youngstown State University. Dr. Ellenwood has been a licensed psychologist since 1988 and has a clinical private practice in Sylvania, Ohio. Her specialties include family, couple and individual therapy, psychological/neuropsychological assessment, traumatic brain injury, Tourettes, neonatal/preschool assessment, attention deficit evaluations, college evaluations, autism, bariatric pre-surgical assessment for laparoscopic banding and gastric by-pass, women’s support groups, and dealing with children’s behavioral or emotional issues. She has served as president for various local, state, national and international psychological associations. Dr. Ellenwood has helped develop Ohio’s telepsychology guidelines.

Dr. Lawrence moved to northwest Ohio in 1993, having completed her PhD at the University of Manitoba in Winnipeg Canada, her pre-doctoral internship and fellowship at Baylor College of Medicine in Houston, and her post-doctoral fellowship in Rehabilitation Psychology and Neuropsychology at the University of Michigan Medical Center in Ann Arbor. Since coming to Toledo, she has worked in faculty positions as an Assistant Professor and Clinical Neuropsychologist at the Medical College of Ohio Department of Physical Medicine and Rehabilitation, and Associate Professor and Director of the Psychological Services Center at Bowling Green State University.

Dr. Lawrence continues to be actively involved in teaching psychiatry and psychology residents as volunteer clinical faculty at the University of Toledo Medical Center Department of Psychiatry. Presently, she considers herself fortunate to be able to pursue her passion for neuropsychology as the Clinical Neuropsychologist at the Community Hospitals and Wellness Centers in Bryan/Montpelier and her love of psychotherapy at the Assessment and Family Therapy Center of northwest Ohio in Sylvania.

Continued on page 20
# Standard of Care and Compliance Care in Neuropsychology

## Peer Review

### Name: Date:

### Reviewer:

### Evaluation Procedure:

### Materials Reviewed:

### Level of Training

1. **Has Acquired Proper License in State (Type and State)**
   - State: 
   - Type: 
   - License Number: 

2. **Membership in Professional Organizations Related to Discipline (List)**

### Neuropsychological Procedures:

#### Area 1: Prior to Administration of Assessment

<table>
<thead>
<tr>
<th>Compliance Area</th>
<th>Exceeds compliance standards</th>
<th>Meets compliance standards</th>
<th>Below compliance standards</th>
<th>Not applicable</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Evidence of diagnostic interview with patient prior to administration of neuropsychological assessments</td>
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<td>Conducts a thorough background history on all subjects</td>
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<td>Conducts a thorough medical file review prior to administration of neuropsychological assessments</td>
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<td>Identifies areas of neurological concerns prior to evaluation</td>
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<td>Displays appropriate selection of neuropsychological tests in order to address patients’ presenting concerns</td>
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**Additional Comments:**

#### Area 2: Administration of Neuropsychological Assessments

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<th>Compliance Area</th>
<th>Exceeds compliance standards</th>
<th>Meets compliance standards</th>
<th>Below compliance standards</th>
<th>Not applicable</th>
<th>Comments</th>
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<tr>
<td>Adequately identifies patient’s date of birth</td>
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<td>Follows standardized procedures for all neuropsychological assessments administered</td>
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<td>Accurately records patient responses in test protocols</td>
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**Additional Comments:**
### Area 3: Neuropsychological Test Interpretation

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<th>Compliance Area</th>
<th>Exceeds compliance standards</th>
<th>Meets compliance standards</th>
<th>Below compliance standards</th>
<th>Not applicable</th>
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<tbody>
<tr>
<td>Clearly describes observation of behaviors of patients during evaluation process</td>
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<tr>
<td>Records patient’s responses and adequately scores test protocols</td>
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<td>Provides a listing of tests administered and result</td>
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<td>Accurately interprets and critically evaluate the results of neuropsychological findings for each assessment administered</td>
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<td>Integrates and summarizes information to adequately address presenting concern</td>
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<tr>
<td>Accurately diagnose the patient’s neurological disorder according to either the DSM-IV or TR</td>
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<tr>
<td>Accurately diagnoses any co-morbid neuropsychiatric conditions that would impact patient’s outcomes</td>
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<td>Provides all results in a clearly articulated, well integrated written report</td>
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**Additional Comments:**

### Area 4: Recommendations Based on neurological and assessment findings:

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<tr>
<th>Compliance Area</th>
<th>Exceeds compliance standards</th>
<th>Meets compliance standards</th>
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<th>Not applicable</th>
<th>Comments</th>
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<td>Is able to develop appropriate recommendations for further intervention</td>
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<td>Adequately conveys recommendations to medical and surgical colleagues</td>
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<td>Adequately educates family members, employers, and institutions about neuropsychological disorders</td>
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**Additional Comments:**
Scheduling & To Do Lists
Streamline your practice management and workflow. Past appointments are automatically added to your To Do List. Sync your calendar to your iPhone. Great multi-clinician scheduling features.

Patient Notes & EMR
Our form-based system makes it easy to keep up with your notes. Templates were designed specifically for mental health and therapists. Also upload any files to your patient records.

Electronic Billing
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My experience with TherapyNotes this past month has been fantastic!
Firstly, the system is easy to navigate, thorough, flexible, and extremely clinically intuitive. Secondly, technical and customer support has been efficient, fast, and very personal. I am leaving another EHR system for TherapyNotes... gladly. I’m very happy that you’ve created such a quality product. Thank you!

Dr. Cristina Zampito, FT, Licensed Clinical Psychologist

Just want to say that I truly love the system!
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Kathleen Werner, RCC-S

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**Abstract**

The evolution of health care has brought models of treatment including Accountable Care Organizations and Patient-Centered Medical Homes to effect. Applications of the models, including new CPT codes and the installation of PQRS, reflect such changes. Six psychologists and one counselor, on staff at Summa Health System, outline their involvement in the provision of integrated care with medical specialties extant within the system. Services provided, interaction with patients and medical staff, and training/ experience are addressed. Participation in the four roles of psychology in health care identified by Belar (2012), i.e. teaching, research, practice (assessment, intervention, and consultation) and policy, are recognized among the positions delineated by the present authors. Limitations of the paper as well as implications for professional development are presented.

“Psychology’s Role in Integrated Health Care,” the theme of the Ohio Psychologist for 2013, is very timely. There has been a substantive number of recent developments pertinent to the delivery of mental and behavioral health services, such as the new CPT codes (American Psychological Association Practice Directorate, 2013) and the institution of PQRS standards (Centers for Medicare and Medicaid Services, 2012). These changes, however, are part of a larger process. “The healthcare landscape in which the independent practice of psychology is embedded is undergoing substantial change.” (Nordal, 2012, p. 535). Initiatives such as Accountable Care Organizations and Patient-Centered Medical Homes will have a profound effect on the field of psychology, requiring changes from traditional modes of treatment but also providing new opportunities for the field.

What follows are descriptions by six psychologists and one counselor employed within Summa Health System, a progressive multi-hospital provider located in northeast Ohio. (Although the focus of this paper is on the role of psychologists in integrated health care, it is essential to recognize the involvement of other behavioral health providers (Belar, 2012) and therefore the contribution of a staff counselor is included for completeness given his participation in Pain Medicine.) There are psychologists in the system who provide traditional psychotherapy and counseling in response to the presence of psychological disorders. However, the integrated care model is well-established, and the services offered by psychologists are not limited to a multidisciplinary care approach (Kelly & Coons, 2012).

It is important to emphasize that in the integrated care model, psychologists participate in comprehensive treatment planning established for the provision of care for an individual. In this way, psychological services are not provided in an insulated manner but are maintained in an ongoing, interactive fashion such that treatment from each specialty influences and is influenced by each other relevant specialty. A number of medical specialties are represented by the authors although there are other areas in which psychologists practice in an integrated manner (e.g. trauma, HIV, oncology) that are not presented due to limitations of this paper. Each contributor speaks in his/her own voice, outlining salient aspects of job description, services provided, interaction with other professionals, and relevant competence/training/experience.

**Family Medicine Education: Jon Thomas**

The emerging body of literature on integrated models of care falls within the context of healthcare reform pushing for medicine to have what are called Patient-Centered Medical Homes. Psychologists can impact this development by educating primary care providers in regards to how psychological issues affect health and the delivery of health care services. Currently in the medical education system the primary opportunity for this is in family medicine. Since its inception in 1969, the specialty of family medicine has adopted a more holistic view of “comprehensive health care” that includes consideration of psycho-social issues as part of diagnosis and treatment. Toward that end, they require that the curriculum in behavioral science be part of every accredited residency program under the Accreditation Council for Graduate Medical Education (ACGME). In order to accomplish this task, each program must have a designated faculty person with appropriate credentials for teaching behavioral science (Fischetti & McCutchan, 1998).

The curriculum requirements are broad and flow from guidelines provided by the American Academy of Family Physicians (AAFP). In the preamble to those guidelines it is stated that; “family physicians incorporate knowledge of human behavior, mental health and mental disorders into their every day practice of medicine.” The family physician must have competency in the following areas:

- Understand normal and abnormal development across the life cycle
- Recognize and initiate treatment and/or referrals for mental health disorders
- Effective interpersonal and communication skill for evaluative interviews on mental health disorders
- Sensitivity to and knowledge of emotional aspects of organic illness
- Ability to intervene effectively and professionally in emergent situations for psychiatric, domestic violence, child abuse and disaster
- Communication skills (AAFP, 2008)
Meeting these requirements for the residency program and the residents within the program is a huge undertaking. Meeting that challenge demands that the psychologist be flexible enough to apply their skills in various ways and in multiple settings. In order to fulfill the faculty role in residency education the psychologist must be teacher, practitioner, confidant and administrator.

The teaching role is the most obvious. However, the methodology used must be flexible. These are adult learners, who are highly intelligent and very motivated. There are formal lectures, but much of the teaching is done on the fly, one-on-one, during the course of a busy office schedule of 15 minute appointments. This one-on-one process is generally known as precepting. Precepting combines teaching with feedback to the resident about how they are doing in the skill area being discussed. This is different from traditional teaching where information is provided to the waiting learner. It requires sophisticated use of communication skills to motivate, while pointing out areas for growth or improvement in the learner. Additionally, this is a resident with whom you will have a learning relationship with for three years. The faculty – resident relationship becomes the most important vehicle through which learning can be facilitated. That skill set needs to be developed in psychologists seeking a faculty position in a family medicine residency. Typically this is done through a post-doctoral academic fellowship.

The faculty person must also be a practitioner of psychology. It is beneficial and educational for residents to see you use your skills with patients who come to the residency clinic. It provides a wonderful practical follow-up to lectures they have had on topics like diagnosis of mental disorders or brief office interventions for depression. The balance that must be struck here is that you are not establishing a psychotherapy practice for yourself. You are demonstrating skills that residents can use themselves within a busy family medicine practice. The focus remains on resident education, even as you and resident work collaboratively to serve the patient. For example, in my own setting, we have a family medicine clinic that has 10,000 patients. I could easily do therapy full-time and never run out of work. My job though, is to educate residents. So, my clinical work is always related to helping the resident develop the skill to address these issues in a busy practice. Decisions regarding when to intervene versus when to refer are crucial to good healthcare and office efficiency.

Additionally, I am viewed by residents as a confidant. Despite the highly intellectual nature of my learners, they have inadequacies that are exposed during residency training, and they need someone to seek support from. They also need advice as they develop their communication skills and deal with challenging people. Temporomandibular joint and difficult patients are just part of the territory they must learn to control as they deliver health care. Sometimes residents just need to blow off a little steam in response to the frustration of trying to be professional in difficult situations.

Finally, administrative skills are required as well. As a faculty person in a residency program most behavioral science positions carry administrative responsibilities. Curriculum development, office policies, accreditation compliance, committees and items like this are part of the job.

The faculty role provides a tremendous opportunity for psychologists to have an impact on the development of integrated models of care. It requires a diverse set of skills and the willingness to put those skills to work in new and different ways than traditionally taught in most graduate schools of psychology. Integration of services and collaborative working styles are the hallmarks of the emerging paradigm of Patient-Centered Medical Homes. The integrated model of care will be the method for making those homes more of a reality.

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**Cardiovascular Behavioral Health and Sleep Medicine: Erin Farrer**

I have the unique opportunity to practice psychology within two medical fields: cardiovascular health and sleep medicine. Both of these fields have similarities but also contain their own distinctive qualities. In the paragraphs to follow, I will highlight both commonalities and differences in addition to giving general descriptions of my work in each.

For both departments, part of my role is to provide education regarding the interplay among emotions, cognitions, and physical health. For instance, someone with sleep apnea may not realize that avoiding using their CPAP machine at night may be contributing to their feelings of depression and low motivation because they are not getting enough sleep. Likewise, some cardiovascular patients are not aware that the anxiety they experience can cause an increase in heart rate and blood pressure and interpret these symptoms as a cardiovascular event. For some individuals, knowledge about how these systems affect each other can be a great relief.

Education alone is not the only role that I play, however. For my work in cardiovascular health, my role beyond education is very specific to the patient needs. Some individuals need help adjusting to the life changes that can occur with a diagnosis of heart disease (e.g., reduced energy; low motivation; diet changes, etc.). Certainly existential issues can be a focus of treatment as well, especially if a patient has been diagnosed with heart failure or is fearful about an upcoming surgery. Some patients need help with smoking cessation which may be a goal for treatment. Others who experienced a life-threatening cardiac event may have trauma symptoms and so reducing anxiety symptoms is key. For sleep medicine, the role of a psychologist is not as varied. Usually the treatment is shorter and consists of discovering barriers that contribute to unhealthy sleep habits and behaviors to help them “re-learn” how to sleep. Maintenance of healthy behaviors is crucial for both cardiovascular and sleep patients.

For both cardiovascular health and sleep medicine, the treatment of choice is typically cognitive-behavioral treatment (CBT). Evidence shows that CBT is helpful in reducing depression and anxiety in cardiovascular patients (Dornelas, 2008). Cognitive-behavioral treatment for insomnia (CBT-I) has also been effective in treating sleep disorders; not only for adjusting maladaptive sleep behaviors but for modifying dysfunctional beliefs about sleep and insomnia as well (Perlis, Aloia, & Kuhn, 2011; Morin, 1993). For both areas of medicine, individuals may be apprehensive or ambivalent about changing behaviors to more health-promoting behaviors. In these instances, motivational interviewing can be helpful (Rollnick, Miller & Butler, 2008). As mentioned previously, individuals who have received a life-changing cardiovascular diagnosis may benefit from supportive and/or values-based treatment for existential concerns. Generally, though, CBT is the first-line of treatment in both fields.

My experience in working with the medical staff in cardiovascular health and sleep medicine has been positive. Generally, most of the referrals for both areas of medicine come from either physicians or nurses. I encourage medical staff to contact me with questions about appropriate referrals, and typically, they do not hesitate to do so. Additionally, if a physician or other medical provider has provided a referral, I reciprocally send the referral source a copy of the intake report with the treatment plan. I have also found that the medical staff regularly follow-up with patients that they have referred for behavioral health treatment.

I do not have additional certification for working in cardiovascular health or for sleep medicine. At this point, there is no additional certification needed for cardiovascular behavioral health. However, for practicing in sleep medicine, further certification is available for psychologists. After training and an exam, psychologists can earn the letters “CBSM” – Certified in Behavioral Sleep Medicine. To practice psychology in both of these fields, it is important to have some knowledge of the medical terminology as well as the medications (including side effects) that are commonly used. Of course, training in CBT is crucial in order to increase the chances of lasting behavioral change.

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**Bariatric Care: Shannon Perkins**

My role as the psychologist at Summa Health System’s Bariatric Care Center involves many different responsibilities. I provide psychological evaluations for patients seeking bariatric surgery, consultation to the
multidisciplinary team, psychotherapy to address binge eating and comorbid psychopathology such as mood and anxiety disorders, and post-operative support groups.

At Summa, our multidisciplinary bariatric team also includes surgeons, a family physician, a nurse practitioner, dieticians and RN case managers. I am located full-time within the same office suite as the rest of the Bariatric Care Center staff. Compared to my previous experiences conducting evaluations for bariatric surgery as a member of a different hospital department or different facility, being a full-time member of the team greatly facilitates communication and has given me a much richer understanding of the impact of weight loss surgery on the lives of our patients.

A primary goal of the pre-operative evaluation is to determine whether a patient is an appropriate candidate for surgery from a psychological perspective. My evaluation process consists of an interview with the patient, brief psychological testing, and a second follow-up visit. Consulting with the team throughout the process can give me additional information in terms of how the patient interacts with other staff members and their adherence to and understanding of the lengthy pre-surgical evaluation process.

My goal is to have an assessment of the following issues: motivation and expectations for surgery; understanding of the surgical procedure, including risks related to surgery and post-operative lifestyle changes; cognitive, memory or learning problems; eating habits, particularly focusing on the presence of binge eating and emotional eating behaviors and adherence to their pre-operative physician-supervised diet program; and psychopathology, such as mood disorders, anxiety disorders, psychotic disorders and substance abuse.

There is no clear consensus regarding psychological contraindications to weight loss surgery (Fabricatore, Cerand, Wadden, Sarwer, & Krasucki, 2006). However, like other psychologists who perform bariatric surgery evaluations, I do not recommend patients for surgery when uncontrolled psychotic disorders, active substance abuse or severe cognitive impairment are present. In the case of other conditions, such as major depressive disorder or anxiety disorders, I evaluate how well the disorder is controlled. I am concerned about the likelihood of symptoms interfering with the patient’s ability to cope with invasive medical procedures and hospitalization as well as maintain life-long changes to their eating and exercise behaviors. Many patients who are seeking weight loss surgery are suffering from untreated or inadequately treated psychopathology. In many cases, these conditions can be successfully treated with psychotherapy, psychiatric consultation or a change in medications through their primary care provider. What I enjoy the most about my position is the opportunity to intervene with patients who would not have otherwise sought out mental health care. I also provide psychotherapy to many patients after surgery to address psychosocial changes in adjustment to surgery and weight loss, exacerbations of mood or anxiety disorders, or exacerbations of binge or emotional eating behaviors.

During the evaluation, I always inquire about traumatic experiences. A high proportion of bariatric patients have been the victim of sexual abuse, physical abuse and emotional abuse in childhood or adulthood (cf., Grilo, Masheb, Brody, Toth, Burke-Martindale, & Rothschild, 2005). In each case, it is important to understand how the trauma history may impact the individual’s symptoms of PTSD, depression, binge eating and substance use. I am also working on a research project in consultation with Summa’s Center for Treatment and Study of Traumatic Stress, and preliminary findings suggest that patients with a history of sexual abuse may lose less weight by 12 months after surgery (Harrington & Perkins, 2011).

I also conduct a monthly support group for post-operative patients called “Staying on Track.” This provides patients with an opportunity to discuss barriers to adherence to their post-operative diet and exercise programs, exchange nutrition and exercise tips with each other, discuss emotional and interpersonal changes since surgery, and generally give each other support and encouragement.

Inpatient General Medical Hospital: Rod Myerscough

The integration of psychology into an inpatient general medical hospital requires adjustments to the usual way we work with patients. Admittedly, it is an exaggeration to compare the challenges of working in a hospital setting to a MASH unit but on some days the comparison seems particularly apt. The typical setting, a patient’s room, is peppered with an assortment of distractions. At any moment the interview can be interrupted by the arrival of a nurse to administer medication, an aide, a housekeeper trying to clean the just vacated bed of the patient’s roommate, another physician consultant, the patient’s roommate, families and friends, telephone calls or a visit from the patient’s priest, pastor, or rabbi. They are all coming and going with solid justification while the psychologist tries to interview the patient who may be sleepy, in pain, frightened, nauseous, or worried about issues at home or work. It commonly occurs that the patient’s primary care physician consulted psychological services without first consulting the patient or gaining the patient’s permission so that when the psychologist arrives she must introduce herself, explain the reason for her visit, and gain the patient’s consent to proceed with an evaluation. Needless to say, many patients are surprised, some are resistant, others are embarrassed, some are quite welcoming, and still others are nonplussed by the psychologist’s arrival.

The psychological assessment of the medical patient in an inpatient setting is also limited by time. Very often the psychologist will only have a single one hour long encounter with the patient. Sometimes there are multiple visits but there is nothing predictable about this. Therefore, the psychologist must be prepared to accomplish a number of tasks in a short period of time. He must rapidly develop sufficient rapport to allow a quick descent into personal matters. He must gather enough information to answer the referring physician’s question. This requires, of course, an assessment of the patient’s current psychological well-being, the clarification of the interacting influence of medical illness and psychological functioning, the development of a treatment strategy, an assessment of the patient’s readiness to pursue recommendations, and identification of who will see the treatment plan through to completion. The successful consultation will also be conducted in such a way that the patient will have a therapeutic experience sufficient to leave him appreciating that the physician consulted the psychologist. With practice all of this can be accomplished.

The psychologist working in an inpatient medical setting must be a generalist and must be comfortable working with a wide variety of patients. Medical hospitals have a unique culture and the psychologist who wishes to be effective needs to learn how to operate in it. There is a new vocabulary, new ways of thinking about illness, and new customs that must be learned. There is a premium placed on being able to think creatively and to adapt to changing conditions. Naturally, the sights, sounds and smells of the hospital must be tolerated. Whereas patients certainly bring tragedies to the psychologist’s outpatient office, in the hospital the tragedies are often happening right before our eyes. All of this requires resilience in the psychologist and a willingness to work collaboratively with multiple professions.

Physicians and other hospital professionals deeply appreciate the work of the psychologist who can be effective. They want the best for their patients and are deeply grateful whenever their patients’ lives are improved by our interventions. Patients too are appreciative of their treatment team when they are able to move the patient from illness to health, and psychologists have a vital role to play in this transition.

Pain Medicine: Leon Howard & Gary Sipps

The Behavioral Health Service at Summa Western Reserve Hospital Center for Pain Medicine has over the past several years developed a system where the medical and behavioral health staff members provide patients with a comprehensive treatment approach in the management of chronic and acute pain. We endorse an integrated patient-centered approach that is consistent with the biopsychosocial (Gatchel, et al., 2007) and behavioral (Fordyce, et al., 1984) models of chronic pain.
When medical professionals and behavioral health clinicians assess a patient’s pain they must consider how pain may influence behavioral, psychological and social functioning (Sips and Howard, 2009). To treat the complexity chronic pain brings to a patient’s life, the Center for Pain Medicine at Summa Western Reserve Hospital team consists of, board-certified anesthesiologists, nurse practitioners, nurses (RN and LPN), physical therapists, a psychologist, a counselor and a pharmacist. As a behavioral health professional working in a multidisciplinary pain medicine department, our responsibilities include: health and behavior assessment, health and behavior intervention (e.g. education regarding sleeping, eating habits, exercise, and smoking as it relates to experienced pain), pain management psychotherapy and counseling, hypnosis, biofeedback, relaxation training, stress management, psychological evaluation and testing, substance abuse screening, and professional consultation and referral.

We spend a considerable amount of time conducting Health and Behavior Assessments (HBA), or doing pain management psychotherapy, assessing and determining ways to maximize and execute a plan of care. We present patients with educational material and interventions to help them cope with their chronic pain. We assist patients in developing realistic expectations about pain relief. One of our primary goals is to help patients maintain or increase their day-to-day functioning with the use of practiced pain management strategies. Quality of life factors are addressed. Often patients struggle to make lifestyle changes necessary to optimize benefits provided by medical interventions. There are common themes which tend to be relevant for those with chronic pain conditions, although specific areas of focus are determined for each patient.

Training and experience in health psychology, with a focus on chronic pain is necessary to be in a position of providing behavioral health services with this client population. Familiarity with the variety of pain-related medical conditions, medications, procedures, and treatment plans allows the psychologist to offer the most effective treatment to clients and efficient consultations with medical providers. There are credentials available specifically for pain management (cf. American Academy of Pain Management) although these are not required at this time as prerequisite to provide such services. One need not be on staff in a hospital system to provide psychological pain management services. Jamison and Edwards (2012) for example, outline means by which a psychologist might add this service to his/her clinical practice.

Psychiatry/ Behavioral Health Administration: David Brinkman-Sull

As Vice Chair of Psychiatry and chief Psychologist of Summa Health System, a seven hospital Regional Health Care System in Akron, Ohio, I have wrestled with the challenges of integrating behavioral health services into the health care delivery system. In addition to the common challenge of getting a system that was built around the medical model to respect and support a biopsychosocial model of health care, the current fee for service reimbursement environment remains one of the biggest barriers to fully integrated care. Fortunately for our patients, reform of the health care reimbursement system is currently underway. However, the reform is happening in steps over the coming years and fee for service payments will remain in place for several years to come. As a result, this time of transition requires creativity and foresight to succeed in the current business model while preparing for the model of the future.

At Summa Health System we have created new initiatives to bring behavioral health interventions to as many patients as possible within our health system. The first initiative was to partner with a local Community Mental Health Center, Coleman Behavioral Health (CBH) and invite them to set up outpatient clinics in two of our city hospitals. One of these clinics is in close proximity to two large hospital based primary care practices that serve a large proportion of Medicaid, low income and indigent patients. The purpose of this collaboration was to address the reality that our hospital’s primary care clinics serve a large proportion of uninsured and Medicaid patients, and our Summa Health System outpatient behavioral health providers receive little or no reimbursement when they see these patients. CBH providers can treat these patients and receive a reasonable reimbursement. By bringing the CBH providers onto our campus we have greatly improved the likelihood that the patients seen in our primary care offices will follow through with their behavioral health appointments and we have improved the level of communication between the medical and behavioral health clinicians sharing these cases. We anticipate that this partnership will improve the continuity of care provided to our patients going forward.

A second initiative was designed to embed behavioral health clinicians directly into our primary care offices at Summa. Because of the current limited financial climate, funding for such positions would only be approved if they could be shown to support themselves with billing revenues. We did not see this as a realistic possibility so we applied for and received a grant from the Margaret Clark Morgan Foundation, a local funder supportive of improving the mental health of local residents, to fund a pilot project in which we will integrate behavioral health care providers within two large hospital based primary care practices and study the outcomes. This funding allows us to embed one therapist and one case manager in each practice where they can provide a variety of behavioral health services without worrying about billing for their clinical work. These clinicians will provide brief evaluation and treatment of patients for one to four visits and will offer behavior modification, psychoeducation, brief cognitive therapy, and motivational interviewing with the ultimate goal of improving the health of the patients served by these clinics. The research we will conduct will measure mental health, physical health, health care utilization and financial outcomes. We hope to demonstrate the value and sustainability of integrating behavioral health into health care settings. This is not a new idea but our system administrators need to see the evidence that this is a cost effective and higher quality approach to care before they will invest more resources toward expanding this integrated approach.

The third new initiative we are pursuing is to shift the way we provide psychiatric consultation/liaison services to our inpatient medical units. This new approach involves having a psychiatrist or psychologist work as an integrated part of the inpatient treatment team on a medical unit and to briefly review each patient that is admitted to the unit on the day of admission to determine which patients need a more extensive psychiatric consultation and which patients will not need further psychiatric assessment. When a psychiatric consultation is recommended it will occur early on the first day of admission and an appropriate plan can be implemented in a more timely fashion. This approach also allows for timely identification of patients who may need intensive psychiatric intervention and connects the patient with this care on the first day of admission. Our hope is to get the appropriate care to each patient in a timely manner which should reduce the length of stay of patients with medical and mental health diagnoses and improve patient and provider satisfaction with the care provided on this medical unit.

Summary

The preceding presents a variety of positions in which psychologists are integrated providers in a large hospital system in northeast Ohio. It is apparent that patients of and professionals in a number of medical specialties benefit from the services that psychologists provide. It is noteworthy that the four roles of psychology in health care identified by Belar (2012), i.e. teaching, research, practice (assessment, intervention, and consultation) and policy, are represented. Both in-patient and out-patient populations are served. A psychologist is able to practice in more than one specialty.

Regardless of the setting in which a psychologist practices and regardless of his/her practice specialty, he/she might give serious consideration to attaining board certification with the American Board of Professional Psychology (ABPP). Board certification is the sine qua non in medicine. The ABPP distinction conveys to both providers in medical practice as well as to consumers that the psychologist has met the requirements necessary to earn and maintain the diploma. As the integration of health care evolves, ABPP certification will likely become more valuable.
These factors provide encouragement to psychologists considering the opportunities afforded by new trends in the provision of health care. Although implementation of the Patient Protection and Affordable Care Act is an ongoing and uncertain process, there are currently areas in which psychologists can play an active role within the new models. Such options are not limited to those working within a health system. Nordal (2012) and Kelly & Coons (2012) for example, explore the implications, both opportunities and challenges, of the changes in health care models for those in independent practice.

There are limitations in the present paper. One health system in northeast Ohio is represented. Not all specialty areas which are integrated with psychology within Summa Health System are outlined, e.g. oncology, trauma. There are populations/medical specialties outside the realm of this system such as pediatrics.

We hope that this paper both informs and inspires. There are circumstances favorable to psychologists in place or in the works. However, as policies are developed it is necessary that psychologists take an active part in determining what course health care takes. What exists at Summa Health System provides one reality of this vision. Initiative and effort will guide what proceeds from this point.

References


About the Authors

David Brinkman-Sull, PhD is currently Vice Chair of Psychiatry, Chief Psychologist, and Director of Behavioral Health Services for the Summa Health System, a seven Hospital health system in the Akron, Ohio region. Behavioral Health Services at Summa Health System includes Inpatient Psychiatry, Geropsychiatry and Alcohol Detox units, Intensive Outpatient programs for chemical dependency and mental health, Consultation Liaison services, and outpatient psychiatry and therapy services. Summa also provides integrated behavioral health care in medical specialty clinics including Cardiology, Oncology, Palliative Care, and Bariatric Surgery. Dr. Brinkman-Sull received his PhD in clinical psychology from Case Western Reserve University in 1996 and received internship and post doctoral fellowship training at the University of Rochester School of Medicine. Past professional positions include Manager of Outpatient Services at Summa Health System, Director of Training and Assessment Services at Applewood Centers in Cleveland, Ohio, and Director of Adolescent Eating Disorder Programs at Laurelwood Hospital in Eastlake, Ohio.

Erin Farrer, PhD has been working as a staff psychologist for Summa Physicians, Inc. since January 2011. She completed her undergraduate training at the University of Michigan and graduate training at the University of Toledo. Her time is currently split between the Center for the Treatment and Study of Traumatic Stress, Summa Cardiovascular Institute – Behavioral Health, and Behavioral Sleep Medicine. She works with adult patients in individual and group settings. She primarily focuses on providing treatment strategies from Cognitive Behavioral Treatment, Acceptance and Commitment Therapy, and Dialectical Behavior Therapy.
Leon Howard, PhD is a Licensed Professional Clinical Counselor-Supervisor who has worked in the counseling field for the past 14 years. Currently he splits his time between working as a consultant, teaching at the University of Akron and working at The Center for Pain Medicine at Summa Western Reserve Hospital in Cuyahoga Falls, Ohio.

Rod Myerscough, PhD earned his PhD in clinical psychology from Kent State University in 1984. Since that time he has worked in a variety of inpatient and outpatient settings in Ohio and Virginia, including adolescent and adult psychiatric units, Employee Assistance Programs, a Functional Rehabilitation Program for chronic pain, and inpatient medical rehabilitation. Since 1990 he has been providing inpatient psychological evaluations with the Consultation-Liaison Psychiatry Service at Akron City Hospital and since 2008 he has been working in Palliative and Hospice Care. He has a special interest in the role of mindfulness and self-care for healthcare professionals.

Shannon Perkins, PhD completed her undergraduate degree at Kent State University and received her PhD from St. Louis University in 2001. She completed a post-doctoral fellowship in Clinical Health Psychology at the Cleveland Clinic and was then employed as a staff psychologist there until 2009. She joined Summa Physicians, Inc in 2009 and provides clinical services full-time within Summa Health System’s Bariatric Care Center.

Gary J. Sipps, PhD, ABPP earned a B.A. in Psychology from Rutgers University in 1976 and a PhD in counseling psychology at The University of Maryland in 1981. He completed a traineeship at the Washington, DC Veterans Administration Hospital and pre-doctoral internship on the staff of Student Counseling Services at Iowa State University. He was a member of the Psychology Department faculty at The University of Akron from 1981 until 1994. He began a private psychology practice in 1983 and continues to perform psychological evaluations on a consulting basis. Since 2006 he has been on the staff of The Center for Pain Medicine at Summa Western Reserve Hospital Behavioral Health Service.

Jon Thomas, PhD completed his doctoral studies at the University of Akron (1980) with an internship at Fallsview Psychiatric Hospital in Cuyahoga Falls, Ohio. He became Associate Director of the Summa Akron City Hospital Family Medicine Residency in July 2000, following 20 years as Clinical Director of the Child & Adolescent Service Center in Canton, Ohio. He completed a Fellowship in Academic Medicine at NEOUCOM in 2001. He is also an Associate Professor of Family Medicine at Northeast Ohio Medical University.

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Using Mouse Tracking to Examine the Time Course of an Auditory Lexical Decision Task

Maura L. Krestar, MA, Sara Incera, MS and Conor T. McLennan, PhD
Cleveland State University

Abstract

Mouse-tracking studies demonstrate that hand movements reveal the progression of responses over time during psychological tasks. In the present study, we examined the time course of cognitive processing during an auditory lexical decision task. The following predicted results emerged to indicate facilitation for words relative to nonwords: 1) shorter reaction times; 2) fewer direction changes, and, compared to the ideal trajectory; 3) smaller deviation; and, 4) area under the curve for words relative to nonwords. We also found predicted differences between words and nonwords in velocity throughout the trials, providing a greater understanding of the real-time processing dynamics throughout the course of spoken word recognition.

Mouse Tracking

Recent research has shown that hand movements with the mouse can reveal how processing changes over the course of responding to psychological tasks (e.g., Spivey, Grosjean, & Knoblich, 2005; Freeman, Dale, & Farmer, 2011). Mouse tracking allows for the examination and comparison of two-dimensional mouse trajectories during online, continuous competition between multiple response options. In this way, movement toward the correct response reflects facilitation, and movement toward the incorrect response reflects interference. Because many cognitive processes occur rapidly, a continuous measure with considerable temporal resolution such as mouse tracking is optimal.

Spoken word recognition is one online cognitive process that occurs with no hearing or speech disorders received partial course credit for participation.

Materials

Auditory stimuli consisted of 12 monosyllabic English words spoken by a male and 12 spoken by a female, 12 monosyllabic nonwords spoken by a male and 12 spoken by a female, and eight monosyllabic control items (four words, four nonwords). All words and nonwords were taken from Experiment 2 of McLennan and Luce (2005). Nonwords from this experiment were created by using sequences with low phonotactic probability, determined by positional segment frequency and biphone frequency.

Procedure

For each trial, participants clicked “START” at the bottom center of the screen, cueing the onset of the auditory stimulus over headphones and the response timer. Participants then clicked one of two buttons at the top right and left corners of the screen labeled “Word” and “Nonword”, respectively. Figure 1 shows a screenshot during the auditory lexical decision task. The MouseTracker software first rescales all trajectories into a standard coordinate space, which has been used in previous research by Freeman et al. (2011). It represents a 2 X 1.5 rectangle, which retains the aspect ratio of most computer screens, leaving the start location of the mouse (at the bottom center of the screen) with the coordinates (0.00, 0.00; See Figures 1 and 2).

Results

See Table 1 for descriptive statistics. Results showed that RTs to words were shorter than RTs to nonwords, t (71) = -10.30, p < .0001. Participants also made fewer direction changes (i.e., x-flips) in response to words compared to nonwords, t (71) = -3.03, p = .002. Trajectories for words had smaller maximum deviations from the ideal trajectory (a straight line from the center of the start button to the center of the correct response alternative) compared to nonwords, t (71) = -12.42, p < .0001. See Figure 2, which displays the mean online mouse...
trajectories for words and nonwords (after responses to nonwords were remapped 90 degrees to the right for comparison). Trajectories for words also had smaller area under the curve compared to the ideal trajectory relative to nonwords, t (71) = -11.31, p < .0001.

A 2 (Stimuli: word, nonword) x 6 (Time Bin: 100-300 ms, 300-500 ms, 500-700 ms, 700-900 ms, 900-1100 ms, 1100-1300 ms) repeated measures ANOVA on velocity showed significant main effects for stimuli, F (5, 355) = 11.87, p = .001 and time bin, F (5, 355) = 103.53, p < .001, qualified by a significant Stimuli x Time Bin interaction, F (5,355) = 39.92, p < .001. Based on the significant interaction, separate ANOVAs were conducted for each time bin. As predicted, results of the ANOVA showed that participants moved the mouse faster for words than nonwords during first three time bins, faster for nonwords during last two time bins, and converge during the last time bin. Table 2 displays differences in mean velocity of the mouse trajectories for words versus nonwords during six successive time bins.

Discussion

As predicted, RTs to correct responses to words were significantly shorter than to nonwords. In addition, compared to the ideal trajectory (a straight line from "START" to the correct answer), the area under the curve for correct responses to words was on average significantly smaller than for that of nonwords. These results are consistent with previous research using a visual lexical decision task and mouse tracking (Barca & Pezzulo, 2012), suggesting that spatial attraction to the incorrect response was larger for nonwords compared to words. Finally, analyses of velocity over time provided information regarding the real-time dynamics of the perceptual processing over the course of a trial. Velocity results suggest that participants moved the mouse faster sooner on average for words compared to nonwords, providing evidence for an effect of facilitation on velocity for words relative to nonwords. Thus, a lexicality effect, reflecting differential processing of words and nonwords, was evident as early as 100 ms into a mouse movement. This evidence of a lexicality effect emerges much earlier using mouse tracking during an auditory lexical decision task relative to what has been reported previously with RT data in studies using traditional button-push responses. It is possible that end-point measures, such as RT and accuracy, may be providing an incomplete picture – or even leading researchers to miss effects altogether. Continuous measures, like that of mouse trajectories, may be more appropriate for examining some aspects of spoken word recognition, as well as other cognitive psychological phenomena.

The results of the current study contribute to the understanding of the online processes involved in spoken word recognition. Moreover, the results provide a solid base from which to examine additional issues (e.g., priming effects) in spoken word recognition.

References


![Figure 1. Screenshot during auditory lexical decision task.](image-url)
Figure 2. Average mouse trajectories for words (in purple) and nonwords (in blue) after remapping all nonword trajectories 90 degrees to the right. Dotted line represents the ideal trajectory used to compute maximum deviation and area under the curve measures.

Table 1

Descriptive Statistics for Words and Nonwords (n = 72)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Word Mean (SE)</th>
<th>Nonword Mean (SE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>RT *</td>
<td>1040 (23) ms</td>
<td>1261 (27) ms</td>
</tr>
<tr>
<td>x-flips *</td>
<td>7.5 (0.2) flips</td>
<td>8.1 (0.2) flips</td>
</tr>
<tr>
<td>Maximum Deviation *</td>
<td>0.25 (0.03)</td>
<td>0.81 (0.03)</td>
</tr>
<tr>
<td>Area Under the Curve *</td>
<td>0.51 (0.05)</td>
<td>1.91 (0.10)</td>
</tr>
</tbody>
</table>

Note. * p < .01.
### Table 2

*Differences in Mean Velocity of Mouse Trajectories for Words and Nonwords for Six Equal Time Bins (n = 72)*

<table>
<thead>
<tr>
<th>Time Bin (ms)</th>
<th>Word Mean (SE)</th>
<th>Nonword Mean (SE)</th>
<th>$F$ (1, 71)</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>100 to 300</td>
<td>.026 (.006)</td>
<td>-.022 (.004)</td>
<td>26.51</td>
<td>&lt; .001</td>
</tr>
<tr>
<td>301 to 500</td>
<td>.085 (.010)</td>
<td>-.065 (.009)</td>
<td>75.70</td>
<td>&lt; .001</td>
</tr>
<tr>
<td>501 to 700</td>
<td>.113 (.009)</td>
<td>.025 (.013)</td>
<td>23.10</td>
<td>&lt; .001</td>
</tr>
<tr>
<td>701 to 900</td>
<td>.092 (.008)</td>
<td>.218 (.014)</td>
<td>47.46</td>
<td>&lt; .001</td>
</tr>
<tr>
<td>901 to 1100</td>
<td>.067 (.009)</td>
<td>.171 (.012)</td>
<td>39.95</td>
<td>&lt; .001</td>
</tr>
<tr>
<td>1101 to 1300</td>
<td>.040 (.009)</td>
<td>.048 (.010)</td>
<td>0.333</td>
<td>.566</td>
</tr>
</tbody>
</table>

### About the Authors

**Maura L. Krestar, MA** is a fourth year doctoral candidate in the Adult Development and Aging program at Cleveland State University. Her research interests include spoken word recognition in younger and older adults, as well as other areas of cognitive aging and psychosocial issues in normal older adults and those with dementia. In addition to working as a Research Assistant in the Language Research Laboratory, she has also taught Introductory Psychology and Gerontology courses at Cleveland State University. Corresponding Author:

Maura L. Krestar, MA  
Psychology Department  
Cleveland State University  
2121 Euclid Avenue  
Cleveland, Ohio 44115  
Phone: 216-687-3834  
Fax: 216.687.9294  
Email: m.krestar@csuohio.edu

**Sara Incera, MS** is a first year doctoral student in the Language Research Laboratory at Cleveland State University. Before moving to USA, she had research experience in universities in Ireland and Spain. She is also a licensed Spanish teacher and has worked in multicultural and bilingual settings. Her research interests include: bilingualism, biliteracy, cognitive psychology, spoken word recognition and language development. She is currently conducting research using the innovative software MouseTracker. Corresponding Author:  

Sara Incera, M.S.  
Psychology Department  
Cleveland State University  
2121 Euclid Avenue  
Cleveland, Ohio 44115  
Phone: 216-687-3834  
Fax: 216.687.9294  
Email: saraincera@gmail.com

**Conor T. McLennan, PhD** is the Director of the Language Research Laboratory and an Associate Professor in the Psychology Department at Cleveland State University. Dr. McLennan is also currently serving as the Interim Special Assistant to the Vice President for Research. His research program, which has received funding from the National Institutes of Health: National Institute on Deafness and Other Communication Disorders, explores the representations and processes involved in the perception of spoken language in younger and older adults. Read more about the research being conducted in the Language Research Laboratory by visiting HYPERLINK "https://www.facebook.com/languageresearch" https://www.facebook.com/languageresearch.  

Corresponding Author: Conor T. McLennan, PhD  
Associate Professor  
Psychology Department  
Cleveland State University  
2121 Euclid Avenue  
Cleveland, Ohio 44115  
Phone: 216.687.3750  
Fax: 216.687.9294  
Email: c.mclennan@csuohio.edu
Abstract

We examined the continuous dynamics of the Stroop task using mouse-tracking. Participants moved the computer mouse to indicate the color of words presented on the computer screen in both congruent (blue in blue font) and incongruent (blue in yellow font) conditions. Mouse-tracking data revealed significant differences in reaction times, spatial attraction, and velocity. In the Stroop effect, word reading and color processing influenced performance, but they did so differently: word reading influenced the early part of the mouse trajectory, but color processing influenced later parts. The data provide important new information about the real time processing dynamics underlying the effect.

Method

MouseTracker measures were used during the performance of the classic Stroop color-naming task (Stroop, 1935). Following Klein (1964), four color words (BLUE, GREEN, RED, YELLOW) were presented in the middle of the screen in all four colors. Ten participants were instructed to indicate the color of each stimulus by moving the mouse from the bottom center to the responses (top right or left). Clicking START triggered the stimulus to appear in both the congruent (blue in blue font) and incongruent (the word blue in yellow font) conditions. Practice trials (XXXX in all colors) served as the control.

Data were collected every 13-16ms. All responses were remapped 90 degrees to the right (Freeman & Ambady, 2010); therefore, correct responses are always on the right and incorrect responses on the left when presenting the results (Figure 1). Within participant t-tests were performed for the overall measures (RTs and area under the curve).

Discussion

The mouse-tracking measures supplied rich trajectory data that revealed robust and significant differences in RTs, spatial attraction, and velocity. First, there were no differences in spatial attraction until around 350ms, the point at which we argue word reading occurred. Participants moved toward the correct response on congruent trials, toward the incorrect response on incongruent trials, and remained neutral in control trials (Figure 1). Second, participants moved toward the incorrect response on incongruent trials until color processing occurred (around 800ms, CI 95%: 674ms-983ms). Velocity data support this argument; congruent trials sped up while incongruent trials slowed down due to interference (Figure 2). These findings support the idea...
that word-related information (i.e., reading) is processed earlier than the color. Overall, we have evidence that 1) word reading and color processing both influence performance in a Stroop task, and 2) they do so at different times. Word reading influenced the early part of the mouse trajectory, and color processing influenced later parts of the mouse movement. To our knowledge, this is the first experiment that used the mouse-tracking paradigm to determine precisely when word reading and color processing occur.

One limitation of the current experiment is that the generality of the time-course differences is unknown. The time-course effects may differ with different stimuli, exposure rates, or a different form of interference. Nevertheless, we believe the order of the processes (first word reading, second color processing) is likely to remain stable. Future directions will directly examine the contribution of interference and facilitation processes, as well as variations of the Stroop task with different populations and different stimuli.

In conclusion, despite over 75 years of research using the Stroop task, these data provide important new information about the real time processing dynamics underlying the effect, revealing the order in which word reading and color processing occur. These results add to our knowledge of the Stroop effect, and to our knowledge of how mouse-tracking could be used to provide a deeper understanding of the time-course of cognitive processes. We agree with MacLeod (1991) that the Stroop effect will continue to challenge research psychologists, but we hope the empirical findings and theoretical implications of the current study contribute to the progress he predicted in the Stroop literature in the new millennium.

References


About the Author

Sara Incera, MS is a first year doctoral student in the Language Research Laboratory in the Psychology Department at Cleveland State University. Before moving to the USA, she gained valuable research experiences at University College Cork, in Ireland and the University of Salamanca, in Spain. She is also a licensed Spanish teacher and has worked in multicultural and bilingual settings. Her research interests include: language development, bilingualism, biliteracy, spoken word recognition, and examining how these processes may differ between younger and older adults. She is currently conducting research using the innovative software MouseTracker.

Corresponding Author:
Sara Incera, MS
Psychology Department
Cleveland State University
2121 Euclid Avenue
Cleveland, Ohio 44115
Phone: 216-687-3834
Fax: 216-687-9294
Email: saraincera@gmail.com

Conor T. McLennan, PhD
Associate Professor
Psychology Department
Cleveland State University
2121 Euclid Avenue
Cleveland, Ohio 44115
Phone: 216.687.3750
Fax: 216.687.9294
Email: c.mclennan@csuohio.edu

Teresa A. Markis, MA
Psychology Department
Cleveland State University
2121 Euclid Avenue
Cleveland, Ohio 44115
Phone: 216-687-3834
Fax: 216-687-9294
Email: t.markis@csuohio.edu

Corresponding Author:
Sara Incera, MS
Psychology Department
Cleveland State University
2121 Euclid Avenue
Cleveland, Ohio 44115
Phone: 216-687-3834
Fax: 216-687-9294
Email: saraincera@gmail.com

Figure 1: Mouse-tracking data for Incongruent, Control and Congruent conditions.

Figure 2: Online Velocity for Incongruent and Congruent conditions.
Exploring the Social and Developmental Roots of Social Mimicry in Preschool Children

Ali Clark-MacKeown, BA and September N. Staley, BA
Ohio Dominican University

Author Note
The authors would like to note that each co-principal investigator contributed equally to the experimental design, data collection, and reporting of these findings. The authors declare no conflict of interest in this study.

The present research was supported by Dr. John M. Marazita and the Ohio Dominican University Department of Psychology as part of a research requirement.

Abstract
Social mimicry, which includes behavioral congruence and similarity in intentions, fosters social relationships (Ondobaka, de Lange, Newman-Norlund, Wiemers, & Bekkering, 2012). This study seeks to explore the social and cognitive foundations of social mimicry during a one-on-one interaction with preschoolers in order to explore the developmental roots of mimicry. Current research suggests that top-down processing may be employed in the decision to imitate an action; however, the study will explore the possibility that young children have not yet developed this ability and alternatively employ automatic processes. Preschoolers played a game in which they touched the larger of two shapes. During the trials, the experimenter subtly reached for either the correct or incorrect shape in order to measure the degree to which young children are sensitive to anticipatory movements. Results seem to show an increase in RT and error rate as a function of the experimenter’s misleading hand movement.

Social Mimicry
Social mimicry is thought to facilitate synchrony between social partners (Ondobaka et al, 2012). Current research focuses on cognitive-mechanistic explanations of social mimicry and has provided support for both automatic and deliberate processing. Social mimicry may occur as a result of repeatedly observing a social partner’s movements (Ondobaka et al, 2012). This may occur even in the absence of common goals between social partners (Ondobaka et al, 2012), as in opponents playing a game. Imitation and social mimicry are thought to facilitate social encounters and assist in the creation of self-identity (Meltzoff & Moore, 1994). As a result, of their findings, Meltzoff and Moore (1994) state, “imitation is to understanding people as physical manipulation is to understanding things”.

Factors that Influence Social Mimicry
Mirror neurons fire in the inferior cortex when observing another person perform goal-oriented actions (Ocampo & Kritikos, 2011). Mirror neurons also seem to discriminate between substantially identical grasping actions associated with different intentions (Iacoboni, 2005). These properties suggest that mirror neurons provide abstract coding of both actions and intentions, thus creating the basis for an understanding of others (Ocampo & Kritikos, 2011).

Infants as young as six months have been found to match facial movements, specifically tongue protrusions (Meltzoff & Moore, 1994). Imitation research suggests that a variety of simple gestures is also imitated; including lip, head and hand movements. Infant imitation requires perceptual skills, cross-modal coordination and motor control (Meltzoff & Moore, 1994).

Early imitation is mediated by one of two processes: Active Intermodal Mapping (AIM) or Innate Releasing Mechanisms (IRM) (Meltzoff & Moore, 1994). AIM occurs when there is a genuine matching to a target caused by cross-modal equivalence between body transformations that are seen and felt in order to generate a matching response. IRM are responsible for imitation when there is no real matching to a target, rather a person sees an action and a fixed-action pattern is released (Meltzoff & Moore, 1994). This mechanism falls in line with mirror neuron research; in order for imitation to occur, a child must see another’s action, interpret that action, formulate their own action plan and perform the motor action (Meltzoff & Moore, 1994).

According to Roivainen (2011), processing speed tasks require hand-eye coordination, motor skills, visual search speed, short-term memory, learning ability and concentration. Males tend to perform faster than females on these tasks as their age increases due to motor and physical development. Typically, from the onset of puberty, males are more muscular than females (Landauer, Armstrong & Digwood, 1980). Movement time is highly predictive of muscular build, thus, this disparity between males and females is not seen until after age 11.

Predictions
The goal of the current study is to examine the effect of leading and misleading movements on preschoolers’ motor behavior during a game. To the extent that automatic processes contribute to social mimicry, children’s RT and accuracy should be disrupted as they attempt to follow the rules and inhibit irrelevant movement information. If automatic processes are not involved, participants should be equally affected by leading and misleading manipulations.

Leading anticipatory movements are predicted to increase accuracy and decrease RT as a result of the presence of the experimenter’s hand movement toward the correct shape, while misleading anticipatory movements will decrease accuracy while increasing RT because the experimenter will be nonverbally guiding the participant toward the incorrect response. This manipulation will also assess a participant’s ability to inhibit irrelevant information in order to complete each block. Participants are expected to engage in social mimicry with the experimenter during the card game. This pattern of performance will support an automatic explanation of social mimicry.

For both males and females, we expect to see an overall decrease in RT with increasing age due to an increase in motor control. We also expect to see an increase in accuracy as a consequence of more developed inhibitory processes and control of attention with increasing age that may help the participant to ignore irrelevant stimuli and focus on the experimenter’s verbal directions at the outset of the card-slapping game.

Methods
Participants
The participants of this study were 27 boys (mean age 4-7) and 23 girls (mean age 4-9) recruited from six area preschools. As a result
of convenience sampling, participants were from three middle class mid-western suburbs.

Materials
Testing materials consisted of cards made from white paper, black ink and clear lamination. Cards were created for an age-appropriate card-slapping game for preschoolers to engage with an experimenter during an individual interaction. The game included four sets (blocks) of sixteen cards with circles, hearts, squares and triangles. All shapes were solid black in order to limit distraction that may occur with bright colors. Cards within each block were placed in random order to limit a practice effect. RT was recorded in seconds with a digital watch.

Procedure
Participants engaged with one experimenter, while another experimenter recorded data, including accuracy, reaction time, and counter-balancing information. After parental consent was granted, participants sat at a table across from the experimenter where the rules of the task were read, explaining that the experimenter would also be playing the game and may "touch the biggest shape, the smallest shape, or no shape at all" and to "remember to only touch the biggest shape as fast as you can". Instructions were repeated after practice and again before each block. The practice round ensured that participants understood the rules, could identify the four shapes by name and recognize the larger shape. Remaining blocks were counterbalanced to include a non-manipulation (no interference) baseline, an incorrect (misleading) anticipatory movement, and a correct (leading) anticipatory movement.

Analysis and Scoring
Results from 50 participants were entered into PASW Statistics 17.0 and analyzed with the alpha level set at .05 to examine statistical differences in RT and accuracy in relation to the presence of a leading or misleading hand movement during the shape-selection task. In some cases, age and sex were examined separately to assess the impact of these variables on task completion.

Results
Reaction Time
RT independent t-test analyses show that males and females performed at statistically similar rates in the baseline block, p's > .05 (see Figure 1). RT was significantly affected by the presence of the experimenter’s hand movement in both the leading and misleading blocks as analyzed with a 2 x 2 mixed ANOVA, F (1,48) = 6.52, p < .05. Inconsistent with predictions, RT increased in both leading and misleading manipulation blocks, instead of only an increased RT in the misleading blocks. See Figure 3 for mean reaction time-difference scores from baseline for males and females.

Accuracy
An independent t-test for accuracy shows that males and females performed at statistically similar rates in the baseline block, p's > .05 (see Figure 2). The average accuracy rate in the baseline block is near 80 percent. Accuracy was significantly affected by the presence of the experimenter’s hand movement in both the leading and misleading blocks as analyzed with a 2 x 2 mixed ANOVA, F (1,48) = 4.56, p < .05. Consistent with predictions, accuracy rates in the leading block increased while the accuracy rates in the misleading block decreased as a result of the experimenter’s hand movement toward either the correct or incorrect shape and the participant’s consequential mimicry of the movement (see Figure 4). Participants experienced an accuracy performance improvement on leading blocks and an accuracy performance decrement in misleading blocks.

Age and Sex
Consistent with predictions, an r correlation coefficient suggests that older males experience an overall decrease in RT across all blocks while older females experienced a RT decrease in the misleading block, which may provide support for a sex difference in automatic social mimicry, and specifically the development of inhibitory processes. See Table 1 for r between males and females across all experimental blocks.

Discussion
The results of the present study lend support to an automatic, IRM-based view of social mimicry in preschool-aged children. This study extends on the findings concerning mature adults to a previously unstudied population of toddlers with different levels of socialization, physiology and cognitive ability. As explored in Ondobaka et al (2012), we found that preschool participants engaged in adopting the experimenter’s motivational goals due to the influence of social mimicry and goal-contagion hypothesis on their actions during the card-slapping task. Due to the high task demands on attention, we suggest designing a follow-up study that looks more closely at the role of attention, executive function, and inhibitory processes in learning and social interactions. As a result of age correlations, future research should attempt to uncover the differences of an irrelevant information threshold between males and females. Should a significant finding be discovered, this could have important implications in classroom behavior and social relationships among preschool children, specifically males. Future research concerning these findings should include participants from varying social backgrounds, due to the usefulness of social mimicry in counseling settings. An important limitation of the present study is the inclusion of an imprecise second, rather than millisecond, RT measurement technique. Due to the speed of processing, a cognitive-temporal gap measurement in seconds may not accurately capture the power of a significant effect of a leading or misleading hand movement on card selection.

References

Tables

<table>
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<tr>
<th>Sex</th>
<th>Type of Movement</th>
<th>No Interference</th>
<th>Leading</th>
<th>Misleading</th>
</tr>
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<tbody>
<tr>
<td>Male</td>
<td>-.55**</td>
<td>-.64**</td>
<td>-.65**</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>-.36</td>
<td>-.25</td>
<td>-.50*</td>
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</table>

* p < .05
** p < .01

Table 1. Relationship between age and RT as a function of sex and trial type. For boys, increasing age was associated with decreasing RT for each trial type. For girls, this pattern was observed only in the misleading-movement trial block, perhaps because these were the most difficult trials requiring greater focus to inhibit the automatic processing of incongruent, misleading movements by the experimenter.
Ali Clark-MacKeown, BA is currently working in pediatric community mental health as a behavior specialist. While at her undergraduate institution, Ali was Student Senate President, Psychology Club President, teaching assistant, peer tutor and a member of Psi Chi. She is currently in the process of seeking admission to graduate schools. Ali hopes to obtain her doctorate in Experimental Psychology with a focus on Social and Health areas of research. As a professional, Ali dreams of days spent researching at a university while serving as a consultant to local physicians at area hospitals. A lot of exciting things are happening in Ali’s life, including graduating from college, obtaining a job in her field, planning a future career and planning a wedding. Correspondence concerning this article should be addressed to Ali Clark-MacKeown, by e-mail at clarka422@gmail.com.

September N. Staley graduated from Ohio Dominican University in December 2012 and is currently working as a Community Psychiatric Support Treatment Specialist in Columbus, Ohio. She was hired upon graduation, following a facilitated internship while in her final semester at ODU. As a student, September was a full-time manager for Walgreens, led a petition campaign in order to pass legislation in the House of Representatives, and received honors. September not only applies herself wholly to her studies, research and her career, but she is a dedicated wife and mother. September hopes to obtain her doctorate in Counseling Psychology in order to fulfill her dream of becoming a child and adolescent psychologist.

About the Authors

Figures

**Figure 1.** Mean reaction time in seconds for males and females in the baseline control block. Males and females performed similarly, p’s > .05.

**Figure 2.** Mean percent accuracy for males and females in the baseline control block. Males and females performed similarly, p’s > .05.

**Figure 3.** Mean reaction time-difference scores from baseline for males and females on the misleading and leading movement blocks. While both “leading” and “misleading” movements increased RT, both boys and girls took longer to respond when “misleading” movements were presented, F(1,48)=6.52, p < .05.

**Figure 4.** Mean percent accuracy-difference scores from baseline for males and females on the misleading and leading movement blocks. On average, “leading” movements resulted in greater accuracy in selecting the bigger shape than did “misleading” movements, F(1,48)=4.56, p < .05.
Importance of Peer Relationships in Doctoral Programs
Brittan Davis, MEd, Sneha Pitre, MA, Tiffany Williams, MEd, Keelan Quinn, MA
Joshua Bagaka’s, PhD
Cleveland State University

Abstract

Doctoral student attrition is a relatively common problem that universities have been battling for many years. There have been a number of challenges that doctoral students report enduring given the intense level of stress inherent in pursuing doctoral education. Many stressors faced throughout the developmental phases of doctoral education (entry, integration, and candidacy) contribute greatly to early departure of students within the various phases. Although relatively high dropout rates exist within doctoral education, international students and women are at heightened risk of premature departure as a result of additional stressors associated with their oppressed identities. In essence, mutually supportive peer relationships among doctoral students are vital throughout each developmental phase of doctoral education to promote resilience, success, emotional stability, and decrease attrition in doctoral programs.

Introduction

Doctoral student attrition has been a longstanding challenge for universities, administrators, and program directors due to the economic, social, and psychological costs associated with the student dropout rate (Golde, 2005). Doctoral student attrition has been reported to be as high as 40-50%, which far exceeds that of undergraduate programs at 10-20% (Golde, 2005). Various common stressors (e.g. dissertation research, financial difficulties, and difficulty establishing relationships with faculty) inherent in doctoral students’ educational endeavors have been reported (Ali & Kohun, 2007; Lovitts, 2001; West, Gokalp, P&Nmac, Fischer, & Gupton, 2011). In fact, just being admitted into a doctoral program is a time of significant life changes and stress (Browman, Bowman, & Delucia, 1990), possibly leading to psychological and physical health problems (Ali & Kohun, 2007; Lovitts & Nelson, 2000; Mallinckrodt & Leong, 1992). Consequently, many doctoral students experience psychological distress, such as anxiety and depression that can lead to early departure from their programs (Lovitts, 2001; West et al., 2011).

While most doctoral students report elevated levels of stress throughout their programs (Kurtz-Costes, Helmke, & Ulkii-Steiner, 2006), women are exposed to stressors that are distinctive from those experienced by men in the same programs, such as family-work-school interface, higher percentages of anxiety-related disorders, and the management of sociocultural expectations (King & Cubic, 2005; Rayle, Arredondo, & Kurpius, 2005; Ulkii-Steiner, Kurtz-Costes, & Kinlaw, 2000). Also, there were 119,641 international doctoral students studying in the US during 2011-2012, yet little research focused on the varying needs of such students (Institute of International Education, 2012; Mori, 2000). While the dearth of literature addressing doctoral student attrition and the culturally heterogeneous fabric of doctoral programs, the present article will offer a brief overview of a developmental model of doctoral education, unique stressors of women and international students in doctoral programs, and the importance of peer relationships among students in doctoral programs.

Developmental Model of Doctoral Education

The development model of doctoral education reflects the socialization process that students transition through as a result of exposure to stressors, social supports, and resources, which begins with students’ expectations and understandings of their program after acceptance (Gardner, 2009a; Lovitts, 2001). This model consists of three phases (entry, integration, and candidacy), which requires students to cope with new and existing challenges throughout this socialization process (Gardner, 2009abc).

The entry phase marks the beginning of the journey of doctoral education. Students must quickly become immersed in the new environment and become oriented to the institution and program requirements and faculty expectations (Baker & Pifer, 2011; Gardner, 2009a). Common challenges of the entry phase include: completing coursework and balancing family work involvement (Ali & Kohun, 2007; Gardner, 2009a). The inability to cope with such demands of this phase can lead to premature departure without support from the department, peers, and faculty (Gardner, 2009a; Bowen & Rudenstine, 1992).

The integration phase signifies the transition from the role as “student” to the role as “professional” (p. 72) through the completion of comprehensive examinations (Gardner, 2009b). Comprehensive examinations represent a common vehicle to measure students’ capacity to distribute and integrate knowledge gained throughout the program. However, the anxiety-provoking process of taking comprehensive examinations is one of the most profound challenges that doctoral students face (Gardner, 2009b). Consequently, dropout during this phase typically occurs due to the student’s inability to manage the challenges of becoming fully immersed within the culture of the discipline and difficulty in completing comprehensive examinations (Gardner, 2009b; Lovitts, 2001).

The candidacy phase refers to the students’ transition from the previously stressful stage of comprehensive examinations to an overwhelming period of conducting dissertation research (Gardner, 2009c). Dissertation research is often coupled with feelings of isolation, detachment from peers and faculty, and high levels of stress; thus, departure from the program at this phase is typically due to insufficient faculty support, distractions from dissertation work, and social isolation (Ali & Kohun, 2007; Gardner, 2009c; West et al., 2011).

Women in Academia

There is a notable educational trend in the US in that more women are earning doctoral degrees, which is continuing to rise, with women earning most of the degrees between 2008-2009 across all levels of education (National Center for Education Statistics, 2011). Compared to men, women are earning advanced degrees in fields of lesser status (e.g. education and social work versus economics and business), less inclined to pursue the higher levels of education despite earning most of the lower level education degrees, more likely to prematurely depart from their programs, and earn less than their male equivalents, despite the same experience and training (APA, 2011). As such, regardless of more degrees being earned by women, gender inequity continues to persist throughout the academy. For example, within counseling and clinical psychology programs, women are earning more than two-thirds of doctoral degrees, yet less than half (44.8%) of psychology faculty are women (Fouad, Brehm, Hall, Kite, Hyde, & Russo, 2000). According to the American Psychological Association’s Task Force on Women in Academe (Fouad et al., 2000), women comprise most (56%) of the psychology faculty at four-year institutions. And of those women (44%) holding faculty positions, a large portion (41%) are part-time, whereas only a minority (28%) of men hold such part-time positions. Therefore, even though women are earning most of the doctoral degrees in these programs, there appears to be a continuation of gender inequities, possibly deterring women from obtaining tenured faculty positions.
As such, peer relationships can minimize premature departure from the program by offering sharedness of experiences and support through the many difficult phases of doctoral education (Gardner, 2009abc). Due to the high rates of attrition among doctoral students (Ali & Kohun, 2006; Dedrick & Watson, 2002), it is particularly true throughout all of the developmental phases of doctoral education. Such reciprocity encourages relationships with peers and faculty can promote resilience, success, and emotional stability, while decreasing attrition in doctoral programs.

### Stressors and Concerns of International Students

Upon arrival and for the duration of their stay in a foreign country, international students may endure cultural changes, learning novel roles, and becoming accustomed to varying communicative behaviors to be successful in their academic and personal life experiences (Reid & Dixon, 2012). Language barriers are one of the most common stressors faced by international students, as many students are not fluent in the English language. Given this struggle with language, ramifications that international students have to manage include: miscommunication with faculty and peers, poor academic performance, and complications with taking examinations, due to their potential inability to read and write in the English language (Lee & Rice, 2007; Mori, Inman, & Caskie, 2009; Reid & Dixon, 2012). In fact, it is not uncommon for international students to experience high levels of anxiety as a result of the perceptions that the host country may have regarding their accents, which can lead to reduced initiative and interaction in classes (Khawaja & Stallman, 2011; Adrian-Taylor, Noels & Tischler, 2007).

Culture shock is another frequent stressor that international students experience, which can impact their adjustment to the new culture. Essentially, culture shock is characterized by differences in customs and values of the new culture, role expectations, friendship networks, perceived discrimination, cultural adaptation, feelings of loneliness, and homesickness (Poyrazli & Lopez, 2007; Tung, 2011; Zhou, Jindal-Snape, Topping & Todman, 2008). Should these students perceive discrimination from peers, instructors, academic and legal institutions; it can hamper their self-esteem, academic performance, and increase psychological distress (Karuppan & Barari, 2011). Therefore, peer relationships along with support from faculty and advisors are vital to promote successful completion of their programs (Schmitt, Spears & Branscombe, 2002). As such, previous research suggests that implementing peer programs (e.g. pairing of international students or assigning international student with a U.S peer-mentor) at the beginning of doctoral education can significantly decrease student attrition while encouraging long lasting friendships, increasing cross-cultural interactions, and promoting a sense of belonging (Minor, Pimpleton, Stinchfield, Stevens & Othman, 2013; Pritchard & Skinner, 2002).

### Peer Relationships

Peer support can mitigate some of the psychological distress experienced by doctoral students, especially women and international students, while transitioning through the developmental phases of doctoral education (Gardner, 2009bc; Roberts & Plakhotnik, 2009; West et al., 2011). Premature departure from doctoral study tends to result from lack of support provided to doctoral students as they transition through the entry, integration, and candidacy phases (Bowen & Rudenstine, 1992; Gardner, 2009abc; Lovitts, 2001). Mutually supportive relationships can buffer anxiety, provide feedback, and promote personal growth throughout the socialization process by providing doctoral students with a sense of belonging and promoting professional and academic development (Lovitts, 2001; West et al., 2011). Such belongingness results from working together through the challenges of coursework, sharing experiences of strain to validate common struggles, preparing each other for the more advanced roles, and helping each other develop meaningful relationships with faculty (Baker & Pifer, 2011; Gardner, 2009ab; Lovitts, 2001; West et al., 2011).

### Conclusion

Despite relatively high dropout rates of doctoral students across all programs, international students and women are at increased risk of premature departure due to additional stressors associated with their oppressed identities. International doctoral students are at an elevated risk of dropout due to stressors associated with cultural adjustment, language barriers, and/or the absence of their families and friends (Mori, 2000). And women continue to earn more degrees than men, across all levels of education, but the glass ceiling of the academy appears to be an unsupportive environment for women as future faculty. Thus, mutually supportive peer relationships among doctoral students are crucial throughout all of the developmental phases of doctoral education. Such reciprocity encourages relationships with peers and faculty can promote resilience, success, and emotional stability, while decreasing attrition in doctoral programs.

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**About the Authors**

**Brittian L. Davis, MEd, PC** is currently a second year Counseling Psychology doctoral student at Cleveland State University. She previously earned her Master’s degree in Community Agency Counseling at Cleveland State University. Her research interests include: identity, feminism/women’s issues, LGBTQ topics, sexuality, maladaptive coping and vocational psychology.

**Sneha Pitre, MA** is a second year Counseling Psychology doctoral student studying at Cleveland State University. She has enjoyed working with children and their primary caregivers in the past, especially children with Autism. Some of her research interests include: concerns of international students, parent-child relationships and work life balance.

**Tiffany Williams, MEd, PC** is a second year Counseling Psychology PhD student at Cleveland State University. Her clinical interests include working with diverse groups of individuals in community mental health agencies, hospital settings, and university counseling centers for varying concerns, such as mental health disorders, anger management, career, and academic counseling with adolescent and adult populations.

**Keelan Quinn, MA, PC** is a third year Counseling Psychology doctoral student at Cleveland State University. She previously earned her Master’s degree in Community Counseling at John Carroll University. Her research interests include: child studies, unemployment and deaf culture.

**Joshua Gisemba Bagaka’s, PhD** is a professor of educational research design and statistics in the Department of Curriculum and Foundations in the College of Education and Human Services, and Director of Assessment of Student Learning at Cleveland State University. He received his Master’s of Science in Probabilities and Statistics and his Ph.D. in Educational Research Design and Statistics from Michigan State University. His teaching responsibilities include: graduate educational research courses, statistics, and educational program evaluation. His research interests are in teacher, classroom and school effectiveness.
### 2013 Ohio Science Day Winners

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 2013 Science Day was held on Saturday, May 4 at the French Field House on the campus of The Ohio State University. 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.”

**Thanks to our outstanding judges this year!**

Marie J. Alnadi, BS – Fairborn, OH, Miriam Velez Bermudez, Rebecca W. Clarke, BA – Dayton, OH, Courtney E. Cummings, PsyD – Mt. Vernon, OH, Pamela G. Deuser, PhD – Columbus, OH, Michele T. Evans, PhD – Columbus, OH, Charles C. Fiumera, PhD – Mt. Vernon, OH, David Hayes, PhD – Columbus, OH, Janine T. Johnson – Fairborn, OH, Jeffrey B. Marinko-Shrivers, PhD – Lewis Center, OH, Mary Miller Lewis, PhD – Dublin, OH, Margaret Richards Mosher, PhD – Columbus, OH, Michael Ranney, MPA – Columbus, OH, Michael Scur, Rose Mary Shaw, PsyD – Kettering, OH, Linda A Siroskey-Sabdo, MA – Worthington, OH, Hunter Sully, Christy S. Tinch, PsyD – Columbus, OH, Janice M. Vidic, PhD – Rio Grande, OH

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 place $75; second $50; third $25; and for grades nine through twelve; first place $75; second $50. Prizes were funded by the Foundation for Psychology in Ohio, with support from Cleveland Psychological Association, Cincinnati 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.

<table>
<thead>
<tr>
<th>Grade</th>
<th>1st</th>
<th>2nd</th>
<th>3rd</th>
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<tr>
<td>5</td>
<td>Bailee A. McNamara - Is yawning contagious?</td>
<td>St. Mary Central, Martins Ferry</td>
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<tr>
<td>7</td>
<td>Kiarra M. Anderson - A-MAZE-ing hand-eye coordination</td>
<td>Miller South Visual Performing Arts MS, Akron</td>
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<tr>
<td>8</td>
<td>Laurel H. Bayless - Correlation between introversion and distraction</td>
<td>Athens MS, Athens</td>
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<td>9</td>
<td>Cole K. Clampffer - Packaging: A dieter’s worst nightmare</td>
<td>Hudson HS, Hudson</td>
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<td>10</td>
<td>Gillian M. Baker - Scent and sales II: The effect of scent on consumers’ product perceptions</td>
<td>William V. Fisher Catholic, Lancaster</td>
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<td>11</td>
<td>Shaleen Goel - The effects of mood on memory retrieval</td>
<td>Sylvania Southview HS, Sylvania</td>
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<td>12</td>
<td>Saarah N. Khan - Mood and math: Boys vs. girls</td>
<td>Springfield HS, Springfield</td>
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<td>13</td>
<td>Benjamin M. Moran - Slime mold decision-making: Is it absolute or relative?</td>
<td>Minerva HS, Minerva</td>
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<td>14</td>
<td>Annemarie R. Krug - The effect of sound on the memory of autistic people</td>
<td>Chaminade Julienne, Dayton</td>
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</table>
The 2013 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: $25) 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.

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

1. Roughly ___ in five Americans, approximately ___ million people, are estimated to currently be enrolled in the national Medicaid program.
   A. 1.60
   B. 2.50
   C. 4.35
   D. 3.80

2. According to Muller-Held, some of the top ten reported circumstances that impact academic functioning at the college level range from:
   A. Stress
   B. Sleep Problems
   C. Common Colds
   D. All the above

3. One of the most common stressors faced by international students was described by Davis et. al as being:
   A. Housing Barriers
   B. Language Barriers
   C. Work-related Barriers
   D. Financial Barriers

4. Demonstrating compliance with the standard of care is done primarily via:
   A. interviews with the psychologist
   B. documentation in the clinical records
   C. interviews with the head of the hospital
   D. visit to the site requesting a standard of care review

5. Gongola and Van Voorhis report that statistics suggest that a ___-fold increase in autism has occurred within the past half-century.
   A. 7
   B. 32
   C. 10
   D. 12

6. The four roles of psychology in health care identified by Belar (2012) are:
   A. Research, assessment, practice and intervention
   B. Education, research, teaching and policy
   C. Teaching, research, practice and policy
   D. Assessment, intervention, consultation and teaching

7. Movement time is highly predictive of muscular build, thus, this disparity between males and females is not seen until after age ___.
   A. 11
   B. 8
   C. 14
   D. 3

8. In the preamble to the American Academy of Family Physicians (AAFP) guidelines it is stated that: “Family physicians incorporate knowledge of human behavior, mental health and mental disorders into their every day practice of medicine.” The family physician must have competency in the following areas:
   A. Understand normal and abnormal development across the life cycle
   B. Recognize and initiate treatment and/or referrals for mental health disorders
   C. Effective interpersonal and communication skill for evaluative interviews on mental health disorders
   D. All of the above

9. The PBHNO is a physician-completed (or other qualified medical professional) self-report measure intended to assess:
   A. the perceived physical health needs for the pediatric population in their practice
   B. the perceived behavioral/mental health service needs for the adult population in their practice
   C. the perceived behavioral/mental health service needs for the pediatric population in their practice
   D. the quality of behavioral/mental health service needs for the pediatric population in their practice

10. One of the biggest barriers to fully integrated care is:
    A. too many options
    B. the current fee for service reimbursement environment
    C. training
    D. not a critical demand

True/False
Please answer the following by selecting True or False:

1. Compared to men, women are earning advanced degrees in fields of higher status (e.g. economics and business) and are more inclined to pursue higher levels of education (Davis, et.al) T_____ F______

2. According to Gongola and Van Voorhis, behavioral concerns frequently coexist with developmental disabilities, particularly when paired with co-morbid mental health disorders. T_____ F______

3. Ohio Psychological Association (OPA) has an advocacy committee that is actively working toward Medicaid reimbursement of the H&B codes T_____ F______

4. There is a clear consensus regarding psychological contraindications to weight loss surgery. T_____ F______

5. Krestar, et. al shared that mouse tracking is optimal for considering temporal resolution as many cognitive processes occur rapidly. T_____ F______

6. Psychologists are often the first health care provider consulted when a child exhibits symptoms of a developmental or behavioral problem. T_____ F______

7. First and foremost, standards of care are in place for the benefits and protection of the patient. T_____ F______

8. Logistical barriers is one of the areas that can contribute to the difficulties of establishing a stable collaborative practice. T_____ F______

9. Males tend to perform faster than females on processing speed tasks that require hand-eye coordination, motor skills, visual search speed, short-term memory, learning ability and concentration tasks. T_____ F______

10. Incera et. al reported that this is the first experiment that used the mouse-tracking paradigm to determine precisely when word reading and color processing occurred. T_____ F______

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Office rental or purchase opportunity: Rent space (full time or shared) or purchase ownership in an established professional building; terrific Kenwood location close to I-71 and Kenwood Towne Centre; collegial atmosphere; excellent potential; for referrals, secretarial services available. Contact: Gary Schneider, PhD, Tom Kalin, PhD, Leslie Swift PhD, 513-791-8849

Neuropsychology practice for sale in northern suburbs of Cincinnati, Ohio. Cincinnati has high demand. Twenty years in the same location. Referrals from physicians, psychiatrists, psychologists, BWC, attorneys, and private IME companies. Low office costs. Will help to transition. Contact: Kathleen Mack, Psy.D., kmack5388@gmail.com or 513-771-8555.

Columbus small group practice seeking licensed psychologists with child and family experience and expertise to work as independent contractors full- or part-time. Please contact Susan Weltner-Brunton, PhD at 614-754-7648 or drsusan@swbphd.com.

Caring for Your Gay Teen is a book in e-book format offering information and gentle support to parents of non-heteronormative teens. It is a product of 30 years of clinical experience working with adolescents, many of whom struggle with issues regarding sexuality and sexual identity. It is also informed by the personal experiences of the author with the adolescent journey of gay family members and their friends. This work is priced very low for maximum distribution to families who might benefit from it. Invite parents who face this challenge with their own children to purchase a download of this helpful resource at www.lulu.com.

Mark Your Calendar!

OPA’s 2013 Convention: Psychology’s Role in Integrated Health Care

October 30-November 1, 2013, Quest Conference Center, Columbus

Featuring:
Keynote Speaker Katherine Nordal, PhD, Executive Director of APA’s Practice Directorate
Plenary Speaker Ben Miller, PsyD, Director of the Office of Integrated Health Care Research and Policy at the University of Colorado

Registration begins online in August at www.ohpsych.org