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As a professional association, the Ohio Psychological Association has so much to celebrate in terms of our contributions to the profession of psychology and advocacy for the mental health population in Ohio. This annual publication reflects the depth and breadth of not only the populations we serve, but also the capacity in which we serve. All of the articles are from psychologists all over the state who practice in clinical, research and educational settings.

Our theme this year is “Future Frontiers of Psychology.” As evidenced by the diversity of topics in this issue we are fortunate in our profession to a plethora opportunity for expanding how and where we practice the science of psychology. I hope, as you read through this issue of the Ohio Psychologist, you will consider a new frontier YOU are interested in further exploring.

Inherent in all the work we do are the ethical implications and considerations. We are fortunate to have two OPA members share their expertise in practicing ethically in different settings. Dr. Kenneth Drude reviews the standards, guidelines and laws and issues in using telecommunication with clients in his article, “Legal, Ethical and Recommended Practices for Ohio Psychologists when Using Email and Texting.” Dr. Drude’s article centers on one of the fastest growing areas in the practice of psychology, the use of technology, for both clinicians as well as clients. Dr. Elizabeth Swenson, provides an ethical perspective in completing an assessment in her article, “Clinical Assessment: Guidance from the Ethics Code.”

Dr. Amel Sweis-Haddad’s article “Using Metaphors to Address Maladaptive Behaviors,” provides a therapeutic tool, to utilize when working with parents and caregivers in addressing children’s behavioral issues.

You will note that half of the articles in this publication address opportunities for personal improvement. Does the future practice of psychology necessitate embracing multiple models of treatment? Dr. Kirby Reutter asserts the contemporary psychologist must consider a more integrated, evidenced-based, brief approach in his article, “Integrated and Brief: A Meta-Framework for the Modern Psychologist.” Dr. Deanna Barthlow-Potkanowicz’s article, “Challenges to self-care in the Workplace: Chronic physical illness in practicing psychologists,” examines the importance of physical self-care. And as has become our tradition we have an article on mindfulness. Dr. Kathie MacCluskie (along with myself) present a model of meditation to not only incorporate in clinical practice but also integrate into a personal practice in their article, “Mindsight: Clinical and Personal Self-Care.”

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

We are very fortunate that as an organization, we are able to continue to support a peer-reviewed publication. Each of these articles has been reviewed by at least three peers. I would like to extend my sincere appreciation to them for the hours they volunteered to review the manuscripts submitted for publication. They include; Paule Ashe, PhD; Marc Dielman, PhD; Charles Dolph, PhD; Andrea Karkowski, PhD; Mary Lewis, PhD; Kathryn MacCluskie, EdD; Kenneth Manges, PhD; Elizabeth Swenson, PhD, JD; and, Ed Wojniak, PhD. I would also like to extend my sincere appreciation to Karen Hardin who has done a wonderful job of managing the editing of this publication. Finally as we look toward our next issue please be thinking about how you would like to contribute to our next edition. The theme for next year is “The strength to lead, connect, and heal.” If you have an interest in publishing or serving as a reviewer please let me know.
Legal, Ethical and Recommended Practices for Ohio Psychologists when Using Email and Texting
Written by: Kenneth P. Drude, PhD

Psychological Testing: Guidance from the Ethics Code
Written by: Elizabeth V. Swenson, PhD, JD

Using Metaphors to Address the Maladaptive Behaviors of Children
Written by: Amel Sweis-Haddad, PsyD

Integrated and Brief: A Meta-Framework for the Modern Psychologist
Written by: Kirby K. Reutter, PhD, LMHC, ICAADC, CADAC-IV, MAC

Challenges to Self-Care in the Workplace:
Chronic Physical Illness in Practicing Psychologists
Written by: Deanna Barthlow-Potkanowicz, PhD

Mindsight: Clinical and Personal Self-Care Practice
Written by: Kathryn C. MacCluskie, EdD and Kathleen (Ky) T. Heinlen, PhD, LPCC-S

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Legal, Ethical and Recommended Practices for Ohio Psychologists when Using Email and Texting

Kenneth P. Drude, PhD

Abstract

Ohio psychologists and their clients are increasingly using email and texting to communicate with each other for administrative and clinical purposes. This is occurring at times, however, without an apparent awareness by psychologists that there are professional standards, guidelines and laws that apply when using telecommunications with clients. Differences in the professional and personal uses of email and texting are not always obvious. This paper reviews the standards, guidelines and laws and issues in using email and texting with clients. A set of recommendations are provided that will assist in complying with them. A telepsychology informed consent form developed by the Ohio Psychological Association is also provided.

INTRODUCTION

The Ohio psychology licensing law, Ohio Revised Code (ORC) Chapter 4732, defines telepsychology to include the use of all forms of telecommunications including email and texting. The law at OCR 4732.10 contains the following definition:

(J) "Telepsychology" means the practice of psychology or school psychology by distance communication technology, including telephone, electronic mail, internet-based communications, and video conferencing.1

Computers and smartphones have increasingly made it easier for psychologists and clients to communicate with each other. In 2015, nearly two-thirds of Americans owned a smartphone, and they are being increasingly used in everyday communications. (Pew Research Center, 2015). Electronic communications are so commonplace that it is not surprising that some clients expect that their psychologists will communicate with them by email or texting. This evolving reality may make it easier for psychologists and their clients to communicate. Yet with conveniences come responsibilities and liabilities.

Some of the advantages are:
• Access – ease of communicating about appointments and rescheduling, avoiding phone tag or waiting until a scheduled appointment to exchange information
• Complements in-person services – allows for between sessions support, and follow-up, and reminders to clients and more frequent short contacts by client between appointments
• Quick and easy use for making and changing appointments, and “tracking” or monitoring “homework” in some therapy models.

Some of the disadvantages are:
• Potential for misdirection by client or psychologist (sent to wrong email address)
• Poor assurance of confidentiality if sent non-secured (i.e. unencrypted); HIPPA violation potential
• Ability of client to produce a “transcript” of word-for-word exchanges with the psychologist resulting in a lack of control of what happens to information on the client’s end. Potential for client to send copies of messages to others
• Potential misinterpretation and distortion of messages by client and psychologist; distortion or misunderstanding of a delayed reply or non-response by the psychologist
• Potential for boundary violations and confusion given the ease of informality in use of email and texting (e.g. distinction of personal versus professional may get blurred)
• Potential access to messages received by client by others who may have access to their device and or messages.
• Lack of reimbursement by insurance for time spent messaging

A major issue is that there are substantial differences between using email and texting in a professional context with clients versus in a personal or informal context with family and friends. These differences, however, may not be readily obvious to either clients or psychologists and warrant careful attention by professionals when using telecommunications with clients (Bradley and Henricks, 2011).

Although concerns by health care practitioners about potential ethical and legal issues and lack of reimbursement for technology-based services have hindered the use of electronic communications with clients, many clinicians are adopting them, but with little awareness of best practices or legal and ethical expectations. Past surveys looking at how psychologists use email and other telecommunications with clients have often found poor compliance with fundamental ethical principles such as obtaining informed consent from clients and ensuring that there are adequate security and privacy protections (Welfel and Bunce, 2003, Maheu and Gordon, 2000, Elhai and Hall, 2015). Other issues include the lack of practice policies about using electronic communications and the use of personal and unsecured email versus professional and secured email accounts. Drude and Lichstein (2005) identified a number of common

1 http://codes.ohio.gov/oac/4732-17-01
issues found in the literature about the use of email by health care practitioners that remain pertinent today to email and texting with clients. These issues will be further discussed in this article.

Health care professionals, including psychologists, have been using email for many years. Guidelines for the use of email by physicians were developed by the American Medical Informatics Association in 1998 (Kane and Sands, 1998) and later adopted by the American Medical Association (AMA, 2000). Suggested email guidelines for psychiatrists based upon the AMA guidelines have been proposed (Silk and Yager, 2003). Sude (2013) described potential benefits and ethical concerns about writing with patients. Silk and Yager (2003), in their proposed email guidelines, focused on three major issues: confidentiality, communication tone of the professional, and professional boundaries. The Ontario Psychological Association (OPA, 2015) and the Australian Psychological Society (APS, 2011) have guidelines for psychologists that apply to the use of email and texting with clients.

Essentially the same professional standards and guidelines that apply to in-person services and communications with clients apply when using telecommunications. The Ohio Psychological Association developed and adopted telepsychology guidelines in 2008 that provide some general guidance in using telecommunications with clients. The American Psychological Association (APA) has two relevant documents—the Code of Ethics (APA, 2010) and Guidelines for the Practice of Telepsychology (APA, 2013). These provide some general guidance to exercise caution to ensure security and confidentiality, but are not specific to using email and texting with clients or prospective clients. Although the Ohio Board of Psychology has a detailed set of rules2 governing the practice of telepsychology, the individual psychologist’s professional judgment about how to interpret and apply the existing standards and guidelines when using telecommunications is paramount.

ETHICAL STANDARDS AND GUIDELINES

It is important to distinguish between ethical standards which are mandatory professional practices and guidelines which are recommended but not mandatory professional practices. Standards use language like “shall” and “will” whereas guidelines use language like “may” and “consider.” Guidelines are useful since they are helpful in interpreting how to apply standards.

A strong foundational knowledge of the ethical and legal requirements regulating communications and correspondence with clients is critical, whether it be in-person or electronically such as using email and texting with clients. Keep in mind that federal and state laws and ethical standards for in-person practice and communications generally apply to electronic communications as well.

Ohio Psychological Association (OPA) Telepsychology Guidelines: The OPA Telepsychology Guidelines (OPA, 2010) provide basic guidance for the practice of telepsychology and the use of telecommunications with clients. These recommended guidelines provided the framework for the enforceable telepsychology rules adopted by the Ohio Board of Psychology in 2011 which will be reviewed later in some detail in referencing legal requirements.

American Psychological Association (APA): The American Psychological Association Ethical Principles of

PSychologists and Code of Conduct (APA, 2010) and Guidelines for the Practice of Telepsychology (APA, 2013) are key documents providing direction and guidance for using email and texting with clients.

Code of Ethics:
The requirement to obtain informed consent from clients is described in the 2010 APA Code Standard 3.10 Informed Consent, and is relevant to the agreement of clients to use email or texting with the psychologist.

“(a) When psychologists conduct research or provide assessment, therapy, counseling, or consulting services in person or via electronic transmission or other forms of communication, they obtain the informed consent of the individual or individuals...”

“(d) Psychologists appropriately document written or oral consent, permission, and assent.”

Privacy and Confidentiality, APA Code Standard 4.01, describes ethical obligations for psychologists to protect the confidentiality of client information.

“Psychologists who offer services, products, or information via electronic transmission inform clients/patients of the risks to privacy and limits of confidentiality.”

This ethical standard explicitly makes reference to “any medium,” which includes electronic communications. Just as important is that psychologists are required by the ethics code to obtain informed consent from the client before providing services. Most relevant to the use of email and texting with clients is Standard 4.02. (c) that states:

“Psychologists who offer services, products, or information via electronic transmission inform clients/patients of the risks to privacy and limits of confidentiality.”

Telepsychology Guidelines: The APA Guidelines for the Practice of Telepsychology (APA, 2013) include seven guidelines that give recommendations for all forms of telecommunications used in the practice of psychology, including email and texting. The following are some key points in the guidelines relevant to the use of email and texting with clients.

Guideline 1, Standards of Care in the Delivery of Telepsychology Services includes this statement:

“...before psychologists engage in providing telepsychology services, they are urged to conduct an initial assessment to determine the appropriateness of the telepsychology service to be provided for the client/patient. Such an assessment may include the examination of the potential risks and benefits of providing telepsychology services for the client’s/patient’s particular needs, the multicultural and ethical issues that may arise, and a review of the most appropriate medium (video teleconference, text, email, etc.) or best options available for the service delivery.”

The intent of this guideline is for psychologists to conduct an assessment and decide what forms of communication are believed to be appropriate for each client. (In Ohio, the Board of Psychology Telepsychology Rules consider the use of
telecommunications with clients, other than for administrative purposes such as scheduling appointments or establishing benefits, to be the practice of telepsychology."

Guideline 3, Informed Consent, includes the statements that psychologists:

“… seek to obtain and document informed consent when providing professional service.”

“… attempt to develop and share the policies and procedures that will explain to their clients/patients how they will interact with them using the specific telecommunication technologies involved.”

“Psychologists are thus encouraged to consider appropriate policies and procedures to address the potential threats to the security of client/patient data and information when using specific telecommunication technologies and to appropriately inform their clients/patients about them.”

“… psychologists may consider developing agreements with their clients/patients to assume some role in protecting the data and information they receive from them (e.g., by not forwarding emails from the psychologist to others).”

Guideline 4, Confidentiality of Data and Information includes this statement:

“Psychologists both understand and inform their clients/patients of the limits to confidentiality and the risks of possible access to or disclosure of confidential data and information that may occur during service delivery, including the risks of others gaining access to electronic communications (e.g., telephone, email) between the psychologist and client/patient.”

Guideline 5, Security and Transmission of Data and Information

“When documenting the security measures to protect client/patient data and information from unintended access or disclosure, psychologists are encouraged to clearly address what types of telecommunication technologies are used (e.g., email, telephone, video teleconferencing, text), how they are used, and whether the telepsychology services used are the primary method of contact or augment in-person contact. When keeping records of email, online messaging, and other work using telecommunication technologies, psychologists are cognizant that preserving the actual communication may be preferable to summarization in some cases depending on the type of technology used.”

LEGAL REQUIREMENTS

Health Insurance Portability and Accountability Act of 1996 and rules (HIPPA):

Be mindful that the federal HIPAA law and rules legally apply to the use of electronic communications with clients. HIPAA has specific requirements for health care providers and their business associates to protect the privacy and security of health data. Use of unsecured or unencrypted communications with clients that contain what HIPAA defines as “protected health information”\(^3\) (PHI) poses serious legal and ethical risks that psychologists must be aware of. Keep in mind that HIPAA defines PHI as any “individually identifiable health information held or transmitted by a covered entity or its business associate, in any form or medium, whether electronic, on paper, or oral.”\(^4\)

Although encryption is generally expected when communicating with clients, HIPAA in fact does allow unsecured communications with clients. This however should be with their explicit consent and consideration of any potential risks that may be involved.

The Department of Human and Health Services, Office of Civil Rights (OCR) which monitors HIPAA compliance has indicated that:

“the HIPAA Privacy Rule allows covered health care providers to communicate electronically, such as through email, with their patients, provided they apply reasonable safeguards when doing so. See 45 C.F.R. § 164.530(c). For example, certain precautions may need to be taken when using email to avoid unintentional disclosures, such as checking the email address for accuracy before sending, or sending an email alert to the patient for address confirmation prior to sending the message.”\(^5\)

The OCR further indicates that:

“other safeguards should be applied to reasonably protect privacy, such as limiting the amount or type of information disclosed through the unencrypted email. In addition, covered entities will want to ensure that any transmission of electronic protected health information is in compliance with the HIPAA Security Rule requirements at 45 C.F.R. Part 164, Subpart C.”

“Patients may initiate communications with a provider using email. If this situation occurs, the health care provider can assume (unless the patient has explicitly stated otherwise) that email communications are acceptable to the individual. If the provider feels the patient may not be aware of the possible risks of using unencrypted email, or has concerns about potential liability, the provider can alert the patient of those risks, and let the patient decide whether to continue email communications.”

Ohio Board of Psychology

The Ohio psychology licensing law gives the Ohio Board of Psychology the authority to regulate the practice of psychology, including telepsychology, in Ohio. Rules to regulate telepsychology in Ohio, which are largely based upon the OPA Telepsychology Guidelines, were adopted in 2011. The adoption of the rules make them legally mandatory expectations rather than the recommended ethical guidelines when practicing telepsychology in Ohio.\(^6\)

The Ohio Board of Psychology Rules of Professional Conduct include a telepsychology rule OAC 4732-17-01 (1)(6)(g)\(^7\) that requires:

“Licensees, whenever feasible, use secure communications with clients, such as encrypted text messages via email or secure websites and obtain and document consent for the use of non-secure communications.”

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\(^3\) https://www.hipaa.com/hipaa-protected-health-information-what-does-phi-include/
\(^4\) http://www.hhs.gov/hipaa/for-professionals/privacy/special-topics/de-identification/index.html
\(^5\) http://www.hhs.gov/ocr/privacy/hipaa/faq/health_information/570.html
\(^6\) http://codes.ohio.gov/orc/4732-33v1
\(^7\) http://codes.ohio.gov/oac/4732-17-01
This rule emphasizes the importance of using secure communications but also allows for the use of non-secured communications with the consent of the client who is informed about the potential confidentiality issues present. Regardless of whether a client agrees to using non-secured communications, the psychologist has the critical responsibility of using their professional judgment about its appropriateness. This might mean that although a client may wish to communicate by texting or email for example, it may not be an acceptable mode of communication based on the judgment of the psychologist, who is under no obligation to use it.

The Ohio Board of Psychology Telepsychology Rule includes requirements that psychologists:

• Be competent with technologies being used OAC 47-17-01(I)(5)
• Assess the appropriateness for using specific telecommunications and services with a client OAC 47-17-01(I)(6)(a)
• Make reasonable efforts to verify the identity of the client when communicating OAC 4732-17-01(I)(6)(c)
• Obtain written consent from the client informing the client of:
  ◊ Any limitations of the technology being used
  ◊ Potential risks to confidentiality
  ◊ Risks of disruption of communications and alternative communications
  ◊ When and how the psychologist will respond to messages
  ◊ What alternatives to use in emergencies
  ◊ Who else may have access to messages – time to discuss for both psychologist and client ends where messages are sent and received
  ◊ Ensuring messages are directed only to the psychologist
  ◊ Storage of electronic communications by psychologists of messages with the client

OPA has developed a Telepsychology Informed Consent Form that incorporates these components and provides a useful way to document client informed consent for telepsychology services, including the use of email and texting. It is available on the OPA website and viewable in Appendix A.

Other Ohio Board of Psychology telepsychology rules include the requirement for psychologists to ensure that access to stored electronic communications are not accessible to unauthorized persons when disposing of electronic equipment or data OAC 7732-17-01(I)(7)

• The telepsychology rule does NOT apply in two circumstances OAC 7732-17-01(I)(8):
  ◊ when electronic communications are limited to administrative purposes such as scheduling appointments, billing or establishing benefits or eligibility for services
  ◊ “for the purpose of ensuring client welfare in accord with reasonable professional judgment.”

SOME SUGGESTED BEST PRACTICES

The following are some suggested ways to comply with the various applicable ethical and legal expectations for the use of email and texting with clients:

1. Have a written policy and procedures for using email and texting that is communicated to clients at the beginning of every professional relationship.
2. Have a written informed consent form signed by clients before using telecommunications that incorporates key policy and procedure elements regarding the types of telecommunications used by the psychologist.
3. Consider using encrypted email such as Hushmail or Zixmail rather than web-based email such as Yahoo or Gmail.
4. Do not use email or texting for emergencies.
5. Establish turnaround times for when clients can expect a response to messages. When are messages checked/read by the psychologist? When will a response be sent to the client?
6. Inform clients about privacy and confidentiality issues and the use of secure communications. Obtain written client consent for the use of telecommunications and if you and your client agree to use non-secured communications. Caution about the use of work email systems because employers may have access to messages. Caution about who else besides the client has access to their email account or device used to send and receive messages. Use passwords for accessing electronic messages or devices.
7. Maintain copies in the client’s record of clinical email and text messages communicated by both the psychologist and client.
8. Inform clients that copies of telecommunications will be kept in their record.
9. Identify what types of information or subject matter are appropriate and not appropriate to include in messages.
10. Assess your own ability to use email and texting with clients.
11. Assess your client’s ability to use email or texting.
12. Get written informed consent from clients about any fees that may be charged when using email or texting.
13. Maintain a “professional tone” in communications by avoiding too informal or personal sounding language. Keep in mind that written communications with clients just as verbal communications need to be professional. Avoid use of emoticons and slang that might be perceived as personal rather than professional.
14. Be aware that relevant state psychology licensing laws and rules apply when using telecommunications both in the state where you are located and where your client is located. The Ohio psychology licensing law only regulates the practice of psychology in Ohio. Other states or jurisdictions have their own psychology licensing laws that may require compliance when providing services to clients located in those jurisdictions.

CONCLUSION

In conclusion, email and texting can be valuable forms of communications with clients. Standards, guidelines and laws relevant to using email and texting with clients exist and ought to be considered before their use. A number of recommendations are described that would assist in complying with them.


About the Author

Kenneth Drude, Ph.D. has a doctorate in counseling psychology from the University of Illinois. He provides psychological services in a general private practice near Dayton, Ohio and is the president of Ohio Board of Psychology. He is a past president and finance officer of the Ohio Psychological Association and served on the OPA board for 28 years. He is active in the Coalition for Technology in Behavioral Science and the Association of State and Provincial Psychology Boards.
As a client receiving psychological services through telepsychology methods, I understand:

1. This service is provided by technology (including but not limited to video, phone, text, and email) and may not involve direct, face-to-face, communication. There are benefits and limitations to this service. I will need access to, and familiarity with, the appropriate technology to participate in the service provided. Exchange of information will not be direct and any paperwork exchanged will likely be exchanged through electronic means or through postal delivery.

2. If a need for direct, face-to-face services arises, it is my responsibility to contact providers in my area such as ____________________, ____________________, or ____________________ or to contact this office for a face-to-face appointment. I understand that an opening may not be immediately available.

3. I may decline any telepsychology services at any time without jeopardizing my access to future care, services, and benefits.

4. These services rely on technology, which allows for greater convenience in service delivery. There are risks in transmitting information over the internet that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties. My psychologist and I will regularly reassess the appropriateness of continuing to deliver services to me through the use of technology.

5. In emergencies, in the event of disruption of service, or for routine or administrative reasons, it may be necessary to communicate by other means:
   a. In emergency situations
   b. Should service be disrupted
   c. For other communication

6. My psychologist may utilize alternative means of communication in the following circumstances:

7. My psychologist will respond to communications and routine messages within ________________________________

8. It is my responsibility to maintain privacy on the client end of communication. Insurance companies, those authorized by the client, and those permitted by law may also have access to records or communications.

9. I will take the following precautions to ensure that my communications are directed only to my psychologist or other individuals:

10. My communications exchanged with my psychologist will be stored in the following manner:

11. The laws and professional standards that apply to in-person psychological services also apply to telepsychology services. This document does not replace other agreements, contracts, or documentation of informed consent.

Client Printed Name ___________________________ Signature of Client or Legal Guardian ___________________________ Date ___________

Printed Name of Psychologist ___________________________ Signature of Psychologist ___________________________ Date ___________

**Liability Disclaimer:** The Ohio Psychological Association (OPA) have attempted to provide guidance with this form in line with current laws and guidelines, but the form may need to be tailored to each situation and individual, laws change, and we cannot guarantee freedom from legal liability. It is up to each psychologist to confirm that they are following legal requirements.

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Questions? Contact the Ohio Psychological Association at 614.224.0034.
INTRODUCTION

Among the tasks that psychologists value in their work is psychological testing. To give our best service to our clients, we need to practice psychological testing ethically. The American Psychological Association’s (APA) Ethical Principles of Psychologists and Code of Conduct (Ethics Code)(APA, 2010) give us guidance though some of the common ethical pitfalls.

The Ethics Code is divided into five general principles and 151 standards. The general principles are aspirational, aiding in decisions for which we strive. These principles, such as beneficence and integrity, set up a moral foundation for our work and our daily lives as well. The standards, divided into sections, are enforceable or mandatory. These are enforced by the legal system, ethics committees and licensing boards. Some of these sections correspond to aspects of our work as psychologists, such as teaching or research, while others deal with ethical issues that transcend a particular kind of work, such as those found in the section on human relations.

In this article we are looking most closely at Section 9, standards specifically on assessment.

Throughout this article, I will quote sparingly from the ethics code. However, it is easy to locate the complete ethics code to fill in the gaps at www.apa.org/ethics/code/index.aspx. The code should be readily available to consult when thorny ethical dilemmas arise. In addition, it bears repeating that one of the advantages to being an Ohio Psychological Association member is that the OPA Ethics Committee provides free consultations to members.

RELEASE OF TEST DATA

Consider the following vignette:

John Michelson, PsyD was asked by a father to do an assessment of his ten-year-old son who was exhibiting behavior problems at home but not at school. Upon completion of the battery, the psychologist is asked by the custodial parent to release the test data to a possible treating psychologist and also to the child’s school counselor. Dr. Michelson has no problem with releasing the results to another psychologist, even though this person is not yet the child’s therapist. However, he objects to releasing them to the school counselor reasoning that this person may not understand the test results and apparently does not have a need to know them. The child has shown no problem behavior at school, and Dr. Michelson fears that releasing the test scores to the counselor could raise the child’s profile as a problem child.

The psychologist has to balance two conflicting interests in this scenario. The father has asked for a report to be released to the school counselor; the psychologist objects based on his view that the counselor might not comprehend them, and because the counselor might misuse the information to the detriment of the child. Releasing the test scores and an interpretive report to another psychologist is not a problem to him. In this case, the Ethics Code provides standards to be considered carefully. At the most fundamental level, it should be understood that according to Standard 9.04a, Release of Test Data, only a report with the child’s responses and accompanying observations and interpretive comments can be released without compromising the security of the tests that were given. (See also Ethics Code Standard 9.11, Maintaining Test Security.) But more importantly here, it is not the psychologist’s decision to whom to release the report. Even though the psychologist believes that the report may be harmful to the child, and that the counselor may not fully understand it, the parent has the right to determine to whom the report will be released. Standard 9.04 permits the psychologist to withhold the data to prevent substantial harm, but possible harm in this case does not rise to the level anticipated in the standard.

Importantly, the Health Insurance Portability and Accountability Act of 1996 (HIPPA) gives a right of access of medical records to patients. Psychological test data is considered to be a medical record; the child’s parent is considered to be the patient. The release of the test data and report to the child’s father clearly means that he can pass it along to whomever he pleases. The autonomy of the patient trumps the judgment of the psychologist in this case.

In retrospect, it is quite possible that these problems could have been avoided had there been a contract or letter of agreement with the father prior to the assessment. This document would make it clear to whom the data can be released, and that some material may be harmful to the child if released to a non-competent person.

TEST CONSTRUCTION

A vignette:

Megan Fester PhD works in the counseling center of a major public university. It is not uncommon for international exchange students to come to the center with complaints that suggest depression, home-sickness, and anxiety about academic procedures, aggravated by language difficulties. Being extremely pressed for time, it just made a lot of sense to Dr. Fester to create an instrument that would confirm a diagnosis of this constellation of complaints quickly, which she has labeled “Ivanov syndrome,” after one of her favorite clients. She selects a few items from the Beck Depression Inventory along with what she considers to be key items from the MMPI psychasthenia scale. She routinely asks new international students to take this inventory before their first session.

Direction in resolving the ethical dilemma in this vignette is found primarily in Ethics Code Standard 9.05, Test Construction. Individuals who construct psychological tests must “use current scientific or professional knowledge for test design, standardization [and]
 validation,...” Even though Dr. Fester is using this test only for her own clients, it is still required that she construct a test that is valid and reliable. Taking test items from a valid and reliable test and using them individually out of their proper context does not fulfill this requirement. No methods for substantiating reliability and validity have been employed. In addition, Ethics Code Standard 2.01a advises that psychologists practice only within the “boundaries of their competence.” Arguably, the construction of a test in this manner indicates that Dr. Fester does not understand the basics of test construction. Finally, Ethics Code Standard 2.04 required us to base our work on “established scientific and professional knowledge of the discipline.” Dr. Fester does not demonstrate such knowledge in this scenario.

Another important consideration in this case is the Federal Copyright Law (1978). This law protects the test publishers from the use of their proprietary test items in a different document.

It must be very tempting at times to take such a shortcut. Unfortunately it is scientifically invalid, ethically flawed and illegal.

INFORMED CONSENT TO ASSESSMENT

This vignette illustrates a situation involving informed consent: Susan Nilson, PhD teaches an undergraduate class in psychological testing. Half way through the semester, she felt that she was losing the students’ interest in the course material. To enliven the class and also to peak student interest, she decided to have each student personally take and score the particular assessment measure to be studied that week. She stressed that these self-administered tests could not be valid indicators of the traits in question. All this led up to the unit on the MMPI-2. Because the time to take this test exceeded the allotted class time, students were allowed to administer the test to themselves the night before the next class. In as grave a tone as possible, Dr. Nilson told the class that they should take the test in one private sitting, be in a quiet room, and not share the questions with anyone. It became apparent in the next class that some of the statements on the test were discussed and joked about in the dorms. After collecting the test protocols, Dr. Nilson scored the tests and planned to return the results to each student in a sealed envelope. At the next class, she abruptly said that she could not return the results as one student had scored in a manner that was truly alarming.

A variety of Ethics Code standards apply to this situation. Using Standard 9.10, Dr. Nilson had a duty to explain the assessment results to the students. This had been the established practice for the past several weeks and the students expected this feedback in addition to learning about the MMPI-2 itself. Standard 9.06 requires that she consider situational factors during the test-taking that may have significantly affected the students’ scores and thus limited the validity of the their interpretation. Although Dr. Nilson might have argued that her procedure was acceptable according to Standard 9.07, since this was a class of undergraduates, the students would not qualify as trainees. And clearly Standard 9.11, Maintaining Test Security, was also breeched.

The more important ethical issue, in my view, is that the students had no idea what they were disclosing to their professor. Standard 9.03 mandates that psychologists obtain informed consent for assessment. This is an especially important consideration, as the information the professor could have gained on her students, had the testing been valid, would be very sensitive, and because the students, due to their relationship with the professor, may have not been able to consent voluntarily. It is arguable that the students may not have been able to give informed consent under the circumstances. As the students never learned individually whether or not they were the person who scored in the alarming manner, or what this meant, one might consider that Standard 3.04, Avoiding Harm, is also involved. Students did not understand that they were in essence waiving their confidentiality as to their mental health.

CONCLUSION

This article has discussed several of the most important and relevant Ethics Code Standards that guide psychological testing. These include release of test data, test construction, and informed consent.

NOTES

Some vignettes in this article are adapted from those used in a webinar presented by the author for the Buros Institute at the University of Nebraska on April 1, 2015. They are used with permission even though the copyright is held by the author.

The author thanks an anonymous reviewer for suggestions.

References


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Bessel van der Kolk, MD  
Boston University  
School of Medicine  

“Francine Shapiro has made an enduring con-  
tribution to the field of psychotherapy.”  
Jeffrey Zeig, PhD  
Founder & Director
Abstract

The use of easily understood metaphors from a wide range of disciplines can help improve a parent’s understanding of behavioral approaches and also improve a child’s motivation for behavioral change. Behavioral psychologists can use metaphors as a powerful therapeutic tool to help parents address the inappropriate and often dysfunctional behaviors of children with poor sequencing skills. For example, parents can be encouraged to develop “Game Plans” by first identifying problems and solutions, and then mapping out undesirable and desirable “Pathways.” Parents can learn how to “referee, coach, and cheerlead” by utilizing concise and positive operational statements. These statements can be conceptualized as “equations” that follow easily understood sequences or associations. The ability to sequence is a critical skill since taking wrong “pathways” or using poor “syntax” may result in children making decisions in “error.” A map with step by step instructions can be helpful.

Behavioral psychologists can utilize a consultative and metaphorical approach when working with parents to address the inappropriate and often dysfunctional behaviors of children. There are two basic goals for helping families: the first goal is to develop a “Game Plan” to identify problems and solutions, and the second goal is to positively communicate and formulate “Pathways” for children; so that, they can demonstrate successful behaviors. Metaphors have been used in therapy over the years to help children (Burns, 2012). This paper illustrates how metaphors borrowed from a number of different disciplines can teach parents important cognitive behavioral principles and sequencing skills; so that, they, in turn, can teach their kids.

Metaphors can be useful for teaching sequencing skills, but before implementing a behavioral approach that utilizes them, it is critical to determine whether any of the following problems exist as a different treatment modality may be necessary. For example, a physiological deficit may require speech, physical or occupational therapy while a cognitive deficit may require specific educational remediation. Inadequate teaching may mean the child needs to be presented with a cognitive deficit may require specific educational remediation. Inadequate teaching may mean the child needs to be presented with a different approach when working with parents to address the inappropriate and often dysfunctional behaviors of children.

Before therapists can use metaphors, definitions of problems and solutions are necessary. Parents need to be given a blank sheet of paper folded in half (lengthwise) and asked to make a comprehensive list of specific “Problem Behaviors” using short action phrases on the left side of the paper. Parents need to systematically identify diametrically opposed specific “Solution Behaviors” on the right side of the paper with a 1:1 correspondence, making sure solution phrases are positively phrased. It should be noted that when definitions of appropriate and inappropriate behaviors are clearly labeled, everyone speaks the same language and is literally on the “same page.” It also helps create a “level playing field” where children learn everyone has to abide by the same definitions of appropriate and inappropriate behavior. Even in the sports arena, there are definitions and valuations of what are fair or unfair, appropriate or inappropriate “plays.” These linguistic definitions are important for sensible, meaningful communication and interaction. They are also vitally important since simply teaching a child what not to do does not mean...we have taught the child what to do. (See table on page 14 for examples of problem/solution behaviors).

Once “Solution Behaviors” are identified, therapists essentially have the counseling goals or “Game Plan” and can help parents learn how to “referee, coach, and cheerlead.” They learn that referees do not just “blow the whistle” or “call a child out,” but also articulate correct “plays,” because there is a “play book” (or “Game Plan”) stating what is acceptable behavior and what is not. Parents “coach” their children through intentional role-modeling and teach specific appropriate behaviors. Parents also learn how to “cheerlead” by positively reinforcing a child’s exhibition of appropriate “plays.” Good coaching and cheerleading lead to less refereeing over time. Skinner (1965) spent a lifetime teaching therapists the “Technology of Teaching.” We must do the same with parents.

Behavioral psychologists are reminded that positively phrased operational statements, or rules, can be conceptualized as “equations” or “pathways.” Indeed, there is no shortage of metaphors or word phrases illustrating the “ingredients” for predetermined sequences and orderly pathways (ie: recipes, blueprints, chemical or mathematical formulas, play books, chain reactions, routes, algorithms, procedures, computer codes, grammatical syntax and the numerous successions of growth through developmental stages, grade levels, and developmental skill sets). These sequences are predetermined and intentionally included. They contain steps that are not purposeless...but are meaningful...in a process that is itself meaningful.

Parents learn to recognize verbal statements as “Pathways,” where two or more steps may be necessary to reach a particular end. An example of this concept is: step one - eat dinner, and step two - eat dessert, in that order. It is understood that dinner precedes ice cream. There are many such examples: finish homework / watch TV; clean room / go to a friend’s house; finish chores / have friends over. The challenge is to help parents teach children how to reach particular goals and exhibit “a good work ethic.” An “economic transaction” emerges, and, yes, another metaphor arises!

Since behaviors tend to be goal oriented, behavioral change requires children to learn how “behavioral equations” operate. Parents learn
TABLE: EXAMPLES OF PROBLEMS AND SOLUTION BEHAVIORS

<table>
<thead>
<tr>
<th>PROBLEM BEHAVIORS</th>
<th>SOLUTION BEHAVIORS (THE GAME PLAN)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fighting with siblings and peers</td>
<td>Getting along with siblings and peers</td>
</tr>
<tr>
<td>Screaming, yelling</td>
<td>Speaking in a quiet (indoor) voice</td>
</tr>
<tr>
<td>Hitting, punching, kicking</td>
<td>Keeps hands and feet to self</td>
</tr>
<tr>
<td>Not sharing, not taking turns</td>
<td>Sharing, taking turns</td>
</tr>
<tr>
<td>Not agreeing to play together</td>
<td>Agreeing to play together</td>
</tr>
<tr>
<td>Not using kind words</td>
<td>Using kind words</td>
</tr>
<tr>
<td>Messy</td>
<td>Clean and Neat</td>
</tr>
<tr>
<td>Will not put things away in bedroom</td>
<td>Puts things away in bedroom</td>
</tr>
<tr>
<td>Toys left on floor</td>
<td>Puts toys away</td>
</tr>
<tr>
<td>Bed not made</td>
<td>Makes bed</td>
</tr>
<tr>
<td>Poor Social Skills</td>
<td>Good Social Skills</td>
</tr>
<tr>
<td>Does not look at person when spoken to</td>
<td>Looks at person when spoken to</td>
</tr>
<tr>
<td>Does not reply when spoken to</td>
<td>Replies immediately when spoken to</td>
</tr>
<tr>
<td>Does not say hello or good bye</td>
<td>Says hello or good bye</td>
</tr>
<tr>
<td>Does not use other person’s name</td>
<td>Uses other person’s name</td>
</tr>
<tr>
<td>Does not say please or thank you</td>
<td>Says please or thank you</td>
</tr>
<tr>
<td>Does not tell the truth</td>
<td>Tells the truth</td>
</tr>
<tr>
<td>Needs requests repeated frequently</td>
<td>Does what is told immediately</td>
</tr>
<tr>
<td>Poor Table Manners</td>
<td>Good Table Manners</td>
</tr>
<tr>
<td>Does not stay seated</td>
<td>Stays seated</td>
</tr>
<tr>
<td>Fidgets excessively</td>
<td>Sits without moving or fidgeting</td>
</tr>
<tr>
<td>Does not eat with utensils</td>
<td>Eats with utensils</td>
</tr>
<tr>
<td>Does not eat quickly</td>
<td>Eats quickly</td>
</tr>
<tr>
<td>Poor Academic Performance</td>
<td>Good Academic Performance</td>
</tr>
<tr>
<td>Not writing down assignments</td>
<td>Writes down homework assignments</td>
</tr>
<tr>
<td>Not bringing home necessary books and papers</td>
<td>Brings home necessary books and papers</td>
</tr>
<tr>
<td>Not doing homework independently</td>
<td>Does homework independently</td>
</tr>
<tr>
<td>Not returning completed work to school</td>
<td>Returns completed work to school</td>
</tr>
<tr>
<td>Gives up easily on challenging tasks</td>
<td>Perseveres with challenging tasks</td>
</tr>
</tbody>
</table>

how to teach basic sequences where work leads to reward... or that reward follows work. A visual representation of this concept is illustrated by the “Road Less Traveled Map” (See diagram on page 15), a map inspired by the poetry of Robert Frost. It illustrates how a particular choice or pathway can make all the difference in the life of a child. Contrary to popular belief, all roads do NOT lead to Rome. Some are circuitous, some are inefficient, and others are just plain dead ends.

By identifying what a child desires, parents inadvertently identify a potential punishment since the absence of that reward (or incentive) may feel like punishment to the child. Punishment, however, is never the goal; it is essentially the consequence of error in judgment. When specific variables are missing from an equation, the equation cannot be completed and error or disappointment results. In many cases, a misunderstanding of definitions and valuations of what is appropriate and inappropriate contributes to faulty decision making by the child. Goal oriented behavior is calculated and well thought out. Metaphors illustrating sequencing simply illustrate that behavioral change requires intentional movement towards a specific goal.

When children learn they have choices, they learn failure to obtain a reward is the result of their own choice, not a choice made by their parent. The map referenced above can be used with parents to illustrate “pathways” (or choices) for children; so that, children understand that their parents wish to see them succeed and be happy. Parents learn “scripts” such as: “Yes, you can (have the reward) AFTER you (do the work).” Phrasing is critical; the reward is mentioned first to grab attention and motivate the child. If the child makes a poor choice, or travels down a pathway that does not take him/her where he/she desires to go, parents are encouraged to use specifically formulated phrases such as: “You know, honey, I told you that you could (have your ice cream) AFTER you (eat your dinner). You chose not to (eat your dinner), so you chose not to (have ice cream).”

Many diagnoses appear to be related to sequencing problems. For example, Kofman, Larson and Mostofsky (2008) found an impairment in strategic planning in children with ADHD. As a result, these children do not focus on the “essential variables” or necessary steps to complete equations. These children are distracted by “extraneous variables” that lead them astray on pathways that ultimately take them to undesirable destinations. Children suffering from anxiety and depression benefit from a cognitive behavioral approach (Sburalati, Lyneham, Schniering, 2014) as they learn to identify pathways between thoughts and feelings. Children with Autism (Smith, 2012) also respond well to behavioral techniques that teach simple sequencing skills because pathway mapping helps them navigate in a confusing verbal world filled with “extraneous data.”

When children are waylaid by “inoperable equations” or undesirable pathways, therapists must help parents communicate simply; so that, extraneous variables interfering with the child’s ability to make good choices are removed. Indeed, sequencing problems underlie many problematic emotions and behaviors. Children need to be taught to...
focus on end results, goals... destinations. They must learn to identify both desirable and undesirable pathways, and must learn the necessary steps to get from point A to point B, from Step 1 to Step 2.

Children must learn to manage their anxiety and improve their frustration tolerance in order for something good to happen. They need to learn they can obtain what they desire AFTER they work for their reward, not before. It is any easy-to-use concept that even a child can learn. One eight year old boy, finally grasping the concept that not working and yet expecting a reward was an inoperable sequence, excitedly exclaimed, “It is like being a robber!” Interestingly, the child developed his own unique metaphor.

Many parents enter counseling offices asking for assistance with children who may be anxious, depressed, oppositional, or just simply feel inadequate. They want to learn how to motivate their children to make good choices, to do the things their children do not naturally enjoy doing nor have an inclination to do. Therapists need to be creative when teaching cognitive behavioral approaches by collaborating with parents, using metaphors to teach sequencing skills in a positive and engaging manner. Destination determines route! When children know where they are going and want to go there, they are more likely to take the shortest, straightest, pathway to that destination. Elementary math teaches that the shortest distance between two points is... a straight line.

**References**


**About the Author**

Amel Sweis-Haddad, PsyD is a former NY School Psychologist who is currently in private practice as a licensed Psychologist in the Youngstown, Ohio area. She enjoys presenting seminars to parents, educators, and counselors. Her love of prose allows her to use metaphors when consulting with parents about the problematic behaviors of their children. She believes metaphors borrowed from diverse fields help parents learn cognitive-behavioral strategies in a fun and easy to understand manner.
Integrated and Brief: A Meta-Framework for the Modern Psychologist
Dr. Kirby K. Reutter, PhD, LMHC, ICAADC, CADAC-IV, MAC

Abstract
In contrast to the early years of psychoanalysis, today’s psychologist must service a diverse spectrum of populations, needs, and disorders within the context of insurance, managed care, and rigorous standards for professional accountability. The exigencies have required modern psychologists to rethink how they conduct therapy in two significant ways. First, psychologists no longer have the luxury of committing themselves to a single model or treating only a select clientele that seems to be a “good fit” for their approach. Second, psychologists must also exercise far greater efficiency in their delivery of professional services. Thus, if contemporary clinicians wish to be competent with clients and competitive with colleagues, they should consider becoming fluent in multiple models while providing successful, evidence-based therapy in fewer sessions. The objective of this article is to address both concerns in a single framework.

INTRODUCTION
Clearly the field of psychotherapy has changed dramatically since the days of Sigmund Freud (Hergenhahn, 2013). In contrast to the early years of psychoanalysis, the psychologist of today must service a diverse spectrum of populations, needs, and disorders within the context of insurance, managed care, and rigorous standards for professional accountability. These exigencies have required modern psychologists to rethink how they conduct therapy in two significant ways. First, psychologists no longer have the luxury of committing themselves to a single model or treating only a select clientele that seems to be a “good fit” for their approach. In fact, the research is clear that certain models are more efficacious than others for particular populations, particular needs, and particular disorders (Corey, 2012). Second, as if the first demand were not enough, psychologists must also exercise far greater efficiency in their delivery of professional services. Thus, if contemporary clinicians wish to be competent with clients and competitive with colleagues, they “had better” (courtesy of Albert Ellis) be fluent in multiple models while providing successful, evidence-based therapy in fewer sessions.

The objective of this task is to address both concerns in a single framework. First, I would like to propose a diagram that subsumes the traditional schools of psychotherapy under one meta-model. Second, I would like to explicate the principles of Brief Therapy as they relate to this diagram. In short, the ultimate purpose of this paper is to demonstrate that all models are clinically useful; that it is possible to conceptualize the same clinical issues from multiple perspectives; and that each approach is amenable to brief applications, as the need arises.

AN INTEGRATIVE FRAMEWORK
Before proposing the meta-framework, I would first like to present my overall findings upon which the framework was constructed. After thoroughly reviewing literature regarding the major traditions of psychotherapy, I have arrived upon the following conclusions:
1. All models of psychotherapy, at their root, deal with various aspects of the mind, various aspects of behavior, and/or various aspects of relationships.
2. There are five crucial factors which both comprise and influence the mind: biology, cognition, affect, volition, and the “missing link” (known for thousands of years as the human spirit).
3. There are five major categories of relationships: intrapersonal, interpersonal, social, environmental, and transcendental. Intrapersonal refers to relationships with the self (e.g., id, ego, and superego); interpersonal refers to relationships with specific individuals (e.g., spouse, boss, neighbor, etc.); social refers to relationships with groups of people (e.g., family systems, organizations, communities, etc.); environmental refers to relationships with a specific setting, context, or milieu (e.g., school, workplace, neighborhood, etc.); and transcendental refers to relationships with the divine (however divinity is understood by the client).
4. All of these various manifestations of the mind and relationships transact systemically to influence behavior. Thus, there are a multitude of layered and multifaceted factors—both seen and unseen—which ultimately underlie behavior. Therefore, behavior can rarely (if ever) be taken at “face value.”
5. Behavior itself also plays a causal role within the system by reciprocally influencing all components previously delineated.
6. None of these components exists in isolation except as abstract constructs. Rather, each “component” co-exists interdependently and inextricably within the context of and as a function of all other components.
7. All models have some fundamental nomenclature for “abnormal” (such as neurotic, dysfunctional, incongruent, irrational, distorted, maladaptive, etc.)
8. In all models, various forms of relationships seem to be the primary indicators of psychological health (as exemplified by terms such as congruence, synchrony, attunement, attachment, goodness-of-fit, etc.).
9. Distinct models can be used alternatively or simultaneously since various schools of psychotherapy represent different aspects or emphases of the same overall system. Thus, the same problem, as well as various solutions, can be viewed dialectically from multiple perspectives at the same time.
10. Psychologists can strategically intervene anywhere in the system to effect change, including those areas that are already functioning well.

These themes are pictorially represented in the diagram.

Let’s take one simple example to illustrate how this diagram can be utilized for clinical purposes. Suppose a client enters therapy complaining of the “common cold” of psychology—depression. Before knowing anything else about the client, the psychologist already has a myriad of starting points from which to conceptualize the presenting problem. After identifying an appropriate starting point, the psychologist then proceeds to select an appropriate model to effect change within the system. The chart to the right represents one possible decision-making trajectory (among a seemingly limitless range of options).

Thus, each component of the diagram represents different possible starting points for treatment. First, the psychologist identifies the most likely etiological factor(s). For example, the psychologist may identify a biological component (e.g., seasonal fluctuations); a cognitive component (e.g., thinking errors); an emotional component (e.g., grief or mourning); a volitional component (e.g., learned helplessness); a spiritual component (e.g., guilt over wrongdoings); an intrapersonal component (e.g., negative self-talk); an interpersonal component (e.g., marital conflict); a social component (e.g., symptom-bearing within the family system); an environmental component (e.g., an oppressive workplace); a transcendental component (e.g., dysfunctional God construct); or a behavioral component (e.g., avoidance / withdrawal).

Next, the psychologist identifies the most strategic area of intervention. Since this diagram is conceptualized as a system, any intervention will theoretically affect the rest of the system; therefore, the point of intervention does not necessarily need to correspond directly to the presenting problem, or even the identified etiology. For example, a spouse may complain of increased marital conflict in January (i.e., an interpersonal issue) while the psychologist may deduce a seasonal component (i.e., biology)—yet recommend an environmental intervention (i.e., take a trip to Florida!) Or a client may blame his depression on behaviors (e.g., “I always mess up, I don’t do anything right”), whereas the psychologist may determine a deeper intrapersonal issue related to self-image—and yet prescribe a cognitive intervention related to automatic thoughts.

Once the psychologist determines the most strategic area(s) of intervention, the next step is to identify an appropriate model (and the corresponding techniques) to effect change within the system. For example, if the psychologist determines that biology is the most strategic area to target, she may recommend a psychotropic medication (i.e., psychopharmacology). If the psychologist identifies cognition as the most strategic area to address, she may suggest an examination of core beliefs (i.e., Cognitive Therapy). If the psychologist decides that affect is the most strategic area of focus, she may prescribe emotional regulation (i.e., Dialectical Behavior Therapy).

### MULTIPLE MODELS, MULTIPLE INTERVENTIONS

<table>
<thead>
<tr>
<th>Starting Point</th>
<th>Possible Model</th>
<th>Possible Conceptualization</th>
<th>Possible Focus / Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biology</td>
<td>Psychopharmacology</td>
<td>Seasonal serotonin deficiency</td>
<td>Prescription of SSRI</td>
</tr>
<tr>
<td>Cognition</td>
<td>Cognitive Therapy</td>
<td>Thinking errors</td>
<td>Automatic thoughts</td>
</tr>
<tr>
<td>Affect</td>
<td>Psychoanalysis</td>
<td>Repressed anger</td>
<td>Defense mechanisms</td>
</tr>
<tr>
<td>Volition</td>
<td>Reality Therapy</td>
<td>Lack of personal responsibility</td>
<td>Goal-setting</td>
</tr>
<tr>
<td>Spirit</td>
<td>Existential Therapy</td>
<td>Loss of meaning or purpose</td>
<td>Reframing</td>
</tr>
<tr>
<td>Intrapersonal</td>
<td>Person-Centered Therapy</td>
<td>Incongruence with self</td>
<td>Values clarification</td>
</tr>
<tr>
<td>Interpersonal</td>
<td>Object Relations Therapy</td>
<td>Insure attachments</td>
<td>Attunement</td>
</tr>
<tr>
<td>Social</td>
<td>Family Systems Therapy</td>
<td>Diversion from other family problems</td>
<td>Family roles</td>
</tr>
<tr>
<td>Environmental</td>
<td>Dialectic Behavioral Therapy</td>
<td>Invalidating conditions</td>
<td>Self-soothing skills</td>
</tr>
<tr>
<td>Transcendental</td>
<td>Various religious traditions</td>
<td>Unhealthy / inconsistent theology</td>
<td>God construct</td>
</tr>
<tr>
<td>Behavior</td>
<td>Behavior Therapy</td>
<td>Avoidance of conditioned stimuli</td>
<td>Prolonged exposure</td>
</tr>
</tbody>
</table>
Therapy)... and so on and so forth. Alternatively, the psychologist may choose not to directly address the problem(s) at all—and instead focus exclusively on the client’s strengths (i.e., aspects of the client’s system which are already functioning well).

Finally, the psychologist must evaluate the efficacy of her intervention. If the prescribed treatment does not result in clinically significant outcomes, the psychologist should re-assess the original conceptualization, identify alternative areas of intervention, or select different models / techniques to treat the issues.

MAKING IT BRIEF: THE APPLICATION OF BRIEF THERAPY

A number of practitioners have noted a plethora of techniques, strategies, and interventions which—irrespective of theoretical orientation—can render therapy considerably briefer than traditional approaches alone. While it is not possible here to delve into specific applications, I have summarized the literature into the following six themes. (To honor the values of Brief Therapy, I would like to keep this section, well, brief!) As you read through the six guidelines listed below, please note how these principles are applicable to any model of psychotherapy (De Jong & Berg, 2008).

1. Identify goals that are concrete, observable, definable, quantifiable, measurable, manageable, realistic, achievable, behavioral, client-derived, client-focused, and solution-oriented—and frequently utilize scaling questions to assess / evaluate progress towards goal achievement.

2. State goals in terms of the presence of a positive phenomenon (as opposed to the absence of a negative phenomenon).

3. Skillfully convert the therapeutic culture from a problem orientation to a solution focus as quickly as possible; identify past and present successes as well as any exceptions to the identified problems; coach the client to think, feel, act, chose, and relate as if the problem were already solved.

4. Learn, understand, and work within the client’s own idiosyncratic, phenomenological, subjective, or personal framework, especially in terms of negotiating the problem, identifying solutions, and framing interventions.

5. Foster the internal and external strengths, skills, capacities, competencies, assets, and resources which the client already has, can have, or has but does not recognize.

6. Instead of trying to discern the specific etiologies of a disorder, identify the patterns or routines associated with the symptoms (however indirectly or tangentially), and then disrupt those dynamics such that the symptoms are less likely to manifest.

CONCLUSION

In summary, there are two fundamental demands which are influencing the direction of contemporary psychotherapy: first, psychologists must service a growing diversity of populations, issues, and disorders; second, psychologists must deliver effective therapy under greater time constraints. Thus, it is no surprise that the field of psychotherapy is increasingly characterized by the ideals of integration and brevity.

The objective of this paper was to propose a meta-framework of therapeutic models for precisely that purpose. First, I have presented a diagram in which various symptoms / disorders can be conceptualized from the perspective of multiple models, allowing the psychologist greater flexibility to deal with greater diversity of needs. Second, I have shown how the major themes of Brief Therapy are applicable to this framework, allowing psychologists to implement their model of choice as expeditiously as possible.

* For a more comprehensive explication of the how this model relates to the traditional models of psychotherapy, please contact the author directly at kirbyreutter@gmail.com.

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References


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About the Author

Dr. Kirby K. Reutter, PhD, LMHC, ICAADC, CADAC-IV, MAC is a bilingual psychologist, mental health counselor, and internationally credentialed addictions therapist. Dr. Reutter has widely presented his unique approaches to psychotherapy throughout the nation. In addition, he has conducted his own international research on coping, the results of which have been published by three different sources. Dr. Reutter specializes in treating traumatized youth, working with Spanish-speaking clients, and providing psychological evaluations for adoptive parents.

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Challenges to Self-Care in the Workplace: Chronic Physical Illness in Practicing Psychologists

Deanna Barthlow-Potkanowicz, PhD
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Abstract

Psychologists frequently discuss the importance of self-care with therapy clients. Practicing self-care in their own professional lives, though, can be an elusive prospect for psychologists especially for those coping with chronic physical illness. Research on psychologists’ well-being in relation to their work has mostly focused on compassion fatigue, burn-out, and impaired judgment. There is little research on managing workplace stress and dynamics for professionals who have chronic “invisible” physical illnesses, such as fibromyalgia, arthritis, inflammatory bowel diseases and chronic fatigue syndrome. This paper seeks to expand the dialogue around the topic of self-care among practicing psychologists with chronic physical illness. Challenges to achieving work-life balance are identified, and reasons why some professionals hesitate to pursue workplace accommodations are offered. Recommendations for expanding this conversation are made, including the need for empirical investigation and strategies to help psychologists move towards a healthier work-life balance.

INTRODUCTION

Psychologists know that self-care is essential, but daily job expectations often compete with self-care efforts. How do you care for yourself when your job is to set aside your needs and care for other people? Examining the literature, one finds a wealth of information around topics such as burn-out, compassion fatigue, or impairment (Grosch & Olsen, 1995; Sherman & Thelen, 1998; Smith & Moss, 2009; Schoener, 2013). Comparatively speaking, there is little information on the specific topic of managing a chronic physical illness as a psychologist. For example, addressing impairment specifically, studies have often focused on substance abuse and sexual misconduct (Sherman, 1996). Others have examined personal distress, resilience, and self-care patterns (Mahoney, 1997; Charlemagne-Odle, Harmon, & Maltby, 2014), or have tried to increase awareness about the need for self-care to prevent impairment (Barnett, Baker, Elman, & Schoener, 2007; Barnett & Cooper, 2009; Good, Khairallah, & Mintz, 2009).

While there is some literature focused on physical illness, it typically describes terminal illnesses and the impact on the psychologist’s practice. For example, Johnson and Barnett (2011) discussed issues involved in maintaining professional competence when facing life threatening illness. But, the discussion was focused mostly on the ultimate closure of one’s practice. More commonly, existing research discusses managing conditions in one’s clients (Williams & Koocher, 1998; Moss-Morris, 2011). Comparatively, we rarely talk about the experiences of psychologists living and working with a chronic, but survivable, physical illness and how to integrate self-care into the workplace.

The time has come for the field of psychology to expand its discussion of psychologists’ well-being to better include the concept of managing chronic physical illnesses, including, but not limited to, conditions such as diabetes, chronic fatigue, arthritis, fibromyalgia and inflammatory bowel diseases. Therefore, the purpose of this review is three-fold. First, the available literature regarding psychologists with chronic physical illness is outlined. Second, challenges to achieving work-life balance are identified. Lastly, recommendations are offered, both for research efforts and for supporting the concept of work-life balance.

LITERATURE REGARDING PSYCHOLOGISTS WHO HAVE CHRONIC PHYSICAL ILLNESS

The majority of the literature relative to psychologists coping with a physical illness tends to be anecdotal accounts of personal experiences with either chronic or terminal illness. For example, Sollod (2002) wrote about his identity as a psychologist dealing with end-stage renal disease, while Laungani (2003) discussed his experience with polymyositis. Both authors offered practical advice for finding meaning and caring for those who are ill. Schoolman (1988), Morrison (1997), and DeMarce (2007) all described personal experiences with cancer, the impact it had on their therapy practices, and the importance of self-care. Others have discussed workplace challenges encountered as a result of their condition. For example, Cox (1985) described an increasing sense of isolation in her workplace as she gradually lost her hearing due to otosclerosis, as well as the need to better integrate psychologists with hearing impairments into the workplace. Additionally, Magni (2007) discussed her experience with managing lupus, while Paparella (2004) described the experience of having Parkinson’s Disease and leading a therapy group of patients with the same condition. Lastly, Stratton, Kellaway, and Rottini (2007) presented personal accounts of graduate students who managed clinical training while going through personal stressors, including one student who developed an autoimmune disease.

The other common theme within the literature relates to the impact of a therapist’s illness on both therapist and client. For example, Dewald (1994) addressed issues associated with therapist illness and countertransference. Rosner (1986) discussed the experiences of four psychoanalysts with life-threatening illness and the experiences of each in deciding how much information should be disclosed to clients, the timing of that disclosure, and who should tell them. Similarly, Abend (1982) described his decision process around disclosing information about his illness to clients. Others have recommended training on this issue for therapists, flexibility in decisions about disclosure, and establishing plans to provide for clients in the event of therapist illness or death (Counselman and Alonso, 1993). Finally, Philip (1993) discussed the need to self-disclose in order to seek peer consultation about proceeding with one’s practice in the face of terminal illness.
There are numerous challenges to achieving work-life balance as a practicing psychologist with chronic illness. First, in terms of group affiliation, Loveys (1990) and Kralik (2002) both noted that people with chronic illness sometimes view themselves as neither sick nor well, but rather, at risk of progressive illness. This conceptualization can lead to a feeling of social isolation, as one does not fit well into any particular group.

Second, having a chronic illness means having a greater need for a healthy lifestyle, including effective stress management habits, a routine schedule, adequate sleep and healthy eating habits. Unfortunately, meeting the demands of a job in mental health care does not always allow for adequate self-care. For example, if the job requires on-call duty, sleep is regularly disrupted. Case-load size, client emergencies, and a hectic schedule can make it difficult to meet one's own needs, including finding time for medical appointments, exercise, or even eating lunch during the workday.

Another challenge is the dilemma of how much to reveal to co-workers and employers about one's health, particularly if there are frequent medical appointments, sudden changes in health status that require adaptation, or additional tasks beyond the original job description. Driedger (2003) pointed out that many employers don't know how to accommodate chronic illnesses, or what the symptoms of various illnesses even are. Unfortunately, the employee might not know what accommodations are needed to manage both job and health effectively either, but they are responsible for identifying the need, being their own advocate, and helping to brainstorm a solution (Driedger, 2003). On a related note, some psychologists might even feel that they are not entitled to accommodations because they do not have an officially recognized disability.

Adding to the challenge of how much information to reveal is the fear of stigma, employment-related discrimination, or marginalization, as well as issues of personal pride and privacy. For example, some people may fear that they will be viewed as unreliable or incapable if their illness is known. They may also fear that by disclosing to one person, they lose control of their personal information and may have their illness revealed to others without their permission. Driedger (2003) pointed out that some co-workers wonder why a person, who doesn’t appear to look ill, is receiving accommodations. Lastly, Oldfield (2013) identified value judgments encountered by patients from their physicians that can also ring true in the workplace, including disbelief that a person has an illness, accusations of symptom exaggeration, blaming the person for lacking motivation to get better, and expressing frustration with the person for having an illness.

**RECOMMENDATIONS**

Given that the majority of the published literature in this area tends to be anecdotal in nature, the following recommendations are offered. Quantitative studies on the prevalence and management of chronic illness in psychologists are needed. In addition to assessing prevalence, it would be helpful to know how many psychologists, of those not self-employed, have informed employers of their illness, as well as reasons for and against disclosure. Research should also examine rates of workplace discrimination related to this issue. Finally, investigations into barriers to work-life balance are needed, including real and perceived barriers to requesting accommodations.

Beyond empirical investigation, methods for creating healthier and more supportive workplaces that welcome those with chronic illness are needed. A good stepping-off point in terms of creating a healthy work environment would include treating co-workers and employees who have a chronic physical illness with the same respect that we give clients. For example, listening, validating, and empathizing with someone who has a chronic illness is an effective way of expressing respect and understanding (Oldfield, 2013.)

Employers can also raise awareness and provide education around chronic physical illness to help reduce judgments and assumptions. Kralik (2002) noted the need to educate oneself on ways to help someone with chronic illness and on the stages of transition that people go through. Kralik emphasized listening sensitively, acknowledging the issues and realities at hand, and building relationships to reduce miscommunication and to understand difference. As we tell our clients, cultivating a strong social support system benefits one’s physical and mental health.

At the professional level, the field of psychology, and its training programs, should focus on better recognition of the inherent stress of being a mental health care provider, as well as better communication of the need for work-life balance. Furthermore, the profession needs to better frame the purpose of work-life balance as being for the happiness and overall well-being of the psychologist, in addition to its focus on the need to remain competent to conduct clinical services.

On an individual level, a person with a chronic physical illness would be helped by learning more about the relationship between stress and health and by improving stress management skills. Coping with a medical illness can be similar in some ways to coping with general stress, and framing it that way can make it easier for a person to identify effective self-care strategies. Self-monitoring and tracking of symptoms, stress, and the effect of interventions is helpful. On an individual level, a person with a chronic physical illness would be helped by learning more about the relationship between stress and health and by improving stress management skills. Coping with a medical illness can be similar in some ways to coping with general stress, and framing it that way can make it easier for a person to identify effective self-care strategies. Self-monitoring and tracking of symptoms, stress, and the effect of interventions is helpful. Self-monitoring and tracking of symptoms, stress, and the effect of interventions is helpful.

This discussion represents only the beginning of a necessary conversation within the field of psychology. As is noted here, it is change at various levels that will lead to a more inclusive environment for the psychologist with a chronic illness.

**References**


Challenges to Self-Care in the Workplace: Chronic Physical Illness in Practicing Psychologists


About the Author

Deanna Barthlow-Potkanowicz is a licensed psychologist in Ohio. She earned her BA in psychology from Lycoming College in Williamsport, Pennsylvania, and her MA and PhD in Clinical Psychology from Kent State University. She completed her APA-accredited internship at the Counseling & Testing Center at the University of Oregon. Deanna is currently an Assistant Professor of Psychology and coordinator of the Women’s Studies minor at Bluffton University. Before transitioning into teaching, she worked in clinical settings for 10 years. Prior to her current position, she was a staff psychologist and Eating Disorders Treatment Team Coordinator at Ohio University. Earlier in her career, she worked for a consulting firm, conducting psychological evaluations for the public safety community.
**Abstract**

There is growing evidence regarding effectiveness of using mindfulness meditation techniques with a variety of clients and presenting problems (Goodman, Kashdan, Mallard, & Schumann, 2014; Dixon, Chapman, Turner, 2015). For the purposes of both self-care and also learning how to effectively teach mindfulness, clinicians may choose to integrate a meditation practice of their own (Gwozdz, 2010; DiBenedetto & Swadling, 2014). Mindsight (Siegel, 2010) provides a framework for assisting clients in learning how to observe their own mind and clinicians in developing a practice of self-care.

Recent years have seen attention in the professional literature to burn-out, compassion fatigue, and secondary trauma; the APA Code of Ethics explicitly identifies the ethical necessity of self-monitoring for personal problems and intervening if they observe another psychologist if impairment is evident. The stress associated with burn-out makes a regimen of regular self-care essential for burn-out prevention. Some studies have confirmed the value of mindfulness as a technique for powerfully effective self-care among psychologists (DiBenedetto & Swadling, 2014; Gwozdz, 2010; Kane, 2010; Shapiro, 2014; Wise, Hersh, & Gibson, 2014). Other studies have focused on mindfulness for therapy trainees as components in helping them establish a healthy foundation of self-care for career longevity and burn-out prevention (Dorian & Killebrew, 2014; Shapiro, Brown, & Biegel, 2007).

This paper is predicated on the recognition of the potential importance of a self-care regimen for anyone and especially those providing therapy on a regular basis. Self-care can take many forms; it may involve setting boundaries around having time for oneself, assertively saying “no” when asked to do additional tasks that cut into one’s free time, exercise, nutrition, spiritual involvement, and techniques for stress management such as meditation.

Mindsight is one form of meditation. Siegel (2010) defines Mindsight as "the capacity to sense energy and information flow in the triangle (mind, brain, and relationships); so that, we can monitor and modify how we regulate, shape, and share this flow with one another and within ourselves" (p. 171). Mindsight arises from a continual process of simultaneously perceiving stimuli from various sources. Stimuli can be conceptualized as being organized in the brain via several channels and modes of integration (Siegel, 2010a, 2010b, 2012). Mindsight meditation focuses on 9 aspects of integration, all of which emanate from the discipline of interpersonal neurobiology. These integrative...
Mindsight: Clinical and Personal Self-Care Practice

aspects include: interpersonal, temporal, memory, state, vertical, horizontal, narrative, consciousness and transpirational. Clinically, if individuals develop a better understanding of their own minds, how their minds work and how to relate to others, they will have the capacity to become more integrated and better able to have empathy and to others. Additionally, Mindsight integrates the practice of mindfulness with neurobiology and our connections with others. In this manner, Mindsight provides a means of connecting thoughts, feelings, the brain and our social relationships.

While mindfulness and Mindsight are both meditation practices geared for therapeutic intervention, they share some similarities and differences. Kabat-Zinn (2003) defines mindfulness as "...actually feeling the present moment to see it in its fullness, to hold it in awareness and thereby come to know and understand it better." (p. xiv). While many integrate mindfulness into a spiritual practice, in the last decade, we have seen clinical research that expands mindfulness beyond spiritual practice, demonstrating the effectiveness of meditation in an effort to improve emotional regulation and distress tolerance among a broad range of clients and presenting concerns (Dixon-Gordon, Chapman, & Turner 2015; Forman, Butryn, Hoffman, & Herbert, 2009; Bishop, 2015). Like most meditation, Mindsight maintains the importance of paying attention and being present to each moment as well as being nonjudgmental.

THE WHEEL OF AWARENESS

In contrast to standard meditation, Mindsight uses the “wheel of awareness” to identify each of the components of this practice. The Wheel of Awareness is organized by sources of neurological input and focuses on the flow of energy, information, and the integration of that information. There are two rims; the outer rim represents our awareness of what happens in the outside world, while the inner rim represents our inner experience. The wheel is divided into four sections that are the focus of the meditation. The spokes connect to the hub or our inner experience, and in meditation, our efforts enable us to move back and forth between this awareness and our own inner experience. As a side note, in clinical practice, we do this frequently as we view and hear the stories of our clients and balance their experience with what we see as clinicians. By developing our own practice of Mindsight, we hone our own skills of understanding how the mind works and gain leverage in helping our clients do the same.

The four quadrants of the wheel are 1) awareness of the five senses, 2) body scan and introspection, 3) awareness of mental activity, and 4) relationship/connection to others. Again like most meditation, the breath is used as a centering process that brings the focus back to all that is within. Individuals who are unfamiliar with meditation techniques might not be aware that one of the most crucial components of meditation is to let go of one’s thought process, whereby we become detached observers of our own thinking. One useful way to accomplish this detachment and meta-observation is by focusing on the breath. This centering on the breath helps to instill an inner calm and quiet the mind.

Sensory awareness: The first part of the wheel is an attention to the five senses. Being present to what we hear, see, taste, smell and feel in the outer world are common means of getting centered and attuned in this moment. This also illuminates the connection between the external world (the rim) and our internal world (the hub). Before moving on to the next area of the wheel the breath is used to get centered.

Body scan: A body scan is the next area of the wheel and is different from either progressive muscle relaxation or other body scans in that the only objective is to simply notice what is happening in each part of our body from head to toe. If there is tension or pain we notice that and move on. Notice how the process in this form of meditation is to move from outer awareness to inner experience. Mindsight is distinct from other meditation because it includes specific attention to the senses as well as the more traditional body scan. While each of these can be done as a separate mindfulness practice, in Mindsight each meditation incorporates this attention and integration of physical information.

Mental activity: The next area in the wheel of awareness is to focus on thoughts and feelings. Common mindfulness practices encourage the meditator to observe the thought and let it move on and come back to the breath. Siegel encourages individuals to invite thoughts and feelings with the objective of understanding how our mind brings these thoughts in and holds on to them. He includes in this a focus on our hopes, dreams, memories and longings, and again suggests that by understanding how these come into our awareness, individuals will not only develop an understanding of their own mind but develop some capacity for regulation as well.

Connectedness to others: The last area of focus in the wheel of awareness is relational. This is similar to loving-kindness meditation (Salzberg, 2002) where one of the objectives is to develop a sense of connection with not only those who are close to us but to those in our communities and the world at large. Again notice, the integration of our awareness of the external and our own internal processes.

IMPLICATIONS FOR PRACTICE AND FURTHER INFORMATION ON MINDSIGHT

With most meditation practices, whether it is the more common form of mindfulness or Mindsight, psychologists might find it quite helpful to be well-versed in the technique themselves before teaching it to their clients. By having some skill in mindfulness or Mindsight, a clinician would be in a good position to troubleshoot, or model, effective use of either technique. Unlike any other intervention we prescribe and/or use with clients, using meditation is something we
can benefit from and by practicing meditation ourselves, we become better able to guide our clients in this endeavor.

Readers are referred to Dan Siegel's Mindsight homepage at http://www.drdansiegel.com/about/Mindsight for a much more comprehensive presentation of the above-discussed concepts. Additionally, there are numerous training programs and continuing education opportunities for clinicians seeking to enhance their own skill set. We hope that readers find this technique for self-care and teaching self-care to others as compelling as we do.

References


About the Author

Kathryn MacCluskie is a Professor of Counselor Education where she has trained clinical mental health and school counselors since 1994. Her areas of expertise are assessment and skill acquisition among mental health trainees. She also has a small practice in Elyria, Ohio.
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Article: Legal, Ethical and Recommended Practices for Using Email and Texting (pg.4)
1. When psychologists use email or texting with clients they should be familiar with:
   a. Ohio Board of Psychology laws and rules  
   b. APA Telepsychology guidelines  
   c. APA code of ethics  
   d. All of the above
2. Ethical standards and guidelines are both mandatory requirements with which psychologists must comply.  
   True  
   False
3. HIPAA prohibits the use of unencrypted email with clients.  
   True  
   False

Article: Psychological Testing (pg.10)
1. The following is true of the Ethical principles of psychologists and code of conduct:
   a. The standards are mandatory.  
   b. The standards are aspirational.  
   c. The principles are mandatory.  
   d. None of the above are true.
2. Standard 3.04, Avoiding Harm, states:
   a. Psychologists should take steps to ensure their own safety, such as by installing a panic button.  
   b. Psychologists should minimize the potential for inflicting or facilitating harm on their clients, research participants, students, and others.  
   c. Psychologists should teach clients to avoid harming other people in their lives.  
   d. All of the above are correct.
3. Standard 9.03, Informed Consent in Assessments, states that:
   a. Informed consent must be obtained for assessments, evaluations, and diagnostic services.  
   b. Informed consent is required in all situations where testing of any kind occurs.  
   c. Informed consent must typically be notarized.  
   d. Both a and b are correct.

Article: Using Metaphors with Children (pg. 13)
1. How can metaphors be useful when working with parents of children with maladaptive behaviors?
   a. Parents understand metaphors more easily than psychological jargon as they are taken from real life “day-to-day” experiences.  
   b. Parents can use them to teach sequencing and pathway concepts.  
   c. Parents can more readily understand and communicate the necessity of “order.”  
   d. Parents learn to parent intentionally.  
   e. All of the above
2. Why is understanding the concept of “sequencing” critical to the therapeutic process?
   a. Parents learn the importance of sequencing and how to communicate positively with their children.  
   b. Sequencing is a concept necessary for teaching goal oriented behaviors.  
   c. Sequencing teaches a child to work toward a given end and learn frustration tolerance.  
   d. Sequencing skills help improve attentional skills as the child must focus on end results to obtain rewards.  
   e. All of the above

Article: Integrated and Brief: Meta Framework (pg. 16)
1. According to Dr. Reutter’s meta-framework, a psychologist’s intervention must directly correspond to the presenting problem, the clinical diagnosis, and/or the most likely etiology.  
   True  
   False
2. According to Dr. Reutter’s meta-framework, a psychologist should remain committed to her theoretical orientation, irrespective of the client’s needs and/or the clinical outcomes of the prescribed treatment.  
   True  
   False

Article: Chronic Illness in Practicing Psychologists (pg. 20)
1. The published research literature on physical illnesses experienced by practicing psychologists has typically focused on:
   a. the experience of psychologists with chronic, survivable physical illness.  
   b. the experience of psychologists with terminal illnesses and the impact on their practice.  
   c. the need to integrate self-care into the workplace.  
   d. how to keep a psychology practice open while managing illness.
2. Moss-Morris (2011) noted that people with chronic health conditions tend to have more negative outcomes if they:
   a. have moderate to high levels of self-efficacy.  
   b. initially hold more negative attitudes about the condition.  
   c. closely track and document their symptoms.  
   d. discuss their condition with others.

Article: Mindsight (pg. 23)
1. Mindfulness has been empirically demonstrated as a viable treatment strategy for which populations:
   a. athletes  
   b. people with eating disorders  
   c. people with Borderline Personality Disorders  
   d. all of the above  
   e. none of above
2. Psychologists are in a high risk group for burn out and need to have a sound self-care plan.  
   True  
   False
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