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Relationships in the Electronic Era

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“Relationships in the Electronic Era” is the focus and theme of the 2012 Ohio Psychologist (OP). This theme is very timely as the Ohio Board of Psychology has recently adopted rules around practices in psychology and the law. This theme helps to remind all practitioners that relationships are being maintained, enhanced and reinforced through electronic means. These relationships are not only being fostered in the state of Ohio, the United States, but also around the world. The theme further prompts psychologists in practice to remember that their clients may be sharing personal reactions to various communications that have been received via electronic means. The nine articles contained within this OP can serve as a means to strengthen, guide and lead the profession into the ever present electronic era.

I hope as you peruse the content within the Ohio Psychologist, you will find a written text that will (a) inspire you to reflect upon how relationships are being maintained, enhanced and reinforced through electronic means, (b) teach you about the most recent science of the profession as it relates to using social media in practice and (c) learn about current research related to the electronic era.

As you read the various articles in the 2012 OP keep an open and mind and allow yourself to be challenged to actively participate at some level in OPA in order to carry on, influence and secure the future of psychology as it analyzes, grapples with, and embraces relationships in the electronic era.

Enclosed you will find articles that address the 2011-2012 OPA theme of “Relationships in the Electronic Era.” The articles center on the advocacy, practice, and science of the profession as related to the electronic era. The articles should help us reflect upon how electronics impact not only our client’s relationships but also our own relationships. In particular electronics and social media now influence the way we think, act and respond in a number of personal and professional ways.

Advocacy

Facebook and Twitter are two social utilities through which people communicate on a daily basis with each other. Kenneth Drude, Ph.D. in his article, “Social Media Use by Health Care Professionals,” overviews how these new forms of technologies embrace both risks and benefits for professional practices. A number of changes will be occurring in the next few years regarding the diagnosis and classification of mental disorders. The coding of all medical disorders in the United States was scheduled to shift to the ICD-10-CM in October 2013, but that shift has been temporarily delayed. Rodger Blashfield’s, Ph.D. article provides an overview of what the ICD and DSM are as well as how the editions of these classifications have changed. The article, “Future Changes in Diagnostic Systems,” explores the implications of the potential future changes in these classification systems for psychologists and the implications for practice in the future. Elizabeth Swenson, Ph.D. draws upon the Ethical Principals of Psychologists and Code of Conduct to help readers become aware of the ethical dilemmas that can arise between traditional classrooms and distance education in her article, “Translating Ethical Dilemmas from the Traditional to the Online Classroom.” OPA’s 2011 graduate non-empirical category Poster Winner, Michael C. Cadaret, Akron University, explores the record level of poverty in the United States and how emerging social media can influence psychologists in the areas of research, advocacy and policy efforts to implement change in sociopolitical situations in his article, “#Revolution: A review of the psychological impact of poverty and how emerging media can change the sociopolitical discussion.”

Practice

Technology Mediated Learning Environments (TLME) are becoming common place within higher education. Jennifer Scott, Psy.D., Jennifer Ossege, Joy McGhee, Psy.D. and Richard Sears, Ph.D., explore issues related to building and supporting relationships within these contexts. They present critical of, best practices and for directions for TMLE environments. Furthermore, Allen D. McConnell in his article, “Education in the Digital Era: The Experiences of a Non-Traditional Student,” reminds us that there are new resources and methods for delivering graduate education especially for doctoral programs. Within the article common perceptions, benefits and limitations based on the experiences of a non-traditional student are presented. From a professional practice standpoint, Richard Van Voorhis, D. Ed., Matthew Paylo, Ph.D. and Audrey Ellenwood, Ph.D. in their article, “Bridging Clinical and School-Based Practices: Using collaboration strategies and technology to meet the emotional and behavioral needs of children and adolescents, increase awareness as to how clinical and school psychologists can reduce treatment confusion and diagnostic efficiency through the use of collaboration and technological strategies.” Melinda Wolford, Ph.D., Richard Van Voorhis, D.Ed. and David Makara present in their article, “Assistive Technology in the 21st Century: Implications for Ohio psychologists, Families and Educators” the history and legislation of technology devices that have been utilized by individuals with disabilities. They also explore how implementing assistive technology methods can enhance the integrity of more difficult interventions and therapies for individuals with disabilities.

Science

Living in a mentally constructed realm of evaluations and thoughts can result in losing touch with one’s direct sensory experiences in relationships and the world around us. Richard Sears, Ph.D. and James Myo Gak Foster help us to become aware of means through which we can pursue knowledge and alter the limitations of confining cognitions through the use of Zen practices in their article, “Relating to Just This Moment: Use of Zen Koans in an Electronic Era.”

The Creation of the 2012 Ohio Psychologist

The Ohio Psychologist is a peer-reviewed publication. Each article submitted has been carefully reviewed by three peer reviewers, their feedback has been provided to every author and changes to each manuscript has been made before the acceptance of the article was official. This process takes time and the volunteer hours of many individuals. OPA is fortunate to have a core set of peer reviewers with a high level of expertise. I would like to extend my appreciation to the following who reviewed manuscripts for this issue of the Ohio Psychologist:

Kerr Almos, Ph.D., Paule S. Asche, Ph.D., William Bauer, Ph.D., Milton Becknell, Ph.D., Charles Dolph, Ph.D., Marc Dieiman, Ph.D., Jeanne Jenkins, Ph.D., Andrea Karkowski, Ph.D., Kathryn MacCluskie, Ph.D., Janette McDonald, Ph.D., Sabato Sagaria, Ph.D., Carol Smith, Ph.D., Elizabeth Swenson, Ph.D. and Richard VanVoorhis, D.Ed.

Heather Gilbert, OPA’s Managing Editor, was highly instrumental in helping to publish the Ohio Psychologist. Her level of commitment and hours of work to produce this publication cannot be understated. We at OPA are very thankful for the expertise that she brings to this year’s publication.

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

Audrey E. Ellenwood, Ph.D.
Editor, Ohio Psychologist
Abstract
Psychologists have used various forms of assistive technology (AT) to address needs of individuals with disabilities. With newer and more affordable technological devices on the marketplace, many older versions of assistive technology are now being replaced. Devices such as electronic tablets and smartphones are being used in innovative ways to access and provide interventions that were previously more difficult to address. This manuscript will discuss the history and legislation of assistive technology devices and how they may be used in the intervention of individuals with disabilities. Research supported examples will also be provided to illustrate how newer technological devices may now be used to augment those more subtle and complex skill deficits found in individuals that have difficulty with social communication, social skills and motivation. Implementing assistive technology methods can enhance the integrity of more difficult interventions and therapies.
It is recommended that the selection and implementation of assistive technology be prescribed in a structured manner. IEP teams are often encouraged to use the SETT method (Zaballa, 2012) when identifying needs for students with disabilities. This method requires team members to ask questions related to the student, the environment, the tasks, and the tools. For examples: What do we want Susan to be able to do? What materials are currently available in the environment and what is the physical arrangement? What tasks are required by students in the classroom, and what exactly would be required for Susan? Finally, based on the answers to these questions, what assistive technology options or tools might be considered to best meet Susan’s needs?

When considering assistive technology supports, there are a number of products ranging from low tech to high tech. Low tech examples include devices that are typically inexpensive, do not involve electronics, and might be found in the natural environment. Some examples include pencil grips, laminated photographs for a picture board, and enlarged pictures and print. On the other end, high tech supports involve more complex technology and may include computer equipment, augmentative communication devices, and electronic text books. It is often recommended that low tech devices be considered before high tech devices because the former cost less, are easily replaceable, and may be more reliable and easier to use. However, it is interesting to recognize that high tech devices are becoming much more readily available to the mainstream and the devices are becoming more affordable in today’s age of instant communication and mobile technologies. For example, many cell phones today are equipped with (or can easily be equipped with) a number of applications ranging from the use of a calculator to those that are capable of providing voice output for various pictures and functions such as voice recording, automated voice choices, text produced electronically, etc. Perhaps it is time to explore various technology products that families and practitioners may already have (or might easily obtain) and explore ways to add and integrate assistive technology applications.

As the practitioner considers assistive technology to address an individual’s specific needs, more affordable options are now available to provide intervention for the individual’s more obvious deficits as well as those that might be more complicated and subtle. When an individual has difficulty with mobility, the choice is simply a device that assists them in getting from one place to another. It is much more difficult to determine what supplements to choose when addressing issues that are not as visible. Along with poor processing skills many individuals with disabilities also have difficulty maintaining attention and motivation in the intervention process. When selecting an intervention device, there is a need to focus how to best address those subtle and more complex issues, while looking for innovative and novel ways to keep the individual interested and motivated to continue the therapy. Finding such a device might seem impossible. However, with today’s technological options combined with good intervention practice finding such a tool is not only feasible, but accessible. To illustrate the concept of choosing a device that can address both subtle issues (that may cause more profound deficits in relationships) and keep an individual’s attention at the same time, consider the following scenario. What if Susan’s needs include those more complicated and subtle social communication skills that are more often a barrier for individuals diagnosed with Autism Spectrum Disorders (ASD)? What form of assistive technology could be implemented to support them? Core skills of communication effect an individual’s interactions across settings and have a critical impact on home, school and community environments. Research suggests that such deficits originate in an individual’s difficulties in recognizing, processing and understanding complex cues. The result is often interference with affective and social learning which, in turn, significantly impacts relationships with others. Difficulty with interpretation of complex clues, not only results in deficient social learning and relationships, but in academic learning (Cafiero, 2008). Traditionally, practitioners have implemented the use of social stories (Gray & Garand, 1993; Gray, 2000), social autopsies, communication boards, Picture Communications Symbols, social narratives, coaching and modeling to assist individuals with the difficulties in social communication and social skills. More recently, with the addition of technology, attempts at video modeling, interactive activities using virtual reality, and facial expression and emotion

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Serving Students in Grades K-12 with Learning Differences
Technology is continuously evolving in sometimes surprising ways. As practitioners, keeping up with the amazing changes can provide opportunities for more effective interventions for individuals with disabilities of all ages. There is a plethora of literature that explores interventions using technology most especially with the ASD and speech/language impaired population. Emerging applications on the market may be used to design individualized interventions that can become a powerful vehicle for delivery of instruction and generalization of skills for individuals that respond to technology so readily. The use of electronic tablets (such as iPads) offers a world of opportunity to combine two or more of these interventions into one application or designated home. These devices can be used to easily address areas of instruction that were once a burden for practitioners. Using an electronic tablet, the interventionist could create a social story, imbed video that provides appropriate modeling of desired behaviors, and include options for the individual to identify facial and emotional expressions. The individual may then participate in a virtual reality experience in which appropriate responses are positively reinforced. With facilitation and an assurance that the interventions are developmentally, socially and academically appropriate for the individual, opportunities are endless. With electronic tablets, the interventionist can create a visual schedule, produce a social narrative, and provide options for augmentative and alternative communication with the same device. The scaffolding of more complex communication skills might begin with presenting a tangible object (such as a cup), then progressing to the use of a photograph of the cup on an electronic tablet. A symbol of a cup may then be introduced to represent a more “general” expression, followed by the text, “CUP”. Again, all of these activities may be created with the use of one device, the electronic tablet itself. With the electronic tablet, one has the capacity to take pictures, record video, sounds (words and music), relay symbols and more.

Recent studies have shown a beneficial outcome to the use of electronic tablets in the instruction of social skills to individuals with Autism Spectrum Disorder. Psychologists, teachers, families, practitioners and therapists across America have begun to implement these devices across settings as learning tools. According to McIlroy (2012), individuals that have incorporated electronic tablets into their daily lives have access to whole new world with endless possibilities for learning. Since students with an ASD have communication difficulties, assessing the mastery of skills can be a challenging task. Between ten to twenty percent of individuals with an ASD are thought to be non-verbal, and three-quarters of people with autism have been classified as having lower intellectual functioning (McIlroy, 2012). Thus it is crucial for practitioners to establish interventions that specifically focus on increasing functional and positive communication skills. In addition, new applications and programs to address specific skills are being developed and marketed on a daily basis. With such technology at our fingertips, interventionists have great advantages with options that increasingly are becoming more affordable.

Choosing a device that addresses needs and maintains motivation can assist individuals in dramatic ways. This article illustrates the use of such tools with more complex and subtle social communication deficits as seen in individuals diagnosed with ASD; however, the focus on social communication and motivation are just some examples of the endless ways that psychologists can use technology to enhance treatment outcomes. Designing individualized intervention is what the psychologist does for the client. Tweaking those interventions with the addition of assistive technology can make established practice methods more attractive and novel. Using these newer forms of technology in the intervention of individuals with disabilities will bring them closer to their same-aged peers (who use these devices for everyday means) and yield positive intervention results. This, in turn, promotes treatment integrity. Furthermore, these devices can be utilized in different settings and provide the remediation and generalization of skills in a more motivating manner. Tipping the scales towards effective and motivating interventions that can be utilized across settings may lead us towards the ultimate goal of improving deficits for individuals with disabilities and thus enhance quality of life.

References


About the Authors

Melinda Wolford Ph.D., NCSP
Dr. Wolford is an assistant professor in the Department of Counseling, Special Education, and School Psychology at Youngstown State University. As a practicing school psychologist with nearly two decades of experience in the public schools, she is also the President and Co-founder of the No Stone Unturned Foundation, a 501(C)(3) nonprofit organization dedicated to the support and research of children with health initiatives and/or disabilities and their families. Dr. Wolford’s research interests include: Autism Spectrum Disorders, low incidence disabilities to include rare genetic syndromes, learning styles, overall personal well-being, and the effects of neurological disorders of childhood on behavioral response and learning.

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David Makara is an undergraduate student in the Beeghly College of Education at Youngstown State University who is currently pursuing an Intervention Specialist License for Individuals with Mild to Intense Disabilities. David works part time at Iron and String Life Enhancement, a local group home facility. His research interests include: assistive technology, social skills instruction for individuals with Autism Spectrum Disorders, and behavioral support plans for individuals with severe/multiple disabilities.
Social Media Use by Health Care Professionals

Kenneth Drude, Ph.D.

Abstract
Many health care professionals are considering or have begun using social media such as Facebook and Twitter in their professional practices. These relatively new forms of technologies come with benefits and risks to both professionals and their clients. This article will overview some of these costs, benefits and resources that are provided for developing professional social media practices to minimize ethical and legal risks.

The use of social media has dramatically become an everyday part of the daily lives of millions of people and is growing exponentially. There are currently worldwide more than 800 million registered Facebook users (Ludwig, 2012). In addition to individual health professionals using social media professionally, health organizations, such as hospitals, are increasingly using it to communicate with health professionals and patients (Bennett, 2012). So how are health care professionals using social media in their practices?

Psychologists
Although most psychologists are probably aware of some of the more popular examples of social media, most have been cautious in adopting them. A survey of nearly 1,900 psychologists done by the American Psychological Association Practice Organization in 2011 (APAPO, 2012) found two thirds of them did not professionally use any social media tools. Twenty eight percent used LinkedIn, 12 percent used Facebook, and 3.6 percent used Twitter for professional networking. In addition to some psychologists not being knowledgeable or skilled in the use of social media, many undoubtedly have reservations about using them with clients due to concerns about personal and client privacy and confidentiality, maintaining professional boundaries, and potential conflicts of interests. Psychologists are, however, beginning to recognize the potential benefits of social media such as LinkedIn and Twitter to communicate with colleagues and to stay informed about topics relevant to their interests. In the future they will likely be seen as having value for marketing and providing information to clients and potential clients.

Physicians
Compared to psychologists, physicians are well ahead in adopting social media in their practices. A 2011 survey of 4,033 physicians by Modal et. al (2011) found that 67 percent physicians used social media professionally. Twenty eight percent used “physician communities,” 17 percent LinkedIn, and 15 percent Facebook, and 30 percent other media (e.g. YouTube, Blogs, Google+, etc.) and three percent “patient communities.” Eighty seven percent of the survey respondents used social media in their personal lives.

Ethical Considerations
Stephen Behnke, APA’s ethics director, points out that although the APA ethics code does not specifically refer to “social media,” the code clearly applies to the use of any electronic communications that psychologists use (Martin, 2010). Behnke identifies the ethics code sections on privacy and confidentiality, multiple relationships and the section on therapy to be particularly relevant to the use of social media. He cautions psychologists to carefully consider how using technological tools such as social media can be done ethically before using them.

It is advised that psychologists seek and obtain appropriate education, training and consultation before using them. Having and using a social media policy is also recommended to avoid potential ethical dilemmas or questionable practices. Developing and using such policies can be helpful in establishing clarity with other professionals, their employees, clients, former clients and potential clients. Since there are no social media guidelines for psychologists at this time, it is advised that psychologists, in addition to reviewing the APA ethics code, consult resources giving guidance about professional uses of social media. The following are examples of readily available resources that might be helpful in that regard.

A Psychologist’s Policy
Klomes (2010a), a California psychologist, in offering advice about the uses of Facebook and Twitter provides some basics about social media use for psychologists. Her website includes a description of her professional experiences that led to her writing and posting a social media policy on her website that she gives permission for use for non-commercial purposes (Klomes, 2010b). Klomes’ policy is an excellent example of explaining to clients how she conducts herself on the Internet and how she responds to potential online interactions that may occur between her and her clients. This includes how she deals with “friend” requests and who posts and sees what on a Facebook page. Other policy examples include a statement that she does not do searches on her clients on Google or Facebook and that she requests her clients to not use Twitter, LinkedIn or Facebook to contact her since those sites are not secure.

Organizational Policies
The following are some examples of social media policies and guidelines adopted by several different organizations, a state and national medical organization and an online counseling organization.

American Medical Association
The American Medical Association has adopted a concise policy for its members for using social media (AMA, 2011). It focuses on maintaining professional boundaries with patients, personal privacy, patient confidentiality, and cautions about the potential impact postings may have upon physicians’ reputations and careers. The AMA policy includes an explicit obligation that when physicians see unprofessional postings by their colleagues, they are obligated to bring that to the attention of the individual.
Ohio State Medical Association (OSMA)
The OSMA has a comprehensive set of guidelines for using social media by physicians, their office staff and patients that differs from the AMA policy statement by focusing more on company and employee practices than individual physicians (OSMA, 2010). The OSMA document encourages having and enforcing a social media policy and presents ideas about how to do this. Examples of questionable situations using social media and suggestions about “what to do” are included. Also included is a list of recommended “best practices” for social media policies and how to involve employees in writing a policy. Sample practice policies are included to illustrate major social media policy areas.

Online Therapy Institute
The most comprehensive social media guidelines for mental health professionals are those on the Online Therapy Institute (OTI) website (OTI, 2010). The guidelines include common ethical issues identified in many ethical codes such as confidentiality, informed consent, provider competency but also identify other ethical issues more specific to using social media. Some of these topics are personal versus professional behavior on the web for practitioners, dealing with friend and follow requests, use of search engines, interacting using email, SMS, @ replies, and other on-site messaging systems, and consumer review sites. The excerpts below illustrate how a couple of those key social media issues are illustrated in the guidelines.

Personal vs. Professional Behavior on the web for practitioners:
Practitioners are aware of the implications of discussing clinical issues within their social networks in tweets, status updates, and blog posts, and they are aware that messages may be read by wide networks of non-professionals. Practitioners are aware that even masked data may provide enough detail to potentially identify a client. Practitioners understand that messages posted on personal and professional networks may be archived and seen by other parties to whom they are not authorized to release confidential information, and they adjust their behavior accordingly. Online case consultation that reflects client material, even with the record appropriately blinded, should occur in encrypted (or equivalent) environments only.

Friend and follow requests: Practitioners are mindful of the ways that connecting with clients on social networks may potentially compromise client confidentiality or may create multiple relationships with people with whom we have already established one type of professional relationship.

Conclusion
Psychologists remain cautious in professionally adopting social media but will likely in the future learn how to responsibly incorporate them in their practices. There are both potential risks and benefits for psychologists in using social media and it is important for psychologists to be cognizant of both when considering using social media. In addition to learning about professional uses of social media, psychologists need to be aware of recommended and ethical practices and policies, especially with clients or former clients.

References


About the Author
Kenneth Drude, PhD is a psychologist with University Psychological Services Association, Inc. He has over 30 years of management, training and clinical experience in outpatient and inpatient settings. He provides individual, couples, family counseling services, and consultation to adults, adolescents, children and older clients. Dr. Drude is a member of the Ohio Psychological Association, Dayton Area Psychological Association and the American Psychological Association.

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Translating Ethical Dilemmas
from the Traditional to the Online Classroom

Elizabeth V. Swenson, Ph.D., J.D. John Carroll University

Abstract

Ethical dilemmas that arise in a traditional classroom have parallels in distance education. This article discusses the use of student personal information, extra credit for research participation, confidentiality, and assessment in online courses and relates them to the Ethical Principals of Psychologists and Code of Conduct. Possible solutions are suggested.

One of the settings in which ethical issues abound for psychologists is that of higher education. The Introduction to the Ethical Principals of Psychologists and Code of Conduct ("Ethics Code") makes it clear that this document "applies to scientific, educational, or professional roles" of psychologists (APA, 2002). During thirty years of involvement in various aspects of undergraduate psychology education I have seen several types of ethically problematic behavior arise somewhat frequently both in traditional and more recently in online classes. Regardless of the course-delivery modality, the Ethics Code is constructed so that its standards are loose enough that they can be transferred from one teaching format to another. These are discussed in this article in order to heighten the awareness of those psychologists who are teaching in the online classroom.

Personal Information

One of the most common scenarios is asking for students to reveal personal information about themselves. Here is an example:

Professor Child believes that one of the most meaningful ways to teach developmental psychology is for students to relate incidents in their own development to current theories and research. Several short reflection papers are assigned each semester. A typical assignment would be to write a 500-word essay about the discipline practices of a student’s parents and how the
student understands the relationship between this behavior to her own attitudes, personality, and behavior today. In yet another paper, students are to discuss the amount and type of sex education given to them by their parents in contrast with what was learned at school in sex education classes. These essays then serve as the basis for class debates and discussions, on a formatted discussion board. Assessment measures have shown that those students taught by the relate-it-to-yourself method as compared to the traditional lecture method have learned the material to a greater extent, thus justifying this approach to teaching the subject.

In developing her course, Professor Child needs to pay special attention to Ethics Standard 7.04, Student Disclosure of Personal Information.

Psychologists do not require students or supervisees to disclose personal information in course- or program-related activities, either orally or in writing, regarding sexual history, history of abuse and neglect, psychological treatment, and relationships with parents, peers, and spouses or significant others except if (1) the program or training facility has clearly identified this requirement in its admissions and program materials or (2) the information is necessary to evaluate or obtain assistance for students whose personal problems could reasonably be judged to be preventing them from performing their training- or professionally related activities in a competent manner or posing a threat to the students or others.

How could this problem be avoided? Students could have had a clear choice whether to do this assignment or another less personally-invasive one. Alternatively, students could have been asked to do something entirely different, or invent family scenarios. Professor Childs argues that because this is an online course she does not know the students and hence there is no violation of their privacy. This is not a good argument because contrary-wise, students cannot be sure which people and whose friends and acquaintances will read their essays.

**Extra Credit**

Some psychology course professors like to give extra credit to students for participating in research projects. This not only helps out those student and faculty researchers who never seem to have enough participants, but also gives a better sense of psychology as a science to students. Here is an example:

Professor Stats requires students in his online general psychology class to participate in the survey research his department colleagues are conducting on the Internet. Because he feels that this is a valuable introduction to psychology as a science, he offers up to ten extra-

credit points for students who go to an online psychology research site, choose up to ten projects to participate in, and then write up their experiences. Consider Ethics Code Standard 8.04, Client/Patient, Student, and Subordinate Research Participants.

(a) When psychologists conduct research with clients/patients, students, or subordinates as participants, psychologists take steps to protect the prospective participants from adverse consequences of declining or withdrawing from participation.

(b) When research participation is a course requirement or an opportunity for extra credit, the prospective participant is given the choice of equitable alternative activities

Professor Stats argues that because this is an online course he needs to devise educational and interesting online activities for the students. But here, there is no equitable alternative activity to both the requirement of participating and for the opportunity for extra credit. Reading research articles instead of participating might not be as interesting but could be made to be equitable activities, both for the initial requirement and for the extra credit.

**Confidential Information**

Disguising examples of disorders and characteristics of clients from ones practice of psychology is a particularly interesting and creative way to teach psychopathology. Because the students are out there is cyberspace, how could they possibly make a personal identification? Here is another example:

Professor Perceptive has never cared for the case studies in the psychopathology textbook she uses. More intriguing ones are often found in her client records. She is excited by the possibility of tweaking the details of people’s lives so that she can discuss them in her classes. Knowing the possibility of a confidentiality issue, she is more likely to do this when teaching a distance education class. Here the connection between herself and her students is so loose that she finds it nearly impossible to imagine that a student could identify the client. But it is a small world, and now someone has made the connection. Consider Ethics Code Standard 4.07, Use of Confidential Information for Didactic or Other Purposes.

Psychologists do not disclose in their writings, lectures, or other public media, confidential, personally identifiable information concerning their clients/patients, students, research participants, organizational clients, or other

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recipients of their services that they obtained during the
course of their work, unless (1) they take reasonable steps
to disguise the person or organization, (2) the person or
organization has consented in writing, or (3) there is legal
authorization for doing so.

What is a reasonable step? Technically, it is one that the reasonable
person would agree is reasonable. That is not too helpful a definition,
but it does point out that the professor needs to put some time in to
thinking through the possible ways that a disguised client could be
recognized.

Assessment

Finally, the issue of assessment is one that transcends course delivery
format. According to Ethics Code Standard 7.06, Assessing Student
and Supervisee Performance,

(a) In academic and supervisory relationships, psychologists
establish a timely and specific process for providing
feedback to students and supervisees. Information
regarding the process is provided to the student at the
beginning of supervision.

(b) Psychologists evaluate students and supervisees on
the basis of their actual performance on relevant and
established program requirements

Sometimes out of sight students encourage teachers to relieve the
pressure to read papers and respond to discussion board entries in
a timely manner. This is a particular problem when there are more
individual papers and entries than one would require in a classroom
setting. But the timely evaluation and reporting of progress is equally
important to student learning online.

For example:
Professor Lethargo loves to teach online. He is able to indulge his
liking for a flexible schedule and can lounge around his home in
sleepwear for days at a time. Unfortunately this attitude towards
scheduling has shown up in his distance education courses. He lets
discussion board entries go for days at a time, finding most of them
tedious to reply to, despite their number and quality being one of the
contributors to the overall grade in the course. To keep students busy
thinking about the course material he has assigned more papers than
he can possibly read in a given time period.

Professor Lethargo needs to know that teaching in a distance
environment requires a concerted effort to be conscientious in
evaluating student progress. Professors can help students learn by
assessing in an accurate and timely manner and then giving regular
and prompt feedback.

Conclusions

One of the features of the current version of the Ethics Code that
is especially attractive is that standards are often not precisely
worded, thus making them applicable to new situations. As therapy,
assessment, research and teaching more commonly move in to
the online environment, new interpretations of older standards
are necessary. Applying the basic ethical standards that define the
profession and discipline of psychology, confidentiality, competence,
informed consent, and doing no harm, can easily be adapted to the
online environment. This article has addressed some of the ethical
issues concerning teaching that are most prominent in the Ethics
Code, and shown how they can be applied to distance learning.

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Bridging Clinical & School Based Practices: Using Collaboration Strategies Involving Technology to Meet the Emotional and Behavioral Needs of Children and Adolescents


Abstract
The purpose of this article is to increase awareness regarding essential and unique opportunities for collaboration between clinical and school psychologists. Diagnostic strategies and treatment for children exhibiting emotional and behavioral symptoms will be presented from both the clinical and educational perspectives and compared. Examples of ways to use technological methods and resources to bridge systemic differences embedded in the two settings will be explored. By increasing awareness and collaboration, clinical and school psychologists may reduce confusion while increasing diagnostic efficiency and improving treatment outcomes for children displaying emotional and behavioral symptoms.

Introduction
Often clinical and school psychologists have similar roles, and they are expected to collaborate throughout both the evaluation and treatment processes. Whether in clinical or educational settings, these mental health professionals frequently use comparable methods when working with children and adolescents who exhibit emotional and behavioral symptoms. Both clinical and school psychologists often administer similar evaluation measures, conduct interviews with children and families, and design appropriate evidence-based interventions in efforts to improve emotional, behavioral and academic functioning. However, confusion naturally may occur as clinical and school psychologists are often expected to use somewhat different diagnostic systems and areas of emphasis when making diagnostic and treatment decisions in their respective settings. In order to establish clarity, it is important to first describe systemic similarities and differences between clinical and educational practices. This is followed by an exploration of collaboration strategies (including those involving technology) so that information gathered within each system can be communicated in a secure and efficient manner to effectively meet client and student needs.

Clinical Paradigm
For diagnostic purposes, clinical psychologists utilize the Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition – Text Revision (DSM-IV-TR) (American Psychiatric Association, 2000) for describing and classifying mental disorders. The DSM-IV-TR divides mental disorders (e.g., Mood Disorders, Anxiety Disorders, Substance-Related Disorders) according to the classification of similar symptoms and similar manifestation of those symptoms. Additionally, the DSM-IV-TR considers the frequency and duration of these symptoms, the level of impairment of these symptoms on an individual’s functioning (e.g., social, occupational, academic), and the presence or absence of other mental disorders in the classification process. Additional information about the DSM-IV-TR and the upcoming DSM-V (expected to be released March 2013) can be accessed on the American Psychiatric Association’s website (http://psych.org/MainMenu/Research/DSMIV.aspx).

In addition to a clinical diagnosis, the DSM-IV-TR utilizes a multiaxial system of diagnosing. This system, which includes five axes, is the current language for discussing and expressing client difficulties, and significantly reduces client-related information into a more manageable, digestible form (Seligman, Walker, & Rosenhan, 2001). These five axes consist of:

- a.) Axis I – Clinical Disorders and Other Conditions,
- b.) Axis II – Personality Disorders and Mental Retardation,
- c.) Axis III – General Medical Conditions,
- d.) Axis IV – Psychosocial and Environmental Problems (client’s psychosocial and environmental problems that may affect the diagnosis, treatment, and prognosis of the mental disorders),
- e.) Axis V – Global Assessment of Functioning (psychologist’s judgment of the client’s overall level of functioning; based on the Global Assessment of Functioning Scale. The client is ascribed a rating from 1 to 100).

Furthermore, a brief summary of associated DSM-IV-TR disorders relating specifically to children and adolescents who may be eligible for special education services through the school based category of Emotional Disturbance (ED) is provided.
• **Disruptive Behavior Disorders** are behavioral disorders that revolve around a child’s lack of attention, hyperactivity, impulsivity, oppositional behaviors, and sometimes-persistent patterns of violating the rights of others. These disorders consist of Attention-Deficit/Hyperactive Disorder, Oppositional Defiant Disorder and Conduct Disorder.

• **Mood Disorders** are patterns of abnormal mood and affect often consisting of a clinically depressed mood, with some clients additionally suffering from experiences of elated moods. These disorders consist of Major Depressive Disorder, Dysthymic Disorder, Depressive Disorder NOS, Bipolar I, Bipolar II, Cyclothymic Disorder, Bipolar Disorder NOS, Mood Disorder due to a GMC, Substance-Induced Mood Disorder and Mood Disorder NOS.

• **Pervasive Developmental Disorders** are characterized by severe and pervasive impairment related to social interaction; communication; or stereotyped behavior, interests, and activities. These disorders consist of Autistic Disorder, Rett’s Disorder, Childhood Disintegrative Disorder, Asperger’s Disorder and Pervasive Developmental Disorder Not Otherwise Specified.

• **Anxiety Disorders** are patterns of emotions consisting of intense worrying, fear, and anxiety related to known and unknown events. These disorders consist of Separation Anxiety Disorder, Panic Attack and Agoraphobia, Specific Phobias, Social Phobia, Obsessive-Compulsive disorder, Posttraumatic Stress Disorder, Acute Stress Disorder, Generalized Anxiety Disorder, Anxiety due to a GMC, Substance-Induced Anxiety Disorder and Anxiety Disorder NOS.

• **Adjustment Disorders** are an individual’s reaction to an identifiable life stressor which is evidenced by marked distress (in excess of what would be expected) and/or clinical impairment (in social or occupational/academic functioning). This can be manifested through a depressed mood, anxiousness and/or behaving without regard for the rights of others or norms.

• **Schizophrenia** is the presence of psychotic features (i.e., hallucinations, delusions, disorganized thoughts, disorganized behaviors, and/or negative symptoms) in a child or adolescent. Schizophrenia is rarely diagnosed in children and adolescents.

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**School Paradigm**

For diagnostic purposes in the educational setting, Ohio school psychologists utilize special education eligibility criteria as described in Ohio’s Operating Standards for Ohio’s Schools Serving Children with Disabilities (2008). These standards can be accessed through the Ohio Department of Education Website (http://www.ode.state.oh.us) and are based on the federal Individuals with Disabilities Education Improvement Act (IDEIA, 2004). Thirteen categories are described which include disabilities such as cognitive disability (CD), specific learning disability (SLD), autism (AUT), visual impairment (VI), and emotional disturbance (ED). As previously explained (and also described in Table 1), the DSM-IV-TR disorders commonly associated with school based (IDEIA 2004) eligibility for Emotional Disturbance are the Disruptive Behavior Disorders, Mood Disorders, Anxiety Disorders, Pervasive Developmental Disorders, and Chronic Adjustment Disorders. It is also indicated in IDEIA (2004) criteria that Emotional Disturbance includes schizophrenia. Although the clinical and educational classification systems are related in many ways, they each have unique considerations. Therefore, special education eligibility through the Emotional Disturbance category does not automatically lead to a DSM-IV-TR diagnosis. Similarly, although they share many overlapping characteristics, a DSM-IV-TR diagnosis would not guarantee special education eligibility as each classification system is governed by its own rules.

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**Table 1**


<table>
<thead>
<tr>
<th>IDEIA (2004), Five Major Emotional Disturbance Characteristics</th>
<th>DSM-IV-TR Diagnoses Commonly Associated With Specific Characteristics of ED</th>
</tr>
</thead>
<tbody>
<tr>
<td>An inability to build or maintain satisfactory interpersonal relationships with peers and teachers</td>
<td>Disruptive Behavior Disorders, Mood/Anxiety Related Disorders, and Pervasive Developmental Disorders</td>
</tr>
<tr>
<td>Inappropriate types of behaviors or feelings under normal circumstances</td>
<td>Disruptive Behavior Disorders, Mood/Anxiety Related Disorders, and Pervasive Developmental Disorders</td>
</tr>
<tr>
<td>A general pervasive mood of unhappiness or depression</td>
<td>Mood Disorders</td>
</tr>
<tr>
<td>A tendency to develop physical symptoms or fears associated with personal or school problems</td>
<td>Anxiety Disorders, Chronic Adjustment Disorders</td>
</tr>
<tr>
<td>An inability to learn that cannot be explained by intellectual, sensory, or health factors</td>
<td>Child may or may not have a DSM-IV-TR diagnosis</td>
</tr>
</tbody>
</table>
According to Merrell and Walker (2004), the federal definition of Emotional Disturbance (ED), adopted by congress in 1974, was based upon a previous definition developed and refined by Eli Bower in the 1960’s. Much of that definition remains consistent with today’s (IDEIA, 2004) special education criteria for Emotional Disturbance. Currently, students must exhibit one or more of the five major characteristics (found in Table 1) to a marked extent and over an extended period of time to be considered eligible for special education services through the category of Emotional Disturbance.

As mentioned, the classification systems of IDEIA (2004) and DSM-IV-TR do not automatically translate as the basic purpose, structure, and methods of the two systems are based on different paradigms (House, 1999). Furthermore, for some cases, there may be an IDEIA (2004) category (other than ED) that better explains the characteristics and behaviors of the particular student. For example, a student diagnosed with ADHD may meet special education criteria for Other Health Impairment, or a student diagnosed with a Pervasive Developmental Disorder may qualify for special education through the Autism category. For another example of inherent differences, students who are only considered “socially maladjusted” do not meet the IDEIA (2004) ED diagnostic criteria, unless it can also be determined that they also have an emotional disturbance. Through this definition, it is implied that students who are socially maladjusted “choose” to break school rules while students with true “emotional disturbances” act out due to their disability. As this social maladjustment clause is broadly stated and defined, it is widely interpreted and leads to diagnostic dilemmas. Therefore, clear communication regarding characteristics and behaviors is extremely important.

In order to qualify for special education services through IDEIA (2004) requirements, school based teams also must demonstrate that identified disabilities significantly impair educational functioning. Therefore, for special education qualification through the ED category, school based evaluation team members must demonstrate a direct relationship between the child’s emotional and/or behavioral symptoms and the child’s poor educational functioning (e.g., grades, attendance, participation in school-related activities, and school based social interactions). This can be well documented through the school-based Response-to-Intervention (RtI) process.

According to information presented at the Ohio Department of Education Special Education Conference (September 25, 2008), RtI is: 1) A systematic approach to reviewing data; 2) A process used to identify instruction or intervention supports that work to improve educational outcomes; and, 3) A way to monitor progress to assure effectiveness of designed educational or behavioral interventions. In Ohio, RtI Teams often involve the classroom teacher(s), the parent(s), school psychologist, building principal, intervention specialist, and other related services personnel. This team functions to design and implement academic and behavioral interventions, as well as to monitor student progress. Ultimately, in addition to the other collected assessment data, RtI teams must use data from the intervention process to determine eligibility for special education services and to make decisions regarding educational supports and access to the general curriculum (Ohio’s Operating Standards for Ohio’s Schools Serving Children with Disabilities, 2008).

When considering services for students with disabilities, school personnel also utilize an additional qualification system beyond special education (Section 504 of the Rehabilitation Act of 1973). This Civil Rights Act protects all students with disabilities, but also broadens eligibility for those students whose disabilities impact performance in any major life activity (e.g. seeing, hearing, communicating, learning, working, performing manual tasks and mobility). As mentioned, students who demonstrate significant emotional and behavioral problems that do not adversely affect their educational performance may not qualify for special education through any IDEIA (2004) disability category. However, these same students may require reasonable school and classroom based accommodations and educational services through a Section 504 Plan should their significant emotional and behavioral symptoms adversely affect a major life activity. In these cases, a current DSM-IV-TR diagnosis may be particularly important to document an existing disability.

Finally, it is important to mention that clinical and school psychologists naturally may emphasize different areas when making treatment recommendations. Educators focus on promoting academic achievement and may view mental health problems as an impediment to this goal, while mental health providers focus on problem behaviors (rather than academic competencies) and approach the work from an individual (rather than a contextual perspective (Cappella, Jackson, Bilal, Hamre, & Soule, 2011). Furthermore, as in diagnostic practices, clinical psychologists often consider all systems within a child’s life (e.g., school, family, community, and peer groups) and design interventions to encompass all areas. For example, for a child who demonstrates significant problems with impulsivity, a clinical psychologist may design interventions that emphasize impulse control strategies with peers and family members in order to ultimately strengthen interpersonal relationships and improve social skills. With a more restricted primary focus, a school psychologist may target those emotional and behavioral concerns that directly impact academic achievement and tailor interventions accordingly. Using the same example, the school psychologist may recommend strategies to improve the student’s impulse control in classroom settings in order to maximize on-task time and learning opportunities. With this understanding, collaboration efforts to bridge cross setting data and existing paradigms are crucial so that students can be supported in a comprehensive and efficient manner.

Cross Setting Collaboration

Clinical and school psychologists often have a wealth of information from which they develop interventions to improve a child’s social, emotional, and behavioral functioning. School psychologists often obtain helpful information from psychological reports written by clinical psychologists. Often these reports carefully and thoroughly describe DSM-IV-TR diagnoses and intervention strategies; rich information, which can be utilized for educational planning. In fact, if available, school district personnel are obligated to consider the evaluation results from external mental health professionals when making educational decisions related to special education and Section 504 eligibility. Clinical psychologists also are able to incorporate beneficial school based data into their own evaluations and treatment planning in a similar fashion. For example, school personnel can provide monthly reports to a clinical psychologist as to how the child’s behavior is changing and describe areas of concern that need to be addressed. Through this collaborative process, clinicians and school-based personnel can update treatment and RtI goals for children and adolescents experiencing emotional and behavioral difficulties. Table 2 describes useful information that may be helpful to include when clinical and school psychologists communicate about a child’s progress and needs. Although a degree of overlap between the two settings is expected, unique data that may be gathered in each setting is presented.

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Protecting Information/Technology Considerations

When sharing information, it is expected that all legal and ethical guidelines be followed to safeguard protected health and educational information, including obtaining written consent for both parties to communicate with each other. Furthermore, this consent should detail the types of protected health and educational information that can be discussed and shared. Clinical psychologists should take every precaution so that collaboration activities do not violate guidelines as detailed in The Health Insurance Portability and Accountability Act (HIPAA). School psychologists should understand these precautions as they have their own compliance standards to follow through the Family Education Rights and Privacy Act (FERPA). In today’s age of instant electronic communication, long term storage of electronic information, computerized progress-monitoring documentation, and video chat it is essential that both parties take necessary precautions to ensure privacy, confidentiality, and security as described by telepsychology guidelines found in Ohio Administrative Code, Rules for Professional Conduct. For some examples of how to do this, it is advised that professionals use secure networks, use password protected measures, and use e-mail notices stating that messages are for private communication only. Also, it is extremely important that client/student information is de-identified. Therefore, when corresponding through electronic communication, usage of a client’s/student’s full name is not recommended. The safest way to protect all parties is to delete the entire name. Furthermore, avoid providing related identifying information (such as a birthdate or address) which also may compromise security. Finally, even with the advancements in today’s communication technology, the importance of face-to-face and verbal communication should not be underestimated. With appropriate parent/guardian permission, clinical and school psychologists often are able to successfully collaborate through jointly attended meetings and telephone conversations.

Discussion

Through ongoing cross-setting and cross-discipline collaboration, necessary requirements from both school-based and clinical practice can be met, and unnecessary assessment duplication can be prevented, thus improving diagnostic efficiency and accuracy. Assuming that appropriate consent and cautionary measures are taken, information can be shared between professionals in a collaborative fashion so that both diagnostic and treatment goals can be reached in a variety of settings. By understanding systemic similarities and differences and by working together, paradigms can complement each other. Rich information from multiple sources can then be combined and utilized to comprehensively meet the needs of children and adolescents who display emotional and behavioral symptoms.
References


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Advances in technology over the past two decades have produced a variety of digital delivery methods that have significantly influenced the education of psychology students. In addition to implementing technology resources in a traditional classroom, many universities are now also providing online courses and an integration of the two models (hybrid or blended courses) in order to augment as well as provide alternative methods of delivering course content to students. These delivery methods are becoming more attractive to both traditional and non-traditional students, with recent studies estimating that over 5.6 million college students have completed at least one online course (Novotney, 2012).

The transition to this new era of classroom delivery has not been without controversy as many professionals within the field of psychology have expressed concern regarding the use of online methods to educate graduate students. A common misconception regarding the hybrid and/or online delivery of courses has been based on the belief that this format does not provide the same quality of education as traditional face-to-face methods of educating graduate students (Bendersky et al., 2008). For example, there is concern regarding the quality and honesty of a student’s academic work, and the lack of face-to-face experiences within an online classroom (Belar, 2012). Furthermore, it is believed that graduate programs offering only online courses, or a combination of face-to-face and online courses, are not providing students the same opportunities for developing student-faculty relationships or professional mentoring in comparison to students attending traditional graduate programs (Murphy et al., 2007). The issue of residency in a distance-learning program is often cited as a concern, with the indication that faculty, advisors, and clinical training staff do not have an adequate opportunity to assess a student’s competence (Demers, Van Horne, & Rodolfa, 2008). Consequently, there is hesitation within accreditation bodies and the overall field of psychology regarding the use of digital delivery of course content that permits graduate students in psychology from learning via non-traditional means (Murphy et al., 2007). As a graduate student who has attended both traditional and non-traditional graduate programs, I would like to address a few of the misconceptions regarding the incorporation of digital methods in graduate education by discussing the benefits and limitations of using technology in educating psychology graduate students.

**Abstract**

The digital era has produced new resources and methods for delivering graduate education to non-traditional psychology students. In addition to educating students in a traditional classroom setting, there are doctoral programs that offer students additional learning opportunities through the use of online and hybrid courses, integrating classroom based teaching with digital communication resources, allowing for both synchronous and asynchronous interaction between and among students and faculty. This approach has not been without controversy as there is concern within the field on whether students attending distance-learning programs receive the same quality of education as students in a traditional program. This article addresses the common perceptions of this new era of curriculum delivery in addition to presenting the benefits and limitations of a distance-learning program based on the experiences of a non-traditional graduate student.

**Distance-Learning Programs: Online and Hybrid Options**

Graduate programs utilizing digital delivery methods are commonly referred to as distance-learning programs; however, there are distinctions within this group. For instance, there are purely online programs where students and faculty interact strictly via the internet and other digital resources (e.g., video presentations). There are also distributed learning graduate programs, such as the PsyD program at Union Institute & University (UIU), that require students to complete a combination of face-to-face, hybrid and online courses during the course of their studies. Most of these programs, such as UIU, require students to complete field training, including two years of practicum of 600 hours per year and 2000 hours of internship, and a dissertation. The UIU curriculum is designed to meet the standard course distribution as described by the American Psychological Association accreditation guidelines, providing generalist training preparing students for entry into the field of professional psychology.

These distance or distributed models integrate various digital delivery methods into face-to-face courses. These include: online

1 In August 2010 the APA Commission on Accreditation added an Implementing Regulation (C-27) stating that “a doctoral program delivering education and training substantially or completely by distance education is not compatible with the G&P and could not be accredited.”
discuss discussion boards, audio and video presentations, and live lectures via professional web-conferencing programs. These provide students with additional opportunities to connect with other students and their professors outside of the traditional class meeting on campus.

**Benefits of Attending a Distributed Learning Graduate Program**

Graduate programs in psychology that offer a distance-learning component are particularly attractive to non-traditional students. Research has found that individuals with a disability, reside in a rural community, or have family and career responsibilities, are attracted to distance-learning programs (Guidos & Dooris, 2008; Rudestam, 2004). The advantages of maintaining their current lifestyle, interacting with other students from various locations, avoiding relocating to a new community, having a flexible course schedule, and benefiting from a wide range of resources and diverse faculty interests are additional reasons why distance-learning programs are more attractive to adult students compared to a traditional program (Irizarry, 2002).

A combination of personal and educational factors resulted in my decision to pursue my doctoral studies at a doctoral program that offered face-to-face, hybrid and online courses. Personally, my family and work responsibilities prevented me from having the opportunity to relocate outside of central Ohio. Therefore, my list of potential graduate programs in psychology that I could apply to was limited. After reviewing my options, the flexibility and educational resources of a distributed learning graduate program was appealing to my situation.

In addition, I wanted to find a doctoral program that required more digital resources and student-faculty interactions than the traditional graduate program I completed in the past. One of the misconceptions of online coursework is that students are not engaged in the course material to the same degree as students in a traditional classroom. Interestingly, Robinson and Hullinger (2008) have provided evidence to refute this common perception of online courses as they found distance-learning students and faculty interacting more often in terms of discussing course readings and other related materials compared to traditional students. My experiences concur with Robinson and Hullinger’s findings, as I have found myself having higher quality and more extended online conversations with my peers and professors regarding course topics compared to my time in a traditional program. In order to fully participate, students need to continuously review psychological research and explore additional sources of information in order to form a scientific rational that supports their opinions.

Finally, I completed a master’s degree in Human Development and Family Science at The Ohio State University and took doctoral courses as electives for my master’s degree. It is my opinion that my current courses are comparable to the courses I had completed. A distinct difference, however, is that the majority of my interactions with faculty in a traditional graduate program was primarily in the classroom, whereas, I have extended interactions with faculty in the classroom, online, and other professional development activities in a distributed learning program. I also have had opportunities to interact with diverse faculty who were experts in their fields, drawn from a wider geographic region than my program’s physical location.

**Limitations of Attending a Distributed Learning Graduate Program**

There are also limitations to attending programs that utilize these models. The most noticeable limitation is the stigma that is associated with online learning. For example, Bendersky et al. (2008) suggest that distance-learning programs are attractive to potential students who have lower grade point averages, work full-time, or are unable to meet the admission standards of a traditional program. While this may be true for some programs, applicants should be careful to select a program with high admission standards.

Prospective students considering attending a hybrid program need to be aware of additional costs that may culminate in addition to tuition. If the program’s campus is not located near the student’s residence, the student may experience additional costs for travel, food, and lodging. I currently live in central Ohio and the campus site for the majority of my face-to-face courses is located in Cincinnati, Ohio. My program also requires bi-annual academic meetings in which students are required to attend during each of the first three years of the program. The fall meeting is held at a UIU campus in Vermont; therefore, I am required to travel out-of-state at least once a year. This requirement may interfere with family and work responsibilities for some prospective students.

**Future Research Suggestions**

Limited amount of research exists on students that have completed distance learning doctoral programs in psychology. The focus of research on online courses in psychology and its success has focused primarily on undergraduate students (Novotney, 2012). A potential barrier to the success of the psychology field embracing this new era of classroom delivery stems from recent research on the high attrition rates within distance-learning programs. Since these programs often attract older students who are addressing different life transition than the typical 21-25 year old graduate student, up to percent of non-traditional students do not complete their doctoral studies (Meister, 2002) or may take longer to complete their doctoral program compared to traditional students (Park & Chu, 2009). Although rates of attrition are valid concerns within the field, future research needs to examine outcomes of doctoral students completing a distance-learning program. Specifically, research should examine how psychology students from a hybrid program compare to traditional students in regards to educational outcomes, professional socialization, training experiences, research and career opportunities. Furthermore, there is currently no research available identifying the similarities and differences between online and hybrid psychology programs. Research in these areas will be beneficial in addressing the field’s questions about the distance-learning programs, while simultaneously helping these programs strengthen the quality of the educational experiences offered to graduate students.

In summary, technological advances have modified the methods of educating graduate students in psychology. Distance-learning programs have embraced digital delivery methods to reach a broader population of students interested in graduate education in this field. Although distance-learning programs continue to expand at a rapid rate, questions remain within the field on whether psychology graduate students can benefit from a distance-learning model. Professional research has identified both the benefits and limitations that separate distance-learning programs from their traditional counterparts. Ultimately, the digital delivery methods that are available have been proven to enhance student learning outside of the traditional classroom; therefore, both traditional and non-traditional programs could benefit from implementing technological resources into the classroom.

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2 Doctoral student attrition rates in both traditional and non-traditional programs are estimated to range from 40-50 percent across disciplines, with the highest attrition rates occurring in the social sciences (Gardner, 2009).

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Building Quality Relationships in a Technologically Mediated Learning Environment (TMLE)


Abstract

As teaching technology continues to improve, the popularity of Technologically Mediated Learning Environments (TMLEs) continues to increase. Commonly, questions are raised about the ability of instructors to build quality faculty-student and student-student relationships when teaching courses in these modalities. In this article, the authors explore the primary issues related to building and supporting relationships for the enhancement of learning in these relatively new environments in higher education. Primary criticisms, best practices, and future directions of TMLEs will be explored in the context of training graduate psychology students.

In the 21st century, we have seen rapid advances in technology. Students are now growing up with cell phones, computer tablets and 24/7 Internet access. How can we capture the attention of the next generation of undergraduate and graduate students, and not only find a way to make technology work, but enhance and improve upon traditional educational models? More specifically, professional development and socialization are considered essential in becoming a psychologist and must be consciously fostered as learning technologies continue to improve.

In this article, we will focus on building quality relationships in online and blended courses in higher education, but it is essential to recognize that use of advanced technology forms only a part of a complete educational package, especially in the training of psychologists. By meeting face-to-face with students on a regular basis, a foundation can be created and built upon with the online portions of the learning program.

Primary Criticisms

“Relationships” and “electronic” are often seen as incompatible, at least when it comes to higher education. Thus, when it applies to technologically mediated learning environments (TMLE), critics state that the education must somehow be sub-par. By better understanding the criticisms, we can become more knowledgeable about how relationships can and do exist within an online course.

It is widely accepted that information can be disseminated electronically. However, the concern is often raised that social interaction is missing in an online forum and that students cannot “know” their students in a meaningful way. Some may even believe that online coursework is as impersonal as correspondence courses by mail. There are large differences in the amount of interaction that can be reached via email at allen.mcconnell@email.myunion.edu.

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lecture rooms with no discussion, while others are small seminars), and significant differences in the teaching styles and interaction abilities of instructors (e.g., some are dry and dull, while others are charismatic and engaging). Similarly, online programs are not all the same and vary in the degree of interaction that occurs amongst students and between students and faculty. Thus, it is dangerous to lump them together as one entity. It is well known that student learning outcomes are affected positively by supportive, cooperative, and responsive interactions between faculty and students (Arends, Hativa, Barak & Simhi, 2001; Kember, 2004 as cited in Vermeulen & Schmidt, 2008). Burge (1994) identified four areas (participation, response, effective feedback and focused messaging) that can enhance interactivity within an online learning environment and where differences can be found in the quality of interpersonal interactions, particularly from the students’ perspective. Similarly, Burge (1994) identified several instructor behaviors that enhance the online learning experience. These include the ability to manage class discussions, encourage creativity, support self-directed learning, and assist students by giving timely and relevant feedback.

There also tends to be a “one size fits all” approach to higher education, in the assumption that the traditional, face-to-face model works best for every student. In fact, there are students with very different needs, who may respond better to different approaches. What about the quiet, reserved student who sits in class but does not participate in the discussions? Is it possible such students might feel more comfortable and effective expressing themselves through other formats? What about the highly motivated student who does not live near an institution of higher learning? Online learning experiences push students to be more active and self-directed in their learning.

If we believe the assumption that effective social relationships cannot occur in an online setting, how do we explain the social media explosion through platforms such as Facebook, LinkedIn and dating sites? These platforms are popular for their very ability to grow and expand social networks. Of course, sometimes the friendships formed are superficial, but oftentimes deeper, more genuine relationships are created. Within the ever enhancing technological world, there is more opportunity than ever for faculty to become engaged, to know their students, to provide meaningful discussions amongst students and with students, and to be more accessible to the students.

**Best Practices**

Building quality relationships in a TMLE requires communicating with students often and with intention. Rather than using technology for technology’s sake, learning experiences must balance reflection and discourse (Garrison & Anderson, 2003). Vermeulen & Schmidt (2008) provide evidence that student learning outcomes are strengthened by high quality faculty-student and student-student interactions around intellectually meaningful subjects. Below are best practices in building strong one-on-one relationships with students, as well as facilitating collaborative inter-relationships among students, in an online learning environment in higher education.

**Building Faculty-Student Relationships**

The key to building strong faculty-student relationships in any learning environment is to focus on the quality of the interaction and to relate to students as individuals (Dykman & Davis, 2008). When inquiries are addressed promptly and in a personal manner, people feel appreciated and respected in their relationships. In a TMLE, this can be accomplished by setting up regular meetings with students to listen to and address their questions and concerns (Dykman & Davis, 2008) and by responding to students’ email communications in a timely manner, making a point to address them by name in all correspondence (Cerniglia, 2011). For example, faculty in our program have adopted a policy of responding to student inquiries, whether submitted via email, discussion post, chat, or telephone, within 24 hours. Additionally, efforts to determine whether a question was answered or a concern addressed to the student’s satisfaction invites further interaction.

There are a number of ways for faculty to effectively communicate with students outside of the course itself. Private emails and phone calls are likely the most common, but in a TMLE, the use of online collaboration tools, such as wikis, blogs, Voice Threads, or Skype, can supplement interactions and further enhance communication with and among students. Once they are comfortable communicating in these ways, students tend to interact more often and more informally than they would in person (Dykman & Davis, 2008).

Learner interaction and engagement is addressed by the Quality Matters rubric (Quality Matters Program, 2011), a faculty-centered, peer-reviewed set of standards used to evaluate the design of online and blended courses in higher education. This model indicates that strong relationships are fostered when a course includes learning activities that nurture faculty-student, content-student, and if appropriate to the course, student-student interactions; clear standards for faculty responsiveness and availability (e.g., turn-around time for email, grade posting, etc.); and openly articulated requirements for student interaction. As an example, a typical syllabus in our graduate psychology program includes posting guidelines, as well as a grading rubric detailing the evaluation criteria (i.e., quantity, quality, relationship to assigned material, critical thinking and professional application), for participation in threaded discussions. Khoo, Forret, and Cowie (2010) also emphasize the importance of providing clear guidelines and expectations for student contributions and participation in an online environment.

**Building Student-Student Relationships**

Vygotsky’s (1978 as cited in Stacey, 1999) understanding of learning as a particularly social process, with language and dialogue being essential for cognitive development, supports the notion that social interaction is a key component (Nichol & Blashki, 2005 as cited in Hutchinson, 2008). Orientation activities, such as ice breakers and student introductions, along with instructor empathy, interpersonal outreach (e.g., welcoming statements, discussion of one’s own online experiences, etc.), and humor (Bonk, Kerkley, Hara & Dennen, 2000 as cited in Hutchinson, 2008) can promote a sense of community among students as they work toward a common learning objective.

A TMLE can be a rich environment for facilitating collaborative student projects and interactions (Stacey, 1999). Participation in discussion forums is an effective strategy for building quality student-student relationships when thoughtfully designed to encourage perspective sharing. Assigning weekly discussion leaders among students, whose role it is to facilitate a more complex discussion by sharing ideas and experiences relevant to the course content, allows for a deeper discussion overall, and leads to real connections.

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among all members of the learning community (Cerniglia, 2011). Some students have reported they learn more from interacting with their peers in a TMLE than from other aspects of an online or blended course (Dykman & Davis, 2008). Faculty can model for students good online communication practices and “netiquette” in how to extend, expand, clarify, or challenge their peers’ ideas appropriately (Cerniglia, 2011; Khoo, Forret & Cowie, 2010), thereby creating an environment where students feel safe to share their ideas and experiences even when their perspectives may be challenged. Instructors should be mindful to participate in discussion boards without dominating the conversation and to tailor their participation level to the needs and abilities of the students (Cerniglia, 2011). Other discussion strategies, such as ensuring ideas that are overlooked are addressed and both providing feedback to and seeking feedback from the students (Hutchinson, 2008), serve to enhance social skills and interactions.

Though a number of strategies that faculty can utilize to improve the quality of the interactions in a TMLE have been presented, the responsibility for effectiveness does not rest solely on the instructor. The behavior of the students themselves, in terms of motivation and level of engagement, which can be mediated by a quality learning environment, leads to superior academic performance and career success (Vermeulen & Schmidt, 2008).

**Future Directions**

The advancements being made in the delivery of education within a TMLE lead to the reasonable conclusion that these methods will continue to be highly utilized. The concerns related to relationships lessen as improvements in technology fill in existing gaps.

In support of the instructor-driven best practices above, there are a few basic technologies that have been used for many years to foster interaction and relationship building within TMLEs and will likely continue to develop. These include course management platforms such as Blackboard, Moodle, WebCT, CampusWeb, and communication tools such as discussion boards, chat rooms, and audio/video conferencing. These technologies have allowed faculty and students, from the very beginning of the class experience, to connect with each other in a way that bridges the physical distance. It is evident that today’s students are clamoring for more technology for building relationships, communicating, collaborating and engaging in the learning process (Revere & Kovach, 2011). As we move forward into more student-centered learning environments, we will see increased use of web-based applications, communication tools, and networking outlets such as Facebook and Ning. Individuals are already using social networking outlets to communicate, share observations, and lend support; in other words, to engage in relationships.

While some instructors may experience slight panic at the thought of using these diverse tools, most students, current and future, are already familiar with them and, in our experience, are eager to apply their “tech savvy” to their educational and professional experiences.

**References**


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Future Changes in Diagnostic Systems

Roger Blashfield, Ph.D.

Abstract
A number of changes will be occurring in the next few years regarding the diagnosis and classification of mental disorders. The coding of all medical disorders in the United States was scheduled to shift to the ICD-10-CM in October 2013, but that shift has been delayed. The DSM-5 is being written and is scheduled to be finalized in 2013. Also, the ICD is being revised by the World Health Organization, and the ICD-11 should be available in 2015. This article provides an overview of what the ICD and DSM are as well as how the editions of these classifications have changed. The article also explores the implications of the potential future changes in these classifications for clinical psychologists.

All clinicians must establish a patient’s diagnosis. Diagnoses are important descriptively, for record keeping, for insurance company filings, and for communication with other professionals. In order to make a diagnosis, American mental health professionals use the Diagnostic and Statistical Manual of Mental Disorders (DSM) as the classification system which defines the diagnostic categories. The numerical codes in the DSM are based on the International Classification of Diseases (ICD). Currently, the official version of the DSM in use is the DSM-IV-TR (American Psychiatric Association, 2000). The edition of the ICD that is standard at an international level is the ICD-10 (World Health Organization, 1992). The only country in the world not using the ICD-10 is the United States which uses the ICD-9-CM. The United States was scheduled to switch from the ICD-9-CM to the ICD-10-CM in October 2013. However, the move to ICD-10-CM coding was recently delayed (see www.dxrevisionwatch.com). The DSM-5 is currently scheduled to be published in May 2013 (www.dsm5.org). Like the DSMs, the ICDs are scheduled for periodic revisions. Currently, the best estimate is that the ICD-11 will be published in 2015 (www.wd.int/classifications/icd/en/). This brief overview is an introduction to how these changes will influence you and your practice as clinical psychologists.

ICD
The ICD and the DSM are quite different systems with different goals and with different internal structures. The ICD is the older of the two. Originally published in the early 1900s, the intent of the ICD was to provide statistical information so that physicians and national governments around the world would have information about the spread of diseases. The first five editions of the ICD focused only on causes of death. Hence, there were no major sub-headings in the original ICDs for psychiatric disorders since most mental patients were unlikely to die as a direct result of their disorder.

However, after World War II, the publication of the ICD was taken over by the fledgling World Health Organization (WHO). The intent of the ICDs under the WHO was to be a clinically useful classification that could be easily learned and used by physicians all over the world, especially practitioners working in third world countries in which poverty was common and access to up-to-date medical technology was limited. Starting with the ICD-6, the ICD became a classification of all medical diseases (including psychiatric disorders). By international treaty obligation, all countries in the world that are members of the World Health Organization must use ICD coding to report medical diagnoses.

DSM
The aftermath of World War II also led to the creation of the DSM. During WWII, the United States had three quite different classifications in existence: the Army had one, the Navy had another and the VA system used yet another. The original DSM was created by the American Psychiatric Association as an attempt to overcome this “Tower of Babel” situation by generating a classification system that all American psychiatrists would use.

The ICDs were intended to be persistently revised and updated so that these classifications would reflect changes in medical knowledge. When creating the ICD-8 (the eighth edition of the ICD), there were a series of international meetings in which different national classifications (e.g., the DSM) for the mental disorders were reviewed, critiqued and analyzed. The ICD-8 contained a subsection that was an internationally agreed upon classification of mental disorders. The DSM-II was the American version of the ICD-8. The differences between the DSM-II and the ICD-8 were very slight.

DSM-III
In 1980, the DSM-III was published. This edition of the DSM classification was truly revolutionary. Prior to the DSM-III, a number of empirical studies had been published that were critical of the poor reliability of psychiatric diagnoses. A major goal of the DSM-III was to improve the scientific viability of psychiatric classification by using explicit diagnostic criteria, by incorporating a multiaxial approach to diagnosis, and by changing diagnostic concepts to avoid the ambiguity inherent in many of the psychoanalytic concepts in use at that time (e.g., “neurotic depression”).

Because the intent of the authors of the DSM-III was to make a major break with previous approaches to classification, there was almost no coordination in the creation of the DSM-III and the ICD-9. However, since the U.S., like other countries had to use ICD codes, a modified version of the ICD was created (called the ICD-9-CM) so that the ICD codes would match with various DSM diagnoses. The DSM-III-R and the DSM-IV continued to use those ICD-9-CM codes even though the ICD-10 was published in 1993. The primary resistance to changing to ICD-10 codes came from insurance companies that complained about the high cost of switching to a new coding system.

DSM-5 / ICD-11
Currently, the DSM-5 and the ICD-11 are being created. Interested readers should notice the switch to Arabic numerals rather than Roman numerals when specifying the edition of the DSM. The reason for this switch is so the different editions of the DSM can be continuously modified with the modifications shown in digits after a decimal point (e.g., the DSM 5.2). The DSM-5 is scheduled to be published in 2013 and the ICD-11 should appear in 2015. As noted above, the authors of the DSM-5 are attempting to generate an edition of the DSM that will be as revolutionary as the DSM-III proved to be. Just as poor reliability was the empirical issue that served as a stimulus for the changes in the DSM-III, what is known as “the comorbidity problem” is the driving empirical issue behind the changes in the DSM-5. The “comorbidity problem” refers to the high degree of diagnostic overlap that occurs among the mental disorders. For example, there are 10 personality disorders (PDs) in the DSM-IV. It is the unusual patient who meets the diagnostic criteria for one and only PD diagnosis. Most patients meet the diagnostic criteria for at least two PDs. Even more striking is the fact that nearly 25 percent of

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patients with at least one PD diagnosis will meet the diagnostic criteria for five or more personality disorders. Data such as these have led researchers to question the validity of the DSM-IV definitions of disorders.

In contrast to the research focus of the DSM-5, the work behind the changes to the ICD-11 is driven by quite different forces. The major goal of the ICDs is to serve public health needs, especially in non-westernized parts of the world. The DSMs make large amounts of money for the American Psychiatric Association which holds the copyright to the DSMs. The World Health Organization, because of its third-world, clinical focus, makes little or no money from its classifications. The ICDs are designed to be as easy to use and are intended to be as accessible as possible to any clinician in the world who wants to use them.

**Change to ICD-10-CM**

The change to the ICD-10 may affect the workload of practicing mental health professionals. But the overall structure of the DSM-IV and ICD-10 regarding mental disorders are reasonably similar. So the major effect of the change for mental health professionals will be to learn the new code numbers. The DSM diagnoses will not change.

Consider, for instance, if you are working with a young adult male patient with recurrent depressive episodes and multiple suicide attempts. Your DSM-IV diagnoses along with the ICD-9-CM codes (shown in parentheses) for this man could be:

- Major depressive disorder, recurrent, moderate severity (296.32)
- Borderline personality disorder (301.83)

The ICD-10 codes for these diagnoses (with the ICD names shown in parentheses) would be:

- F33.1 (Recurrent depressive disorder, current episode moderate)
- F60.31 (Emotionally unstable personality disorder, borderline type)

It is important to notice is that the ICD-10 codes use both letters and numerals, thus increasing the number of possible codes that exist in the system. Using numbers only, the ICD-9-CM had 13,600 options for all medical diagnoses; using numbers and letters, the ICD-10-CM has approximately 68,000 medical diagnostic options. This increase in possible codes has led to criticism of the ICD-10, since the change will require the staff in medical offices to learn a potentially more complex system. For the mental health field, the change in complexity is much smaller. The ICD-10 contained 424 diagnostic categories for the mental disorders; the DSM-IV has 394 categories. The impact of switching to the ICD-10 for the staff in the offices of clinical psychologists should not be large.

**Change to DSM-5**

The change to the DSM-5, which is due to be published next year, could have a much greater impact on what American mental health professionals must do. The DSM-5 will require all mental health professionals to learn a substantively different approach to diagnosis than the DM-IV. One major goal of the authors of the DSM-5 has been to make the DSM-5 system more dimensional in structure and to start moving away from the exclusive use of categories. However, because this move to personality trait dimensions has stimulated substantial controversy, the currently proposed DSM-5 will be a hybrid system that will use both dimensions and a reduced set of categories for diagnosing personality disorders.

Potentially, the DSM-5 diagnoses for the man discussed above might be:

- Major depressive disorder, recurrent, moderate, with suicide risk
- Personality disorder traits specified (traits listed in the chart might include: emotional liability, hostility; interpersonal dependence; impulsiveness; and risk taking)

At the current time, the ICD-10 coding for DSM-5 diagnoses have not been established. How this coding translation will occur, especially after the United States finally shifts to the ICD-10, will complicate the ICD-10 is entirely categorical in its organization.

**Change to the ICD-11**

The ICD-11 is currently in development, but will be the last of the three to appear. The mental disorders section of the ICD-11 is being coordinated with the DSM-5. The intent of the mental disorders section of the ICD-11 is to have it match DSM-5 reasonably closely. The ICD-11 is attempting to incorporate dimensions in a way that will allow flexible coding for the DSM-5 system. Given that the United States was the last country in the world to adopt the ICD-10, predicting when ICD-11 coding will actually be adopted in the U.S. is difficult to do.

**Suggested Readings**

The changes associated with the move to the DSM-5 have stimulated controversy. Blogs that contain overviews of these controversies can be found at the following websites: www.huffingtonpost.com/ellen-frances/, www.garygreenbergonline.com, and www.dxrevisionwatch.com. An excellent, terse presentation of the issues associated with classification can be found in a monograph by Kendell (1975) which, despite its age, is the classic in the field. The best recent discussion of psychiatric classification is contained in a thoughtful, but dense book by Sadler (2005). For a chapter overview of the changes in the DSMs and ICDs, a graduate-student-level analysis can be found at Blashfield, Keeley and Burgess (2009).

**REFERENCES**


Roger Blashfield, PhD, ABPP is a member of OPA and is a retired professor of clinical psychology from Auburn University. He was on the DSM-IV workgroup for personality disorders and currently serves on the personality disorder workgroup for the ICD-11. The opinions expressed above are his alone and are not intended to represent the official positions of either the DSM or the ICD. The author thanks Dr. Andrew Hinkle for his helpful comments on an earlier version of this manuscript.
Introduction
Psychologists exist in a field that proudly espouses the values of social justice and whose practitioners and researchers seek to bolster the health of the individual. One undeniable effect on the health of an individual is the contextual environment within which the individual exists. It must follow, then, that issues related to socioeconomic status (SES), race, ethnicity and unemployment cannot be outside our realm of practice.

The U.S. Census Bureau’s September 2011 report indicates the nation’s official poverty rate is at the highest it’s been in the 52 years poverty estimates have been published - 15.1 percent. Coupled with an unemployment rate lingering close to nine percent, the current sociopolitical economic climate is not devoid of psychological and social implications.

As psychologists, we must acknowledge that the sociopolitical atmosphere has significant implications for the well-being of a large number of individuals in the populations we aim to serve. The rising notion of “social justice” in psychology and its impetus to work towards social change, as elucidated by Mays (1999) who states, “No one should have their future, their health, or their well-being compromised for reasons of class, gender, national origin, physical and psychological abilities, religion, or sexual orientation, or as a result of unfair distribution of resources” (326). Psychology has taken initiatives to address these problems, recognizing the systemic forces which greatly impact our field. The American Psychological Association (APA) created an Office and Committee on Socioeconomic Status in 2008, demonstrating the vision and imperative for psychology to take seriously the sociopolitical environment within which we exist. In order for psychologists to effectively take social action, it is important to structure our work within sociopolitical spheres which are informed by a psychopolitical understanding.

The work of this paper is to advocate for such an understanding, examined through appreciating the implications of the sociopolitical environment on adverse mental health outcomes due to wealth disparity and lack of work. Through examining these areas, suggestions are made, integrating the resources available through the digital age to assist psychologists toward action in the domains of research, advocacy and policy efforts.

The Sociopolitical Environment
To begin, let us first attempt to understand the current environment within which individuals exist. The social implications which stem from political actions and policies have shaped an environment where the distribution of wealth and privilege has been skewed. One way to quantify this difference is the GINI index (a measure of statistical dispersion used to examine inequality, where 0 is express as total equality and 1 as total inequality of wealth). Among the countries determined as “High Income” according to a report published by Organization for Economic Co-operation and Development (OECD, 2008), the U.S. GINI coefficient was .3814 in 2005, compared to Canada’s .3169 and Denmark’s .2334 index rating. It is interesting to also note that among these countries the rate of poverty as a percent of the population was 17 percent, 12 percent, and 5.3 percent respectively and social spending as a percentage of the GDP was 16 percent in the U.S. compared to 28 percent in Denmark. The World Bank compares High income OECD countries on a number of different levels; the U.S. as compared to the average of High income OECD countries is lower in primary grade school enrollment and higher for under-five mortality rates. This is an indication of what the OECD reported regarding inequality:

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The Psychological Impacts of Poverty and Under/unemployment

For those individuals in lower SES brackets due to economic, historic, and/or systemic factors, our current sociopolitical environment provides increasingly difficult circumstances. A review of the literature shows that lower SES has been associated with higher rates of suicide (Newacheck, Hung, Park, Brindis, & Irvin, 2003), higher levels of emotional and behavioral difficulties (Weissman et al., 1984), as well as higher odds of depression (Lorant et al., 2003), higher levels of aggression (Molnar et al., 2008), hostility, perceived threat, and perceived discrimination for youth (Chen and Paterson, 2006). Furthermore, studies have shown that children experiencing poverty have higher rates of depression, anxiety, and antisocial behaviors (Samaan, 2000). The effects of lower SES on families can be detrimental. Sareen and colleagues (2011) found that “low levels of household income are associated with several lifetime mental disorders and suicide attempts, and a reduction in household income is associated with increased risk for mental disorders” (p. 419). The health of lower SES individuals is only exacerbated by the lack or inequality of treatment. Many individuals who lack sufficient income or health insurance receive inadequate care (Journal of Public Health, 2007). The National Health Interview Survey (2011) reported that 49.1 million persons of all ages were uninsured at the time of the interview and that 60.8 million had been uninsured for at least part of the year. Other reports reveal that the disparities which exist in health care are only increasing. The National Healthcare Disparities Report’s (NHDR, AHRQ, 2009) main conclusions highlight the continued racial, ethnic, and income inequality in areas of access, quality, and interventions in health treatment.

The Electronic Era and Advocacy, Research, and Policy

Equipped with the above information, how is the psychologist to respond? The resources available within emerging media (web-based journals, interactive media, mobile applications, etc) provide a unique and ubiquitous option for disseminating information and engaging in advocacy, research and policy in new and exciting ways.

Advocacy

Traditionally advocacy work has been engaged in bringing awareness to injustice and working for systemic or institutional change. Advocacy can often influence policy, but does not need to be directly linked with governmental policy. An important component of advocacy is creating a collective voice that represents a marginalized group of persons. Efforts can include circulating petitions, creating websites or blogs that document and illustrate the experience of those in lower SES brackets, and work to bring the needs of those experiencing poverty or unemployment into a larger public conversation. Becoming involved in the needs of individuals and families directly affected by the current socioeconomic climate can help to inform psychologists on an individual and organizational level of the psychosocial needs to be addressed in research and practice.

Research

Changing the role of the psychologist may also need to address the notion of “publish or perish.” Although impact factors lead to greater notoriety among professionals, an honest examination of their utility in disseminating information to the public is warranted. Tremendous mobile applications (“apps”) are being engineered to change the ways in which individuals interact with media and information is presented. Psychologists must not miss the opportunities available within emerging media formats. Published work need not be restricted to esoteric journals, but also become part of the public conversation. Becoming involved in the needs of individuals and families directly affected by the current socioeconomic climate can help inform psychologists on an individual and organizational level of the psychosocial needs to be addressed in research and practice.

Policy

Finally, by utilizing the media resources mentioned above, the psychologist of the digital era can utilize media to influence public policy on direct and indirect levels. Through educating the public on the important research within health, clinical, and social realms of psychology and responding to the needs in vocational training among
others, the field of psychology offers a breadth of information like no other field. Working to communicate this information and research to the public, the field of psychology raises its prominence as an important and valuable partner in alleviating mental illness and social distress concerns among the public.

Conclusion
As unemployment and poverty rates rise, psychologists must become better prepared to serve the majority of those in need through research, advocacy and policy efforts. New research must focus on utilizing emerging media to elucidate the effects of the current sociopolitical environment on individuals, exploring the ill-effects of low-wages, temporary and underemployment, and stress on families as well as the psychological gains made from job training, steady employment, health insurance, and stable housing and income. Additionally, new psychologists must increasingly utilize APA’s advocacy and consulting positions to continue psychology’s transformation into the “electronic age” to work more effectively with politicians and officials who make policy. In this capacity, psychologists themselves can become lobbyist for social rights and laws that will assist the marginalized of the society.

References


About the Author
Michael Cadaret, M.A. is currently a doctoral student in counseling psychology at the University of Akron. His research interest broadly includes areas concerning social justice, multicultural competent research methodology and ethics. Current research projects and further information can be found at www.michaelcadaret.com.
In a world where we are increasingly connected via electronic means, individuals often feel less connected to the natural and social worlds in which they live. The practice of Zen was designed to help individuals reconnect to what is happening right now, as our experience unfolds from moment to moment. Such a practice helps ground a person from living solely in an artificially created mental world. Zen practices inspired some of the current evidence-based practices of Mindfulness-Based Stress Reduction, Mindfulness-Based Cognitive Therapy, Dialectical Behavior Therapy, and Acceptance and Commitment Therapy (Sears, Tirch, & Denton, 2011).

Many have written about Zen and therapy (e.g., Austin, 1998; Bein, 2008; Birx, 2002; Brazier, 1995; Fromm, Suzuki, & DeMartino, 1960; Martin, 1999; Pawle, 2008; Rosenbaum, 1999; Watts, 1961). While we don’t feel it is likely (or necessary) to fully develop a systematic, self-contained “Zen Therapy,” we feel that there are many concepts and techniques employed by Zen that may be useful in a psychotherapeutic context, both for the mental health specialist as well as their client.

At the March 2012 Union of Psychology and Spirituality Retreat, we were able to offer a workshop on Zen Koans for Psychotherapists. Zen koans are designed to help us loosen our attachment to the mentally created problems with which we struggle. Such a method can be helpful for therapists who sometimes get caught up in the cognitive constructions of the client. The practice reminds us that the reality of each moment is often more simple than our interpretations of it.

The characters for “koan” (Japanese) or “kong-an” (Korean) translate as “public case,” as they often involve stories about Zen teachers and their students. The koans are designed to hook the student with a problem that only exists in the student’s mind, not in reality. Hence, the problem seems unsolvable until the student lets go of his or her conditioned way of looking at things.

The koan work in a formal sense has its origins early in the Tang dynasty when sayings of former and current masters were circulated and used in meditation. In the Song dynasty these stories were collected into anthologies, which formed the basis of a curriculum. The tradition crossed to Korea and Japan.

The seminal Korean Zen Master Jinul, based on the work of the Chinese patriarch Dahui, established the Korean method of koan practice. For Jinul, this method was the practical means for achieving the sudden awakening described within the Avatamsaka, or Flower Garland Sutra, an influential Buddhist text (Buswell, 1991). While Jinul was the Zen Master who introduced this method of practice to Korea, it was Zen Master Jin Gak who compiled the very first koan.
collection in Korea, opening up a concrete path for practitioners to engage in this method of awakening (Kang, 2006).

In Japan, teachers who had awakening experiences and a strong inner connection to the koans revitalized the Japanese tradition from time to time; one of these figures was Hakuin Ekaku, who in the 18th century emphasized transformative enlightenment experiences and life-long deepening of wisdom. Hakuin and his immediate successors put the koans into a specific order and formalized a system that gave one a way to navigate past the point where most spiritual guidance stops.

In the modern era, Zen Master Seung Sahn travelled from his homeland of Korea to teach in Japan. While there, through interactions with his Japanese Zen counterparts, he experienced their curriculum and style, and through his diligent practice and deep insight, brought together this organized approach with the down to earth practicality of the Korean method. This unique marriage produced a system of engaging koans that elucidates two stages – what we call "Ascending the Mountain" and "Descending the Mountain." In Ascending the Mountain koans, the focus is on awakening to ultimate reality, while in Descending the Mountain koans, the focus is on revealing how to live one’s everyday life with wisdom and compassion. It is important that one’s koan practice and one’s daily life connect. Moment to moment, paying attention to one’s situation, the relationship to the person you are with, and to current roles and functions gives rise to wisdom and compassion (Lynch, 2006).

When engaging in koan work, it is important to bear with the feeling of risk, failure, and inadequacy that sometimes appears. Koans draw out resistance, and the resistance always has the flavor of the particular koan that drew it out. Ultimately, students must get over their need to be right and to impress their teacher, and risk offering the understanding they have.

Often the seemingly bizarre questions in koans (e.g., “Before your father and mother conceived you, what was your original nature?”) cause us to fall into a state of not knowing. Too often, our impulse is to try to figure it out intellectually. However, as we know from our therapy work, a tolerance of ambiguity is essential to remaining open to truly understanding the client, and remaining open to possibilities. Very often, from this open state, the answer becomes clear. An example of this process can be seen in the koan “No Fear of Death” (Haeng Won, 1992, pg. 58):

“The wise have no fear of death, too often they have died to Ego and its vanities, to all that keeps them tied.”

After giving the student this koan, the teacher then prompts them with questions designed to test their insight, their degree of being hooked or free. A question such as “If you are not tied to anything, then what?” can send the student spiraling into conceptual and abstract thought. But when this is dropped and the question is engaged “in the Zen way,” the answer appears as the student stands, walks, and flaps his arms around, demonstrating untied freedom.

Reggie Pawle (2008) uses a method he calls “koan therapy,” which involves finding and clearly defining the seemingly unsolvable problems in a client’s life, and having them sit with it until the problem can be related to in a new way.

Zen grew out of the Buddhist tradition, and it emphasizes direct experience over philosophical speculation. The late Zen master Seung Sahn emphasized the importance of “don’t know mind,” a state which is open to direct experience. He talks about reality being “like this,” meaning that we do not need to add intellectual evaluation or interpretation. Likewise, Shunryu Suzuki (2006) writes about the concept of "beginner’s mind," which is open to all possibilities. Similar to Acceptance and Commitment Therapy, Zen teaches not to confuse thoughts with reality.

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Koans are taught through direct exchanges with a teacher. Lynch (2006) gives some examples of the kinds of answers Zen teachers look for:

When the student enters the interview room; the teacher places a cup and a pen on the floor and asks if the cup and the pen are the same or different. The four kinds of “like this” answers could be:

- Without like this: maintain complete silence, a don’t know mind.
- Become one like this: hit the floor or shout KATZ!
- Only like this: saying “cup is cup, pen is pen.”
- Just like this: drink from the cup, write with the pen.

(Lynch, 2006, p.21)

Hirai (1989) tells the story of a famous television reporter visiting a Zen priest in Japan. Both the priest and the reporter were connected to EEG and other physiological recording devices. After 10 minutes of meditation, a lovely, young, bikini-clad woman came into the room and sat down across from them. The reporter showed quite a bit of physiological reaction, but the priest’s showed almost none.

Next, the crew dropped a realistically looking rubber snake from the ceiling. Even though he was in on the joke, the reporter showed EEG disturbances that lasted for a while. The priest showed a momentary reaction, but quickly returned to equilibrium.

Hirai quotes the priest as saying, “...this is the meaning of not being obsessed. Although I am a trained Zen priest, the appearance of a beautiful young girl in a bathing suit and the sudden dropping down of a snake are stimuli to which I react. This is proof of the awareness during the [meditation] state. But I was able to return to a normal state of tranquility quickly” (Hirai, 1989, p. 153).

This is one of the goals of Zen training – to react appropriately in the moment, but not to linger too long over things in a constructed mental world. This is why Hirai (1989) believes that Zen training can be useful for anxiety, which is maintained through ruminations and worries.

Too often, we get caught up in the electronic world in which we are participating throughout the day, and lose touch with what is really happening in our lives from moment to moment. So, take the time to put down the words you are reading. What do you see, hear, smell, taste, and feel right now? What other truth could you possibly be looking for, outside of your own ideas and thinking?

It is important to keep in mind that Zen and psychotherapy have different purposes and goals. However, psychotherapy may gain important insights from this ancient tradition. Of course, more systematic research is necessary to demonstrate clinical benefits.

References


Richard Sears, Psy.D., MBA, ABPP, is a licensed Ohio psychologist, board certified in clinical psychology by the American Board of Professional Psychology. He has been practicing and teaching Zen and mindfulness for over 25 years. He has been authorized to teach koans by Paul Yuanzhi Lynch, in the lineage of Seung Sahn. He is director of the Center for Clinical Mindfulness & Meditation and core faculty in the Doctor of Psychology Program at Union Institute & University, where he also runs a private practice. He is lead author of Mindfulness in Clinical Practice and Consultation Skills for Mental Health Professionals.

Rev. James Myo Gak Foster is a third-year graduate student in clinical psychology at the Union Institute & University. He has also been a practicing Buddhist for almost 25 years, and ordained for half of that. Rev. Myo Gak is a Zen Buddhist priest in the Korean Son (Zen) lineage of Dae Sosan (Great Zen Master) Seung Sahn, the founder of the Kwan Um School of Zen, North America’s largest Zen Buddhist denomination. Rev. Myo Gak Boep-Sunim has received full precept transmission; authorization to take personal students, and teach kong-ans (koans), received Inga (Inka Shomei), the final “Master’s Seal of Approval” in this lineage of Zen. Rev. Myo Gak is the founder and president of the Five Mountain Buddhist Seminary, the nation’s first Distributed-Learning, non-denominational seminary program, where he also serves as a member of the core faculty. Rev. Myo Gak serves as the local Guiding Teacher and Abbot for Great Cloud Zen Center, in Cincinnati, Ohio and has served as the National Abbot for his Korean Zen denomination since 2008.
## 2012 Ohio Science Day Winners

The Ohio Psychological Association continued its tradition of supporting the Ohio Academy of Science’s State Science Day by providing the judges for the Behavioral Health Projects. The 2012 Science Day was held on Saturday, May 5 at French Field House on the campus of The Ohio State University. The Behavioral Health project category is defined as “relevance, creativity and understanding of human behavior as demonstrated by the project. A project with animals may be considered if it is relevant to human behavior. Projects referencing psychological science will be given preference.” Thanks to our outstanding judges this year: Rose Mary Shaw, A.J. McConnell, Angela Ray, Christy Tinch, Jeff Markino-Shrivers, Lindsey DeMuth, Mary Mills, Peg Mosher, Michele Evans, Nate Tomcik, Pam Deuser, Linda Sirosky Sabado and Michael Ranney.

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

Prizes were funded by the Foundation for Psychology in Ohio, with support from Cleveland Psychological Association, Central Ohio Psychological Association and OPA member donations.

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

### Grade 6

1st: Robert J. Chesonis - **Does paper color affect memory**  
St. Mary Central, Martins Ferry

2nd: Joel J. David - **Music with a heart beat**  
Ann Simpson Davis MS, Dublin

#### Grade 7

1st: Jennifer A. Malashevitz - **Do midline brain exercises affect the memory and sped doing math facts?**  
Incarnation, Centerville

2nd: Nicholas R. Scott - **The effects of distractions on driving**  
Mother Teresa Catholic, Liberty Twp

3rd: Nicholas A. Lehmkuhl - **How does cheating affect pulse rate**  
St. Joseph, Sylvania

#### Grade 8

1st: Adam G. Ben-Porath - **Reading comprehension: A comparison of print versus digital media**  
National Inventor’s Hall of Fame School, Akron

2nd: Lauren J. Finkenthal - **Vocal volume variability: The effect of hand movement and positioning on speaking volume**  
West Geauga MS, Chesterland

3rd: Taylor A. Skolik - **Hemispheric brain dominance: Does it impact academics?**  
Dayton Christian School, Miamisburg

#### Grade 9

1st: Charles D. Pei - **An examination of the correlations between racial behaviors and obesity rates**  
Upper Arlington HS, Upper Arlington

2nd: Shuo Liu - **Use and perception of social media in society**  
Upper Arlington HS, Upper Arlington

#### Grade 10

1st: Ryan H. Huston - **Sleep deprivation’s effects on various regions of the brain**  
Upper Arlington HS, Upper Arlington

2nd: Eric Y. Qian - **Class schedule, structured activities and education performance**  
Upper Arlington HS, Upper Arlington

#### Grade 11

1st: Nazeer S. Abbed - **A study of zero sum theory games on teenager decision making**  
Springfield HS, Springfield

2nd: Sean C. Maynor - **Cardio effects**  
Dayton Christian School, Miamisburg
The 2012 OP Quiz for Continuing Education

The articles selected in this issue are sponsored by the Ohio Psychological Association. OPA is approved by the American Psychological Association to provide CE for this home study. Complete this form in its entirety. A total of 80% of responses must be correct to receive 1.0 CE credit. Submit this form and payment (OPA members: $20; Non-Members: $25) to OPA OP Home Study, 395 East Broad Street, #310, Columbus, OH 43215. Pending successful completion of this test, you will receive a certificate of completion within 20 business days of receipt.

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

Clinical Paradigm

1. According to Van Voorhis et al. for diagnostic purposes, clinical psychologists utilize the ________ while school psychologists utilize the _________.
   A. Both use the DSM-IV-TR
   B. Ohio's Operating Standards for Ohio's Schools Serving Children with Disabilities (2008); DSM-IV-TR
   D. None of the above

2. McConnell indicated that distributed learning graduate programs are:
   A. Require face-to-face instruction on line
   B. Require all students to have access to Skype
   C. Require the students post once a week to a discussion board
   D. Require students to complete a combination of face-to-face, hybrid and online courses during the course of their studies

3. According to Swenson one of the features of the current version of the Ethics Code that is especially attractive is:
   A. The standards are often not precisely worded, thus making them applicable to new situations
   B. The standards are law and must be precisely followed
   C. The standards do not address on-line learning
   D. The standards clearly define what online professors can and cannot do

4. Drude reported that online case consultation that reflects client material should be:
   A. Open for all to review
   B. Include the client's name
   C. Typed and in APA format
   D. Encrypted

5. Cadaret indicated that the changing job market and rising disparity has left many individuals:
   A. With the ability to pay for all necessities
   B. With the ability to pay for basic necessities, such as housing, medical insurance, child care, and healthy options for food
   C. Avenues for college students to go to universities
   D. Avenues for college students to go to universities

6. Scott et al. reported that Quality Matters rubrics are:
   A. Informal faculty –made rubrics
   B. Used by traditional schools to monitor student effectiveness
   C. Faculty-centered, peer-reviewed set of standards used to evaluate the design of online and blended courses in higher education
   D. Not recommended for use at any time in higher education

7. Sears et al. shared that in Ascending the Mountain koans, the focus is on awakening __________, while in Descending the Mountain koans, the focus is ___________.
   A. On awakening to ultimate reality; revealing how to live one’s everyday life with wisdom and compassion
   B. On detoxifying limbs and arms; detoxifying legs
   C. On revealing how to live one’s everyday life with wisdom and compassion; on awakening to ultimate reality
   D. On detoxifying legs; detoxifying limbs and arms

8. Blashfield indicated that diagnoses are important descriptively, for:
   A. Record keeping
   B. Insurance company filings
   C. Communication with other professionals
   D. All of the above

9. Wolford et al. shared that the SETT method (Zaballa, 2012) requires team members to ask questions related to the student’s:
   A. Environment
   B. Tasks
   C. Tools
   D. All of the above

10. According to Blashfield the major goal of the ICDs is to________.
    A. Serve public health needs in America.
    B. Provide a system that matches the DSM-IV criteria,
    C. Serve public health needs, especially in non-westernized parts of the world
    D. All of the above

True/False

Please answer the following by selecting True or False:

1. According to McConnell one of the stigmas to online learning is that distance-learning programs are attractive to potential students who have lower grade point averages, work full-time, or are unable to meet the admission standards of a traditional program. T_____  F______

2. Drude reported that The American Medical Association’s focus is on maintaining professional boundaries and personal privacy and client confidentiality. ______

3. Cadaret reported that the social implications which stem from political actions and policies have shaped an environment where the distribution of wealth and privilege has a normal distribution. T_____ F______

4. Van Voorhis et al. reported that the classification systems of IDEIA (2004) and DSM-IV-TR automatically translate well as the basic purpose, structure, and methods of the two systems are based on the same paradigms. T_____ F______

5. Cadaret reported that resources available within emerging media are ineffective for engaging in advocacy, research and policy making. T_____ F______

6. Scott et al. indicated that instructors should be mindful to participate in discussion boards without dominating the conversations. T_____ F______

7. Sears et al. shared that Zen koans are designed to help us loosen our attachment to the mentally created problems with which we struggle. T_____ F______

8. Wolford et al. reported that assistive technology can assist a person with a disability in a number of areas; the marketplace is a good for the learning of limited products. T_____ F______

9. Sears et al. indicated that instructors should be mindful to participate in discussion boards without dominating the conversations. T_____ F______

10. According to Blashfield the ICD and the DSM are quite different systems with different goals and with different internal structures. T_____ F______
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