Mary Banks Gregerson *Editor*

Technology Innovations for Behavioral Education

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Foreword by James C. Kaufman

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To
My husband Christopher, whose humor and support enliven life for our family

Foreword

Technology innovation brings creativity to behavioral education. One question rarely voiced by creativity researchers – yet often implicitly asked by those less entrenched in the field – is *why creativity?* Few businesses, educators, or researchers explicitly question the importance of being creative or understanding creativity. Yet the question is nonetheless present when time, money, and resources are directed at other venues (often providing more short-term gain).

Technology Innovations in Behavioral Education illustrates key reasons as to why creativity is important. Large-scale or global creativity changes paradigms. The entire concept of eHealth and telemedicine has changed the way medicine is taught. Entire classes can be held in Second Life, students can practice on virtual patients and in simulations, and videoconferencing enables remote areas to receive vital medical training. Such Big-C or genius creativity can virtually change the fabric of time and space.

It is equally important, however, to recognize the little-c or everyday creativity that is needed to propel a discipline forward. In order for the larger mechanisms to work, people need to think and act creatively in their daily routines. Such creativity has certain requirements. A basic amount of domain knowledge is needed – as several chapters here articulate, both trainers and students need to be technologically savvy to take full advantage of the benefits of eHealth. People also need to be motivated. It takes effort to start country-wide initiatives such as the *Televisa*'s Sabido method, which uses the foundation of social learning to model positive health outcomes. It takes the basic intelligence to understand, for example, which Google search results are authoritative and which are not. And perhaps, it takes the character to know how to navigate uncertain ethical waters using this new technology.

Technology Innovations in Behavioral Education reflects both Big-C and little-c contributions alike. This slim yet important volume discusses in easily applied terms the key issues facing behavioral and medical educators or trainers who want to get the most out of the latest technological advances. Readers of this book will gain key practical information. They will learn how to use such new media as film and social networks to better teach health issues. They will find gripping discussions of ethical issues in media psychology and best practices for using televideo to teach psychology and psychiatry. Readers will get specific solutions for how to find accurate sources on-line and how to use new media to train cultural sensitivity.

The authors offer ways for people to discover how to best teach and learn about psychology and medicine with the most modern technologies. Readers will likely be inspired to engage their own creativity in finding which best practices work for them.

November 5, 2010

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Preface

Technological innovation has a special place in the future of behavioral education for both students and educators. Technology is today's ticket for tomorrow's work force.

It is predicted that 75% of tomorrow's jobs will require computer use (Bureau of Labor Statistics, 2000). Seven years ago 77 million workers used the computer or internet at work, with the greatest use by more highly educated individuals (Bureau of Labor Statistics, 2003). Clearly the relationship of technology and higher education has enduring meaning for tomorrow's workforce and today's students.

For students, a new multimedia pedagogy integrates new technologies for a more effective *and* appealing educational environment. Effectiveness needs no further explanation, but attractiveness does. Student choice rules in education today. This consumer-driven higher education environment necessitates a more student-centered approach to learning, one in which technology plays a large part.

Today, the electronic environment permeates students' lives outside of school – the Entertainment Software Association (2010) reports that 67% of American households own a connected device to play videogames. Of those playing games, 60% are boys and 40% are girls. Yet more women than men use computers in their employment (Bureau of Labor Statistics, 2010). So, the integration of technology into education not only capitalizes on home life trends but also anchors the educational experience relative to future work activities.

Yet, technology innovation in behavioral education is not only about students using technology but also about technology enhancing their learning experience. In America the psychology of multimedia has traditionally implied the use of film and other electronic modality adjuncts such as PowerPoint. Newer technologies than these expand the horizons of behavioral education.

Multimedia education maximizes learning by involving many different sensory modalities. Newer technologies of the virtual environment activate more senses than the standard PowerPoint and overhead projections. These engender flexible learning skills that foster receptivity to innovation, a key to future mastery of technology that does not yet exist. (More is said later about the latitude required for successful technology integration into education.) Visionary leadership is required to guide judicious and careful design of technological innovation plans and their implementation as well as evaluation. Technology plans, evaluation strategies, and community

liaison regarding these new technologies require strong, resolute leadership. Leadership in technology may prove the cutting edge in today's student consumer-led educational environments, whether traditional or innovative.

Leaders in integrating technology into education need guides like this edited volume. "*Technology Innovations in Behavioral Education*" serves as an applied handbook that shows real world examples demonstrating rigor, creativity, and excellence. Having described the crucial role of technology in education today, this preface turns to each chapter in terms of these three dimensions.

Techno-Savvy Erases the Digital Divide

A digital divide separates the techno-savvy from the techno-naïve (Rice, 2002). To dissolve an economically-based digital divide, the 1996 US *E*-rate program has resulted in 95% of public classrooms having Internet access by 2005 (National Coalition for Technology in Education and Training, 2007).

Now, the focus turns from gaining access to cultivating that access into effective techno-learning holding environments (Winnicott, 2000). Such digital literacy in education (Hartley, 2011) may mean the crucial difference between institutions thriving, even surviving, or vanishing in a "wire-free" dust cloud when disappearing students "vote with their feet." Not only is technology use and management included in the higher education curriculum but also as an aid to administration at the classroom, school, and system level. Furthermore, studies in other countries have investigated the integration of technology into classrooms and found excellent results (Jacobson et al., 2010).

Three keys to effective technology integration into education are leadership, learning, and latitude.

Technology Leadership in Education

Leaders in technology are fast becoming the directors and decision-makers in educational settings today (Brown, 2011). Already professional gold standards and codes have evolved for the use of technology in education (Papa, 2011). Curricula for training educators include training in technology and technology management best practices (Armfield, 2011).

So firm is the acceptance of the place of technology in education that discussion has turned to how technology can improve leadership skills in terms of management and administration. For management, the role of technology standards in evaluation and accountability is considered (Brown, 2010). For administration, optimal education environments technologize not only the classroom but also the administrative conference room with data-driven decision making (Papa & Papa, 2011).

Finer points of leading with technology have started to emerge. For instance, educators consider how to build bridges eliciting community support for the growth rapidly advancing technology requires (Papa, 2011). Ways for leaders to tie technology to institutional mission and goals are being explored (Creighton, 2011). Others address what are important considerations to assess and evaluate in a school technology plan (Brown, 2011).

Technology Learning in Education

Technology leadership in education reaches students on their own terms. In 2000, Roberts reported that one-third of a youth's day is spent with media consumption, and Chapin found that students reported more media time than being in school or with parents. Ten years later these teens are adult learners in higher education. As early as 1957, Hoggart observed that today's teen fad appears to become tomorrow's scientific approach.

Although classic learning theories have not changed, technology mediation is a new dimension considered (Papa & Papa, 2011). Some studies indicate that technology enhances learning (Lee, Wong, & Fung, 2010), which is tied to higher self-efficacy (McCoy, 2010; Shea & Bidjerano, 2010). One clever study documents enhanced training outcomes with technology-assisted education for technology students (Tiernan, 2010).

Technology Latitude in Education

Finally, latitude is a key to effective technology integration into education.

According to the YouTube video "Information Technology" (http://www.youtube.com/watch?v=OSjRpgT_hXM) former US Education Secretary Richard Riley noted "The top 10 jobs in demand in 2010 didn't exist in 2004…We are currently preparing students for jobs that do not exist…using technologies that haven't been invented yet…to solve problems we don't even know are problems yet…."

One study of biomedical students' connectivity use documented changing patterns of use as new technologies emerged (Judd & Kennedy, 2010). The challenge of new technologies underlines the basic fact that students need to "learn how to learn" rather than focus solely on content. Learning itself is the life skill higher education imparts.

Flexibly adapting new technologies to *creatively* master any content domain and then *rigorously* evaluate strategies and outcomes facilitates *excellent* performance. Excellence receives definition in gold standards and codes for technology facilitators, technology leaders, students, teachers, and administrators (Papa, 2011). Each chapter in this edited volume describes creative, rigorous, and excellent use of technology in behavioral education.

Applications of Technology Innovation in Behavioral Education

This veritable handbook describes applications ranging from cultural sensitivity training to Internet strategies for sound scholarship to the use of popular films to teach behavioral principles. The brief description following the chapter author and title listing guides discerning readers to each specific application.

Regan Gurung's Introduction, "Heads in the Clouds: The Evolution of Educational Technologies" delineates important changes and initiatives in health care and health care education, and then provides a brief overview of the different diverse technologies being used excellently in pedagogy, with implications of their use. He challenges education leadership across America to creatively integrate new technologies such as those presented in this volume and to rigorously evaluate the impact.

Mary Gregerson's "Creative Higher Education Draws upon Popular Approaches for Cost Effective Pedagogy" details the rigorous challenge for an America proactive graduate and medical education as a by-product of creative entertainment fare such as popular films and television as well as entertainment that produces excellent medical and behavioral education.

Jeffrey Ring's "Virtual Classrooms and Communities of Practice: New Tech Strategies for Enhancing Culturally Responsive Health Care" describes two unique, excellent online community educational and support efforts to creatively train cultural sensitivity, and their rigorous evaluation.

Pauline Wallin's "Internet Research Strategies for Finding High-Quality Content on Topics of Psychology and Mental Health" highlights creative data-basing techniques and resources to uncover rigorous, science-based, authoritative information from excellent free public Internet sources.

Eve-Lynn Nelson, Thao Bui, and Susan Sharp's "Telemental Health Competencies: Training Examples from a Youth Depression Telemedicine Clinic" notes that while psychiatry has been the most common telemedicine service, excellent psychology services are becoming more common over televideo and warrant consideration in creatively training competencies for the next generation of psychologists with three main rigorous aims: (1) Technology competency; (2) Clinical competency; and (3) Outreach competency.

Meredith Cary's "How Can Educators LEAD Professionals through New Technologies That 'Connect the Dots' to Quality Care?" offers how clinical educators could share rigorous performance-based training in self-management support skills to **L**everage distance learning and creative new social media technologies to **E**ngage inter-professional students in an excellent capstone project for clinical prevention and population health to **A**ccelerate health consumer demand to do what works, and **D**isseminate through outcomes on their "peer-reviewed" health information website.

David Shapiro's "Ethical Issues in Media Psychology" rigorously covers ethical and legal issues that apply to these creative new technologies in the previous chapters and to excellence in more traditional media presentations as well.

Both students and leaders in behavioral education find useful examples and guidance for what has already occurred when new technologies reach these classrooms. This compendium not only reveals the genius applications already in service, but also sparks the pedagogical imagination. It is hoped that this volume prompts further creative attempts to rigorously and excellently integrate new technology innovations into behavioral education. We have only just begun the technology revolution in our society and in our education.

Leavenworth, KS Mary Banks Gregerson

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Heads in the Clouds: The Evolution of Educational Technologies

Regan A.R. Gurung

If you consider yourself technological savvy, the play on words in my title should have been self-evident and perhaps elicited an internal smile. Perhaps the literary allusion evaded you. We live in a world where "cloud computing" is becoming ubiquitous. Data is progressively moving to off-site servers. Your office computer and university account probably do not save your work on the machine at the desk you sit at. Instead, data is now archived, elsewhere at locations only privy to the informational technology folk on your campus or at your institution. With the explosion of online degree granting institutions and the migration of classes from face-to-face formats to online formats, education is truly moving into the clouds and our students' heads explore virtual worlds as educators increasingly use technology in their practices. Parallel to this general trend, there is national recognition that more needs to be done to educate health care providers to better match emergent needs and developments. What are the implications for learning? In setting the stage for the six chapters in the rest of this volume, I first highlight important changes and initiatives in health care and health care education and then provide a brief overview of the different diverse technologies being used in pedagogy, with implications of their use.

The United States spends more per capita on health care than any other country. Yet, the professional health workforce is not consistently prepared to provide high-quality health care (Institute of Medicine, 2010). Almost at every turn, there is a call for a greater focus on the preparation of the health care workforce. Ron Rozensky, chair of the Advisory Committee on Interdisciplinary, Community-Based Linkages (ACICBL) within the Bureau of Health Professions notes that the 2010 annual report to the Secretary of Health and Human Services and to the Congress will focus on "Preparing the HealthCare Workforce to Address and Manage Health Behaviors." Cynthia Belar of American Psychological Association's Education Directorate with similar foresight focused the 2009 Educational

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Leadership Conference on "Preparing Tomorrow's Health Workforce." Technology will play a major role in the development of new training models for health care.

Technology: Tools for Delivery of Health Care

Telehealth or more broadly eHealth is no longer a new term or a novel way to deliver health care. Behavioral telehealth has been used in one form or the other for over 40 years, but current technological developments such as high-speed internet and wireless capabilities are making this form of delivery of service even more common. There has already been a call to ensure that more traditional interventions are translated into telehealth modalities and to test whether such interventions remain effective when implemented from a remote site (Saab et al., 2004). Recognizing the growing use of Information and Communication Technology (ICT), the Federal Communication Commission initiated the Rural Healthcare Pilot Program Broadband Initiative in 2007 to provide funds for the deployment of broadband networks to rural areas. As can be expected, organizations receiving the funds still had problems with program deployment highlighting the need to pay attention to the rolling out of telehealth (Whitten, Holtz, Krupinski, & Alverson, 2010). This teething problem aside, it is clear that the development, adoption, and implementation of a broad range of new eHealth applications (e.g., online health information websites, interactive electronic health records, health decision support programs, tailored health education programs, health care system portals, and mobile health communication programs) hold tremendous promise to increase consumer and provider access to relevant health information, enhance the quality of care, reduce health care errors, increase collaboration, and encourage the adoption of healthy behaviors (Kreps & Neuhauser, 2010, p. 329). The chapters in this volume stand as vivid testimony and exemplars of this potential of technology to health education.

Technology: Its Role in Health Care Education

Although informational and computing technologies have been used to deliver health care for sometime now and with significant success both in terms of cost savings and efficacy not as much attention in the USA has been paid to training health care providers in how to use the technology well or in optimizing the use of ICT to train providers in the first place. Many nations have worked on curriculum for training in telemedicine based upon international experience and regional needs (e.g., Pakistan, Zafar et al., 2008) but still more needs to be done. This is not to say that there has not been a lot of focus on the use of technology in education in general. It is important to parse out all the different levels at which technology can be used.

Technology is a broad term when used in the context of education. It varies in terms of tools: presentation slides (PowerPoint), "clickers," YouTube videos,

course management systems (e.g., Blackboard, Desire2Learn, and Moodle), interactive whiteboards, and virtual worlds (e.g., Second Life); type of course (hybrid, wholly on-line, and wholly face-to-face) or the intended outcome or goal (e.g., advising, encouraging student interaction or collaboration, and quizzing). There are a number of recent and excellent guides to help educators think about how current and emerging tools in our increasingly digital age can positively impact their students, whether close at hand or in virtual communities (Dunn, Wilson, freeman, & Stowell, 2011; Richardson, 2009).

Technology's use can also vary depending on the level it is used at: Undergraduate, graduate, medical school, and continuing education levels. Technology is particularly influential for continuing education (CE), the main purpose of which is to update, refresh, and reinforce knowledge. Once delivered primarily by lecture attendance or seminars, today CE is heavily technologically enhanced with "webinar" online seminars both in real time or asynchronous, designed to allow professionals to get CE, especially for credits for licensure and credentialing. Unfortunately, there is no comprehensive, well-integrated system of CE in the health professions.

Recently, CE has morphed into continuing professional development (CPD), a learner-driven form of CE with broader learning methods and formats, most technologically driven. In response to a growing concern about problems with CE, the Institute of Medicine (IOM) formed a Committee on Planning for a Continuing Health Professional Education Institute. The committee reviewed the literature on the effectiveness of continuing education methods and has created a set of recommendations that are critical to the topic at hand (Institute of Medicine, 2010). Most importantly, the report notes that the "science underpinning CE for health professionals is fragmented and underdeveloped" (IOM, p. 2). Specifically, the report notes that it is difficult to identify effective educational methods. Technology is the educational method of the time, not just the future, and anyone in education, but especially those providing CPD must explore the best practices for the use of ICT. In 2007–2008, only 11% of the activities accredited by the Accreditation Council for Pharmacy Education were Internet based. This is bound to skyrocket in the years ahead as national initiatives aim to transform learning with technology.

Key Challenges

Increase educators' tech-savvyness and resources. In March 2010, the Office of Educational Technology released a draft of its National Educational Technology Plan titled *Transforming American education: Learning powered by technology*. A major finding is that there is a gap in technology understanding that influences program and curriculum development and one that prevents technology from being used in ways to improve instructional practices and learning outcomes (p. ix). The report calls for the building of an infrastructure for learning that provides every student and educator adequate technological resources. Specially, the report recommends that professional educators should be "supported individually and in teams

by technology that connects them to data, content, resources, expertise, and learning experiences that enable and inspire more effective teaching for all learners" (p. xiii). One major way to provide this is the example set by Ring (2011) whose Communities of Practice model involves a virtual community of professionals across the nation dedicated to enhancing institutional efforts in cultural medical education.

Measure Effectiveness. With the advance of technology into the classroom and clinic, it is important to keep our eyes on critical issues of effectiveness. Although the use of ICTs is becoming widespread in undergraduate education, there are few experimental studies evaluating its effects on learning. Researchers need to monitor the effective of e-learning in light of traditional means.

There is a growing body of such assessments in different settings. Spaulding, Davis, and Patterson (2008) compared the perceptions of school professionals who received education about students with chronic illness by videoconference (VC) or by face-to-face (FTF) presentation. Both groups indicated that they were very satisfied with the instruction they received, but FTF participants were significantly more satisfied than the VC participants. Similarly, comfort with the sessions, perceived preparedness, convenience, and other items were also highly rated in both groups, although the FTF group rated many of these perceptions significantly higher. The key here is that VC delivery appears to be a viable alternative when FTF is not possible, particularly in rural areas. Another study showed the feasibility of formally assessing the learning effect of an innovative tool. Providing online exercises to students has a direct effect on learning numerical operations related to statistics (González, Jover, Cobo, & Muñoz, 2010). Among the 94 students who actually employed e-status, the effect size was 0.63 (95% CI: 0.17–1.10).

Although e-learning may not be for everyone and some professionals prefer face-to-face contact (Jianfrei, Tregonning, & Keenan, 2008), e-learning frees one from the constraints of time and place for CE and to set one's own pace, review content when needed, and otherwise personalize one's learning including the pacing and duration of a session (Wakefield, Carlisle, Hall, & Attree, 2008). Of course, e-learning is cheaper and can bring together large numbers of professionals otherwise separated by distance (Bryant, Ringrose, & Bryant, 2005). As increasing number of educators explore the use of virtual worlds for education (see Ring, 2011), not just online classes but programs such as Second Life, there is a need to consider which pedagogical approaches can provide an opportunity to do more than recreate the traditional classroom by leveraging the unique characteristics and potential that the technology can offer (Girvan & Savage 2010).

Exemplars of Successful Technological Use: The Current Book

The six chapters that follow well exemplify the needs outlined in the preceding discussion and even illustrate innovative approaches to the use of technology. Areas of attention identified by both the IOM report (2010) and the National Education

technology plan (2010) are addressed by the material in each of the different chapters. The authors highlight critical needs such as creating an *integrated infrastructure* for the sharing of content and practice tools (e.g., using a social media platform to LEAD, Cary; effects to increase communication between educators using technology in the Communities of Practice, Ring; a systems approach to treating youth depression in rural clinics, Nelson, Bui, and Sharp), use technology to *increase cultural awareness* (e.g., the case study of a masters of medical education program, Ring), and implement *diverse styles of teaching and learning* (e.g., films, Gregerson; internet searching, Wallin). Of particular importance is an explicit focus on legal and ethnic issues (Shapiro), an area often neglected in pedagogical considerations (McCarthy & Landrum, 2012).

There are many natural links here. Many of these chapters illustrate methods that can be used at any level of education. You can use films and television shows in an undergraduate classroom, in graduate school, or even in medical school (the latter explicitly illustrated here). Similarly, any educational setting can benefit from know how to use the internet to find high-quality content and material from these two chapters capitalize on the strength of technology as a *pedagogical device or tool*. Technology can also serve as a *medium of delivery of information* both for training purposes (e.g., Cary; Nelson, Bui, and Sharp; and Ring) and for public education (Cary). As is clear in these chapters, many of the fears of the results of the encroachment of technology have not been realized. Many could not see a virtual world substitute for face-to-face contact. Many could not imagine training students for medicine or clinical psychology in anything but a personal real world context. The results of the innovations in these chapters clearly show the potential of the virtual worlds.

Perhaps the most underutilized, but growing, use of technology is as a great connector. Both in the Community of Practice (Ring) and in the chapter on social media platforms (Cary), we see how cloud computing and virtual worlds can serve as a hitherto unimaginable hub of knowledge and social connection between educators, practitioners, and their "clientele" –students, patients, and the general public.

These different presentations run well the gamut of the key issues involved in considering the role of technology in education and in particular the major domains we can turn our attention to. To this end, these chapters both set the stage for future work along similar lines and identify areas where more work is needed.

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Creative Higher Education Draws upon Popular Approaches for Cost Effective Pedagogy

Mary Banks Gregerson

America lags behind developing countries in drawing upon creative media to facilitate behavioral change in health mores.

Why?

What is happening worldwide?

In education, since 1996 the University of Buenos Aires has used the Fariña film approach to teach human rights ethics to over 35,000 students in basic and applied sciences such as medicine, psychology, biology, and law. As the proverbial pebble dropped in a pond, moving popular creative techniques from education to culture can maximize lessons learned for preprofessionals and also for a populace.

For the general populace, from the 1970s to 1990s, Miguel Sabido, Vice President for Research at the Mexican national network *Televisa*, termed his evidence-based and -evaluated serial dramas "entertainment with proven social benefit." The Sabido method applies behavioral change theory through creative mass media outlets and has scientific proof of effective positive behavior change in more than 200 health intervention programs in over 50 countries in Latin America, Africa, and Asia (Singhal, Cody, Rogers, & Sabido, 2004). In Mexico, an independent research firm documented a dramatic increase in AIDS testing for listeners (four times for men and three times for women) as well as a significant reduction

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in prejudice toward those with HIV/AIDS (Barker & Sabido, 2005). Entertainment and education were wedded successfully for effective social and behavioral change.

From 2002 to 2004, in Ethiopia, this eight step Sabido methodology resulted in 47% of Ethopian men and 42% Ethiopian women tuning into a 257 episode radio serial drama *Yeken Kignit* ("Looking Over One's Daily Life"). In Uganda, the US Agency for International Development funds an entertaining and educative television, radio, and community-based game show called "The Good Life Gameshow," which has an accompanying telephone hotline, print materials, and neighborhood Good Life Teams. Such innovative melding of science and entertainment on behalf of societal improvement appears successful for developing countries.

What about the USA?

We Americans seemingly value such progress for developing countries while America languishes, or, does it? Perhaps, the creative approaches from humanistic science lie hidden in the entertainment fare. For instance, in the DVD audio commentary following the 2008 Academy Award winning movie "The Hurt Locker," the movie's Academy Award winning director/producer Bigelow (2008) invoked the Sabido method by describing one character as a transitional figure, a basic ingredient in that method.

Also, a closer look at American entertainment may uncover a social benefit just emerging for us from such quality entertainment: We can educate enjoyably young professionals. Learning does not have to hurt!

This closer looks starts with a popular media overview, moves to medical education, then to graduate education, and, finally, to a very real taste of entertaining education: A video clip called "The Public Drinking Cup" from the play "Red Blood and High Purpose" about the emergence of the public health field with a scene dramatizing the dangers of the shared public drinking cup.

In this chapter, a brief look at entertainment with a social message in popular media will follow with a focus on education using such popular media to mold young professionals.

Popular Media

For the general populace, since 1985, a private organization in New York called PCI-Media Impact has used creative media for worldwide programs on health, human rights, and social advancement. Over 75 radio and television creative programs have received production assistance from PCI-Media Impact in African nations such as Kenya and Rwanda, Asian nations such as China and Pakistan, and South American nations such as Peru and Honduras and Mexico. In preproduction, experts determine cultural norms of the particular country and then adapt

storytelling to those norms (Andaló, 2003). The PCI-Media Impact portfolio, though, does not seem to include the USA.

Currently about 30 US television shows exist in the news or news magazine format. For example, the Santa Barbara, CA County Public Health Department's monthly series "Healthy for Life" (see http://www.sbcphd.org/documents/press/H4L20090818.pdf). In the mental health field, "The Healthy Place" consortium is the hub of TV, films, website, and videos (see http://www.healthyplace.com/). Yet, no creative programming, reality or otherwise, exists to specifically disseminate public health information, pose public health dilemmas, or question public health ethics.

Historically, the short-lived PBS series drama "Medical Investigation" aired from September 2004 to March 2005. Its story line described "a mobile medical team from the National Institutes of Health (NIH) who are summoned in a heartbeat to scope out – and hopefully snuff out – outbreaks of unexplained and fearful diseases" (http://www.tv.com/medical-investigation/show/24271/summary.html). This show, while evidently not viable, had impact worldwide. Perhaps a soap opera titled "All My Healthy Children" might last longer than the 54 years the venerable soap opera "As the World Turns" concludes this September.

Glimpses of healthy living are found sporadically throughout various TV fare. Successful and viable television series about medicine such as "House" as well as about crime investigation such as the series "CSI" (whether in Las Vegas, Miami, New York, or the Navy), weave medical information intricately into plot lines. For 10 years, the "Monk" criminal investigation series featured an obsessive-compulsive detective, capitalizing more on the entertainment value of his affectations rather than the healthy management of such an affliction. Some television series have received an American Psychological Association Golden Psi Award given for ethical excellence in the portrayal of psychology and psychologists in select episodes. For instance, one Golden Psi winner "Law and Order: Special Victims Unit" has the exemplary medical person Neal Baer, M.D., heading their production team. A published analysis of a popular television series "Grey's Anatomy" (Farina, 2009, pp. 5–8) examined both the presence and the absence of pertinent teaching moments.

Sometimes exemplary public health messages from dramatic series do prevail (Arango & Stetler, 2009). Recently, the New England Journal of Medicine published an article on the surgical safe list (see Haynes, Weiser, Berry, Lipsitz, Breizat, Dellinger, Herbosa, Joseph, Kibatala, Lapitan, Merry, Moorthy, Reznick, Taylor, & Gawande, 2009 at http://content.nejm.org/cgi/content/full/NEJMsa0810119) that had been featured a few months earlier in a dramatic turn on the series "ER" that featured the life-saving necessity of having a particular special solution on hand (see Martin, Mason, Findlay, Sanders, Jameson, McCambridge, Kypri, Elbourne, Levin, Haynes, & Gawande, 2009 at http://beesight.com/er/er-season-15-episode-19-recap-and-review-old-times/all_pages.html).

Successful collaboration between medicine, public health, and television is too rare and too haphazard while misleading instances too frequent and too familiar. We could do better. Vicky Beck from the University of Southern California's (USC) Hollywood, Health and Society program noted that the most popular TV show in Kenyan history is a 1987 television series focused around family planning (Andaló, 2003).

For American media, the USC Hollywood, Health, and Society program at the Norman Lear Center "provides entertainment industry professionals with accurate and timely information for health storylines" (see http://www.learcenter.org/html/projects/?cm=hhs). This effort is funded by the Center for Disease Control (CDC), The Bill & Melinda Gates Foundation, The California Endowment, and the Health Resources and Services Administration's Division of Transplantation and Poison Control Program. In 1999, the CDC developed and funded through the USC annual Sentinel for Health Awards to recognize television writers with outstanding achievement that "inform, educate and motivate viewers to make choices for healthier and safer lives through their storytelling" (see http://www.learcenter.org/pdf/SentinelFactSheet.pdf).

And, still, consistently mistakes are made. The 2009 summer series "Royal Pains" about concierge medicine on Long Island, New York, featured a scene where the potent antibiotic vancomycin, called the Cadillac of antibiotics by some medical personnel, was handily and readily available in a mobile makeshift vehicle carrying all sorts of medical support equipment and supplies to avert an epidemic at a house party. This medicine must be refrigerated and has a short half life, so just carrying some around in ready supply such as aspirins conveys a false conception of accessibility and viability.

So, dramatization of public health issues can be successful, if we are careful, both as entertainment and as dissemination of scientifically accurate information to society, and as a training tool for budding professionals, both in medicine and in graduate education. In both medical and graduate education, America appears ready to partner with more creative approaches using popular media.

Education

Let us look first at medical education and then turn to our graduate education.

Medical Education

Wall Street Journal Health columnist Melinda Beck wrote in the June 8, 2010 issue: "Increasingly, professors from Psych 101 to medical schools and psychoanalytic institutes are using fiction and film in classroom assignments or outside electives." In her article, Ms. Beck opened by noting a presentation at the recent American Psychiatric Association of the University of South Carolina School of Medicine popular elective psychiatry diagnostic course "Therapy Bites," which views and diagnoses the vampire and non-vampire characters in the *Twilight* series. Online syllabi from around the country are available, such as "Images of the Medical Profession in *Popular Film*" which then Instructor Dr. Donald E. Guenther taught 10 years ago at Northeastern Ohio Universities College of Medicine in the *Human Values in Medicine* Program.

Since 2000, a steady stream of books exam portrayals of medicine and medical personnel in films.

1. Dans, P. E. (2000). *Doctors in the movies: Boil the water and just say Aah*. Lansing, MI: Medi-ed Pr.
2. Friedman, L. D. (2004). *Cultural sutures: Medicine and media.* Durham, NC: Duke University Press.
3. Reagan, L. J. (2008). *Medicine's moving pictures: Medicine, health, and bodies in American film and television (Rochester studies in medical history)*. Rochester, NY: University of Rochester Press.
4. Glasser, B. (2010). *Medicinema – Doctors in films*. Manchester, United Kingdom: Radcliffe Medical PR.

Two 2005 books were published on cinemaeducation in medicine.

1. Alexander, M., Lenahan, P., Pavlov, A., & Stuart, M. R. (2005). *Cinemaeducation: A comprehensive guide to using film in medical education.* Oxford: Radcliffe.
2. Harper, G., Moor, A., & Claman, K. (2005). *Signs of life: Cinema and medicine.* Middlesex, UK: Wallflower Press.

Clearly a cultural consciousness exists for the presence of and fascination with medicine in film, and, now for the use of film to teach medicine. What about graduate school? Have films invaded the classrooms there, too?

Graduate Education

In graduate education, among other subjects, cultural anthropology, psychology, French, and sociology have online syllabi using popular films. Linguistic anthropologist Friedman (2006) noted "One topic which is quite popular with the linguistic anthropologist crowd is Star Trek…"

Since 1995, many books have appeared relevant to graduate education. Listed chronologically as follows.

1. Solomon, G. (1995). *The motion picture prescription: Watch this movie and call me in the morning: 200 movies to help you heal life's problems.* Fairfield, CT: Aslan Publishing.
2. Wahl, O. (1997). *Media madness: Public images of mental illness.* New Brunswick, NJ: Rutgers University Press.
3. Gabbard, G. O., & Gabbard, K. (1999). *Psychiatry and the cinema* (2nd Edn). Arlington, VA: American Psychiatric Publishing.
4. Singer, I. (2000). *Reality transformed: Film and meaning and technique*. Cambridge, MA: The MIT Press.
5. Solomon, G. (2001). *Reel therapy: How movies inspire you to overcome life's problem.* Fairfield, CT: Aslan Publishing.
6. Hesley, J. W., & Hesley, J. G. (2001). *Rent two films and let's talk in the morning: Using popular movies in psychotherapy* (2nd Edn). New York, NY: Wiley.

7. Litch, M. M. (2002). *Philosophy through film.* New York, NY: Routledge.
8. Robinson, D. J. (2003). *Reel psychiatry: Movie portrayals of psychiatric conditions.* Port Huron, MI: Rapid Psychler Press.
9. Ulus, F. (2003). *Movie therapy, moving therapy.* Bloomington, IN: Trafford Publishing.
10. Smith, W. G. (2004). *Plato and popcorn: A philosopher's guide to 75 thought-provoking movies.* Jefferson, NC: McFarland & Co.
11. Wolz, B. (2004). *E-motion picture magic: A movie lover's guide to healing and transformation.* Centennial, Colorado: Glenville Publishing.
12. Blessing, K. A., & Tudico, P. (2005). *Movies and the meaning of life.* Chicago, IL: Open Court.
13. Gilmore, R. A. (2005). *Doing philosophy at the movies*. Albany, NY: State University of New York Press.
14. Grace. M. (2005). *Reel fulfillment: A 12-step plan for transforming your life through movies.* New York, NY: McGraw Hill.
15. Solomon, G. (2005). *Cinemaparenting: Using movies to teach life's most important lessons.* Fairfield, CT: Aslan Publishing.
16. Sluyter, D. (2005). *Cinema nirvana: Enlightenment lessons from the movies.* New York, NY: Three Rivers Press.
17. Morris, G. (2006). *Mental health issues and the media: An introduction for health professionals.* New York, NY: Routledge.
18. Falzon, C. (2007). *Philosophy goes to the movies: An introduction to philosophy* (2nd Edn). New York, NY: Routledge.
19. McGinn, C. (2007). *The power of movies: How screen and mind interact.* New York, NY: Vintage.
20. Shaw, D. C. (2008). *Film and philosophy: Taking movies seriously (short cuts).* London, England: Wallflower Press.
21. Niemiec, R., & Wedding, D. (2009). *Positive psychology at the movies: Using films to build virtues and character strengths.* Cambridge, MA: Hogrefe Publishing.
22. Wedding, D. (2009). *Movies and mental illness: Using films to understand psychopathology.* Third edition. Cambridge, MA: Hogrefe Publishing.
23. Gregerson, M. B. (2010). *The cinematic mirror for psychology and life coaching.* New York, NY: Springer Sicence+Media.

Clearly, the relevance of popular films for graduate education matches that for medicine. For psychologists, in particular, these select titles teach about psychopathology, relationship, life challenges such as transitions and trauma, and cultural differences.

1. Solomon, G. (1995). *The motion picture prescription: Watch this movie and call me in the morning: 200 movies to help you heal life's problems.* Fairfield, CT: Aslan Publishing.
2. Wahl, O. (1997). *Media madness: Public images of mental illness.* New Brunswick, NJ: Rutgers University Press.
3. Gabbard, G. O., & Gabbard, K. (1999). *Psychiatry and the cinema.* Second Edition. Arlington, VA: American Psychiatric Publishing.

4. Solomon, G. (2001). *Reel therapy: How movies inspire you to overcome life's problem.* Fairfield, CT: Aslan Publishing.
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Are We Ready Now?

The challenge posed today, though, is not just for medical education as a by-product of entertainment fare as is currently starting in America's hallowed halls of medical and graduate academe.

We should aim directly for entertainment that produces medical education for both our populace and our students in medical and graduate education. America needs to be proactive in the design of popular media fare, with a socially conscious eye to the education, unwittingly or by design, imparted by this fare.

We need to do better. Our children are spending more of their time with new technologies such as texting and computing than they are talking (Robson, 2009). They spend more time with various media than with their parents (Graydon, 2004). If we do not access these new media, we risk losing our youth (Gregerson, 2009)!

The Kansas Health Foundation's drama "Red Blood and High Purpose," through entertainment, tells the story at the turn of the century of one of the founders of public health with scenes such as the dangers of the common communal drinking cup. The Lawrence, KS Seem-to-Be-Players performed this play by their Artistic Director Ric Averill.

Perhaps now we are ready?

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Virtual Classrooms and Communities of Practice: New Tech Strategies for Enhancing Culturally Responsive Health Care

Jeffrey M. Ring

Introduction: The Problem

With the publication of the landmark 2003, Institute of Medicine (IOM) report on racial and ethnic disparities in health care (Smedley, Stith, & Nelson, 2003) a piercing light illuminated the devastating morbidity and mortality disparities in the USA. While many scholarly books and papers had previously documented the disparity problem (e.g., Byrd & Clayton, 2000), the IOM report seemed to catch fire, catalyzing federal and state mandates for the provision of culturally and linguistically appropriate healthcare services (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003). Central among these mandates is that healthcare practitioners and their hospital and office support staff receive training in the provision of culturally responsive healthcare. Many training programs, websites, and curricula have been developed over the past years to address these unmet training needs (e.g., Ring, Nyquist, Mitchell, Flores, & Samaniego, 2008).

The progress made in physician education and clinical delivery system changes across the country toward the elimination of health disparities has been spotty and limited, at best. The Issue Brief produced by the Center for Studying Health System Change, published in February, 2010, was aptly titled, "Modest and uneven: physician efforts to reduce racial and ethnic health disparities" (Reschovsky & Boukus, 2010). The findings from this national survey highlight a disappointing 56% of practices offering interpreter services, and only 40% of physicians indicating that they had received training in minority health. For the 40% who did receive training, one wonders about the quality, focus, and sufficiency of the training offered.

This chapter describes two innovative online community educational and support efforts in the cultural medicine arena.

The first is a training program for medical educators that meets in a virtual classroom as part of a master's program in medical education. Participants enhance

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their capacity to train learners in the awareness/attitudes, knowledge, and skills components of a cultural medicine curriculum through a combination of didactic and creative experiential and web-based exercises that will be described in this paper.

The second portion of the paper describes a "Community of Practice" and will more specifically describe a virtual community of professionals from across the USA dedicated to enhancing institutional efforts in cultural medical education. Through a combination of virtual monthly meetings, an archival wiki, and ongoing online listserv communication, participants grow and help each other to develop creative and effective educational interventions, while simultaneously problem solving such dilemmas as optimal curriculum delivery strategies and dealing with reluctant learners.

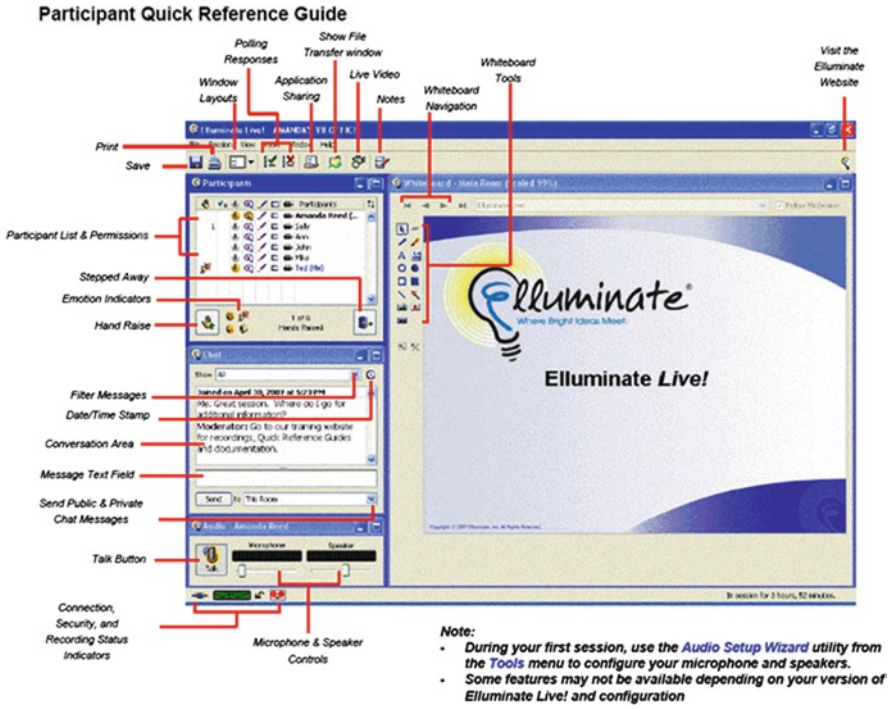
Innovation #1: Virtual Classroom Learning

The author teaches a cultural medicine course as part of the Master of Academic Medicine Degree Program offered through the Keck School of Medicine at the University of Southern California. This online course is geared toward medical school and residency faculty and program directors who want to improve their capacity to teach professionalism and culturally responsive healthcare. The class meets twice a week for just over 3 weeks, whereby approximately ten learners from across the USA and internationally, gather in a virtual classroom accessed through www.elluminate.com.

Admittedly, I initially approached this teaching assignment with great trepidation and skepticism. As a clinical psychologist and medical educator, I have always believed that in-person learning is essential, particularly to stimulate learner self-awareness and self-reflection, as well as for accurately understanding and developing intercultural communication skills. Moreover, for the development of culturally responsive healthcare practitioners, I believe that hands on skills training and difficult discussions about race, ethnicity, power dynamics, and oppression must unfold in person in the presence of a skilled educator. While I still believe that in vivo learning is essential at some point along the way, I have been unexpectedly impressed with the virtual classroom platform.

These virtual classrooms come alive on the computer screen and allow for ample student and teacher interaction (See Graphic 1). In one corner of the screen is the list of participants who have logged into the secure classroom via a password and security code. Not only does this listing allow all to see who is present, but also it provides participants with opportunities for expression through virtual hand-raising indicators for the instructor when they are prepared to speak.

Here, too, can participants indicate their ongoing responses to classroom topics through emoticons of pleasure, confusion, applause, and disagreement. One column of icons next to the students' names indicates if they have stepped away from the virtual classroom, while a second indicates if they are engaged in writing text messages to the instructors or other students, or to the class as a whole.



Graphic 1 http://its.uiowa.edu/support/collaboration/webconferencing.shtml Retrieved July, 7, 2010

A third column indicates which students have their microphone on as they prepare to or are actually speaking to the group.

The classroom also includes the possibility for participants to see each other via webcams, though I have not used that feature in my teaching thus far. Classroom sessions can be recorded and these recordings can be accessed by students and instructors (including absentees) at future dates by easily logging in. Absenteeism, by the way, tends to be less of a problem in virtual classrooms, given that students can log in from any computer with internet connection. As an instructor, it has been a pleasure to teach classes from wherever I may be traveling. Students can meet virtually among themselves or with faculty anytime in the classroom outside of class hours.

As mentioned above, indicator icons illuminate when participants are writing messages to others in the virtual classroom. These chat messages can be sent either to individuals or to the group as a whole, though instructors can read all chat messages sent between learners. A larger conversation box provides the space in which public and private messages are posted and can be responded to in real time. I have encouraged learners to post chat texts and dialog during class, allowing a simultaneous venue for learning and discussion during, for example, a didactic presentation on the white board.

Most prominent on the screen is a large white board on which the instructor and/or students can post PowerPoint slides for all to see. Participants can also write and type on the white board simultaneously, as well as move the elements. A task for the group during an Elluminate training session, for example, consisted of the group of participants taking a pile of human bones and assembling them into a proper human skeleton.

Additional features of the platform include a web touring function, in which a teacher (or learner) can bring all the students along to visit websites of interest. Application sharing functions allow participants to share their personal computer desktop and any graphics or files they wish. Breakout room features help to divide participants into small groups where they can work independently from other groups in smaller teams. Additionally, a polling function allows an instructor to quiz the learners on facts and/or opinions, with the results of such polls posted immediately for all to consider, similar to the ever more popular audience response systems used in classroom and auditorium settings.

Virtual classroom meetings, as such, can me marked by a flurry of exciting simultaneous channels of communication via voice, chat texts, and whiteboard graffiti and typed text. A question posed to the learners can be answered via text in the chat box, written or typed on the white board, a quick poll response for yes/no or multiple choice questions, and/or through speaking. Sometimes I direct how I would like their responses to an inquiry, other times I let them choose. Through these multiple venues, I actually experience greater learner participation in discussions and activities than in traditional classrooms, and have been surprised by the familiarity and intimacy developed, despite never meeting the learners in person, nor even knowing what they look like! The platform design allows the instructor to easily determine the activity and involvement level of the learners.

The first session of the course on teaching culturally responsive health care includes activities such as a small group hunt for similarities and differences between participants conducted in breakout rooms and a debriefing discussion on participant self-awareness of social dynamics of difference and power. While not quite as effective as the live, interactive version, participants do get a taste of their own experiential attitudinal response to people who are similar and different across a number of demographic variables. This is followed by a group brainstorm on the rationale for culturally responsive care, with participant contributions and ideas captured on the whiteboard for all to see. Finally, a didactic PowerPoint presentation helps learners understand the course objectives, assignments, and definitions of basic terminology associated with culture, ethnicity, power, and oppression (Pinderhughes, 1989).

A stereotype imagery exercise (Ring et al., 2008) works very well in the virtual classroom, helping learners to identify their own stereotypes and biases. Role-playing exercises in which learners explore culturally responsive, respectful, and patient-centered communication work fairly well, despite the lack of visual cues and close proximity of a live encounter. A narrative medicine assignment in which learners do some creative writing in response to a poem also works very powerfully in the virtual classroom, as participants read their creations either to each other in pairs or to the group as a whole, depending on group size and time available.

Perhaps the most popular virtual classroom activity is the web scavenger hunt, in which perplexing scenarios are presented to the learners who must seek answers as fast as they can on the internet, and bring these answers back to the instructor before receiving their next scenario. Examples of these scavenger hunt mission scenarios include as follows.

1. A very jittery adult male immigrant from Somalia presents with a number of cavities and oral health problems. Upon exam, you notice his teeth have a greenish hue. What is your diagnostic hypothesis?
2. You are precepting a resident who is irritated with his very ill Jehovah's Witness patient who is refusing life-saving blood transfusions. You want to help your resident understand the reasoning behind the patient's insistence. What do you tell the resident?
3. A resident rotating through your office points out that your intake form does not adequately address gay, lesbian, bisexual, and transgendered issues. You want to find a prototype of such an instrument that would be more welcoming to members of these communities in your practice.

The road to becoming a culturally responsive health provider is paved with bricks of attitudes/awareness, knowledge, and skills. Through the virtual classroom course in culturally responsive care, learners have ample opportunities to explore their attitudes (as in the stereotype imagery and similarities/differences exercises), knowledge (as in the web scavenger hunt), and skills (as in the role play exercises). The web scavenger hunt actually provides additional skills of mining the internet to find quick and accurate answers to pressing cultural clinical quandaries toward the enhancement of the quality of care delivered toward the elimination of health disparities.

Virtual classrooms provide the advantages of ease of access, multiple communication modalities, immediate web access, potential participation of learners at great distances, and the possibility to create a learning environment of respect and safety. Limitations include the clearly missing human encounter so important for communication and skills training and for navigating difficult dialogs and situations. I worry about the temptation of distractions during class time such as reading email and surfing the net. Virtual classrooms offer grand possibilities for serious awareness enhancement and experiential learning, given the great unmet need for improving culturally and linguistically responsive healthcare provision among health practitioners across the nation.

Innovation #2: Community of Practice

A community of practice (COP) is composed of a group of individuals either from within one organization or collaborating across organizations for a number of shared purposes.

Wenger and Snyder (2000) suggest that COPs add value to organizations by driving strategy, developing new lines of business, solving problems quickly,

transferring best practices, developing professional skills, and helping companies recruit and retain talent. All of these objectives are especially appropriate for the newly emerging and often amorphous field of culturally responsive health care in which unfunded mandates for culture and language programs face many barriers including financial, attitudinal, and historical, given racism and oppression and discomfort around issues of race, gender, and sexual orientation that exist in this country. As such, it is easy to see why individual and institutional change is slow, as highlighted by the research findings of Reschovsky and Boukus discussed above. For those people responsible for overseeing the cultural and language aspects of health delivery in organizations, their work is often fraught with frustration, loneliness, exasperation, and hopelessness.

The leaders of diversityrx.org, a think tank and resource clearinghouse on culturally and linguistically responsive care decided to take these barriers head on through a California Endowment funded initiative for developing COPs in areas such as the collection of racial/ethnic data, and the role of education in facilitating healthcare organizational change toward culturally responsive care. From the website, COPs are described as follows.

> A Your Voice Community of Practice is a small group (12–15 participants) of professional colleagues who "meet" monthly on a specific topic through teleconference or virtual learning platforms to discuss common practice challenges and share information about strategies and resources. The group is supported by a listserv for ongoing dialog between meetings and a wiki where the information base developed over the course of the project is documented for use by others. The initial meeting period is 8–12 months, and there is no fee to participate in a Community of Practice once on is selected.

These programs have been described in greater detail on the diversityrx website (http://www.diversityrxconference.org/Your-Voice/Communities-of-Practice/140/).

This author facilitated such a COP consisting of 12 participants during monthly meetings between September, 2009 and May, 2010. Participants were selected from a robust application pool, and as desired, they were all point people in their respective organizations for managing culture and language access programs, including employee education. The meetings were organized through gotomeeting.com, a portal less elaborate and flexible (and less expensive) than elluminate.com, but quite sufficient for the needs of the COP. As elluminate.com, gotomeeting.com allows for real-time chat, voice dialog, and a white board for PowerPoint presentations.

The initial COP meeting consisted of several team-building exercises, as the participants did not know each other. Through poll questions and allowing each participant to introduce him- or herself, the group took initial steps toward bonding and familiarity. COP members also received an overview of the COP, including participation and confidentiality guidelines including their responsibilities to post several times each month to the group discussion listserv. This was important for both continuity and connection of participants between monthly meetings.

Each monthly session began with a 10–15 minutes "launch" of a topic related to culture and/or language organizational and educational issues, followed by 45 minutes of group brainstorming and discussion. Topics were selected by participants

and were intimately connected to challenges and/or successes at their individual work setting. Presentation topics included the following:

Definitions of "culture"

Mandated vs. voluntary participation in cultural trainings

Navigating resistance from organizational leadership

How to conduct an organizational cultural assessment

How to roll out cultural/linguistic training in an organization with limited time and financial resources

Self-care and well-being challenges in the face of heavy work demands/pressures

Effective teaching strategies for cultural competence

Conflict resolution

Special populations: Deaf and Hard of Hearing patients

Culturally responsive mental health services

Video technology for interpretation services

Given the richness and complexity of the topics covered, and the great passions that COP members brought to these discussions, 1 hour each month was far from sufficient to explore the topics exhaustively. As such, the percolation of the listserv discussions between meetings served as a very rewarding venue for ongoing brainstorming and feedback. Most prominent in both real-time discussions and listserv communication was the abundance of resource sharing as COP members generously and rapidly responded to inquiries and quandaries with suggestions of articles, websites, books, conferences, and cultural consultants.

The virtual monthly meetings seemed to grow in intensity, connection, and intimacy by the third meeting. Sessions were marked by humor, laughter, support, and encouragement. Upon a request from the diversityrx.org organization, the COP participants collaborated virtually on a presentation proposal for a conference symposium on our collective experience with the COP. This assignment was like rocket fuel poured on the group's cohesiveness, inspiring a spirited flurry of emails as the members strove to articulate the meaning of the experience. With the proposal now accepted, the group looks forward to meeting each other for the first time in person to reflect on the experience.

A central theme of this symposium, as is predicted by COP theory, is that participants especially benefited from sharing organizational problems in a confidential setting with peers in faraway places. Group members appeared to share a larger sense of shared mission in their work, dedicated to improved care of underserved populations, dismantling language and racism barriers to care, and with an emphasis on the elimination of racial and ethnic health disparities.

A wiki is an online storehouse of documents around a central theme. The wiki developed in relation to the COP is housed at wikispaces.com, but is not accessible to anyone other than COP participants, given the sensitive and confidential nature of some of the communications. This wiki contains a summary description of every

COP session, highlighting those resources that were shared. One can also find comments posted subsequent to the session, along with pdf files of relevant journal articles. This is also the place that houses COP documents such as participation guidelines, the conference proposal, and other co-created documents through brainstorming sessions, such as a collective description of the aspects of optimal cultural competence training as well as educational do's and don'ts as related to training.

The final meeting of the COP was an extravagant potluck brunch. Each participant shared photos of the feast foods they had "prepared" for the party, sharing these with much laughter and humorous comments about the most delicious, cholesterol and calorie-free feast he or she had ever attended. Participants also shared summary comments about their experience of participating in the COP. These uniformly positive comments are summarized as below.

Appreciations of the group for its open-minded attitudes and adaptability

One of the best experiences I have had

Pleased with the interactions and information shared

Hope to keep this momentum going forward

Learned a lot about the dynamics of culture and how we adapt and change, even without realizing the changes in our own culture

Heartfelt appreciation expressed to the group for an experience that enriched the understanding of this field and best practices

"A fabulous experience"

I very much appreciated and trusted the confidentiality held in the group, allowing for important and sensitive discussions

Amazing and wonderful

I learned tremendous amounts as someone newer to this field

I appreciated the sharing of wisdom and best practices

I feel I can bring forward my learning from this COP into my organization as we aim to better meet needs of diverse clients

I wish I had participated more in WIKI and listserv

This was a refuge to turn to for personal and professional support

As my first virtual COP experience, it was wonderful…the key was 15 individuals who share deep passion for the work and value connectedness to others

Appreciation for this protected time on a monthly basis to spend together…valuable in its' regularity and continuity

The strength of COP was community sharing…very enlightening…of both triumphs and frustrations. Appreciation for shared successes

I received many useful tools to help meet challenges…it is if we may be at the tipping point where more and more people understand and appreciate the importance of this field.

Final Thoughts

The devastating health disparities in this country must be remedied. This overwhelming task will require a complex amalgam of change strategies for individuals and institutions alike. From a slightly different perspective, the task at hand is to identify and destroy racism, sexism, and heterosexism in this country as they have become manifest in the field of medicine and health care. To do so in a time of limited economic resources, unpredictable healthcare reform and both social and personal barriers is an even greater challenge….as well as an opportunity.

As described in this chapter, internet technology offers great potential for educating health professionals in culturally responsive care (and perhaps patients as well!) along with the means for resource and support sharing for those on the front lines of this ever-challenging work. The field of psychology has much to offer to this effort, including strategies for social and individual change, an embracing of bio-psycho-social-spiritual perspectives, and a rich understanding of creative and effective educational strategies. The virtual classroom and COP described above are but two examples of what the future holds in terms of harnessing the internet for connection, dissemination, inspiration, justice, and change.

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Internet Research Strategies for Finding High-Quality Content on Topics of Psychology and Mental Health

Pauline Wallin

"Just Google it" – three words that promise the answer to whatever your question may be. That's true if you're looking for specific information, such as Freud's birthday, a DSM code, or medication side effects. Simply type your keywords into the Google search box, and up pops the answer, usually on the first page of your search results.

But when your query is complex, or when you want results only from top-quality sources, a simple Google search is not enough. Google has indexed over a trillion web pages (The Official Google Blog, 2008, July 25)[1] – most of them from commercial websites, blog posts, social networking sites, and YouTube videos. If you want to filter these irrelevant sources from your search results, and hone in on authoritative content, you'll need to use advanced techniques and strategies.

You may already have access to a journal database through your academic institution or through your professional association (such as the American Psychological Association's PsycInfo.) While such databases contain only scholarly and authoritative content, most are not comprehensive; nor do they include the most recent developments in a given field. Thus, even with access to these proprietary databases, you will probably extend your search to public Internet websites.

This chapter will highlight techniques and resources to uncover science-based, authoritative information from free public Internet sources. There is plenty of valuable content available for free online, if you know how to search and where to search. You will also learn how to evaluate the accuracy and objectivity of information on a website. Finally, you'll be introduced to useful resources for organizing the content that you collect in your searching – so that it is easily accessible when you are ready to start writing.

[1] Retrieved May 6, 2010, from The Official Google Blog: http://googleblog.blogspot.com/2008/07/we-knew-web-was-big.html.

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What Is Authoritative Content?

Authoritative content includes peer-reviewed articles and research reports, statistics and facts based on reliable collection methods, and summaries, analysis and commentary by experts recognized in their fields.

Sources of authoritative information include universities, textbooks, journals and trade magazines, government agencies, research labs, professional associations and other entities where content is scrutinized prior to publication.

Ways to Find Authoritative Content Online

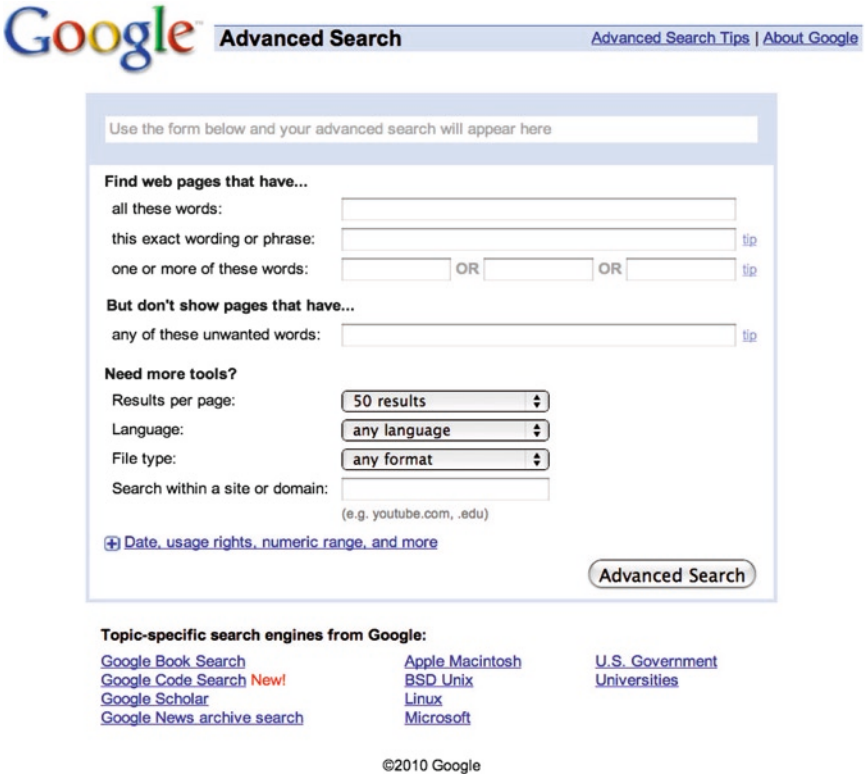
You have several options for finding high-quality content: search engines, information hubs, databases, news sources… and, of course, humans.

Which you choose will depend partly on what you are searching for, and at what stage you are in the search process.

Search Engines

If you know specifically what you are searching for, use a general search engine such as Google or Yahoo. But in order to filter out as many irrelevant hits as possible, use the search engine's advanced features.

For example, here is a screenshot of Google's Advanced Search interface:



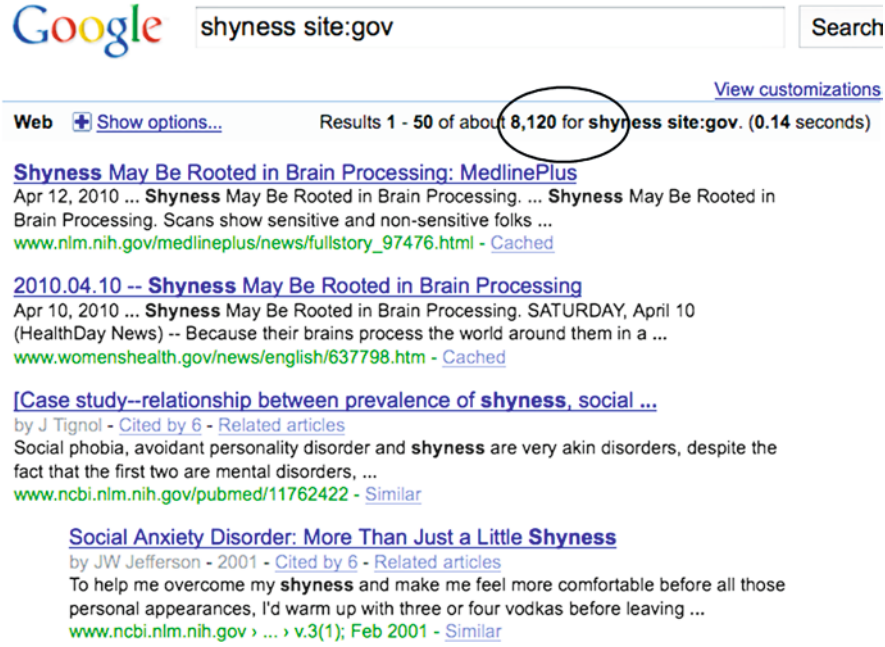
As you can see in the image, you can refine your search to include or exclude certain words or phrases; or to limit your search to certain filetypes (pdf, ppt, doc, etc.) or domain (.com, .gov, .edu, etc.). By clicking on "Date, usage rights, numeric range, and more" you have options to limit your search results to the past 24 hours, the past week, month or year.

It's not necessary to use the Google Advanced search window. All these functions can be accessed from the main Google search box, by adding simple syntax to your search terms. Here are some examples:

Filtering by Domain

Suppose we are looking for information on *shyness*. If we just run a simple Google search, the results will look something like this. Note that there are over 2.9 million hits:

Now see what happens when we add *site:gov* to our search terms (no spaces in site:gov.) This tells Google to return results only from US government websites. Note that there are far fewer hits, but they are all from highly respected sources:



Similarly, a search for *shyness site:edu* would yield results only from educational institutions.

In addition to telling Google to display results from selected domains, you can also instruct it to filter *out* one or more given domains.

Thus, a search for: *shyness -site:com* (no spaces in –site:com) yields hits from every domain *except* .com sites. This is a handy way to filter out most commercial websites from your search results. To also filter out .net websites your search syntax would be: *shyness -site:com -site:net*

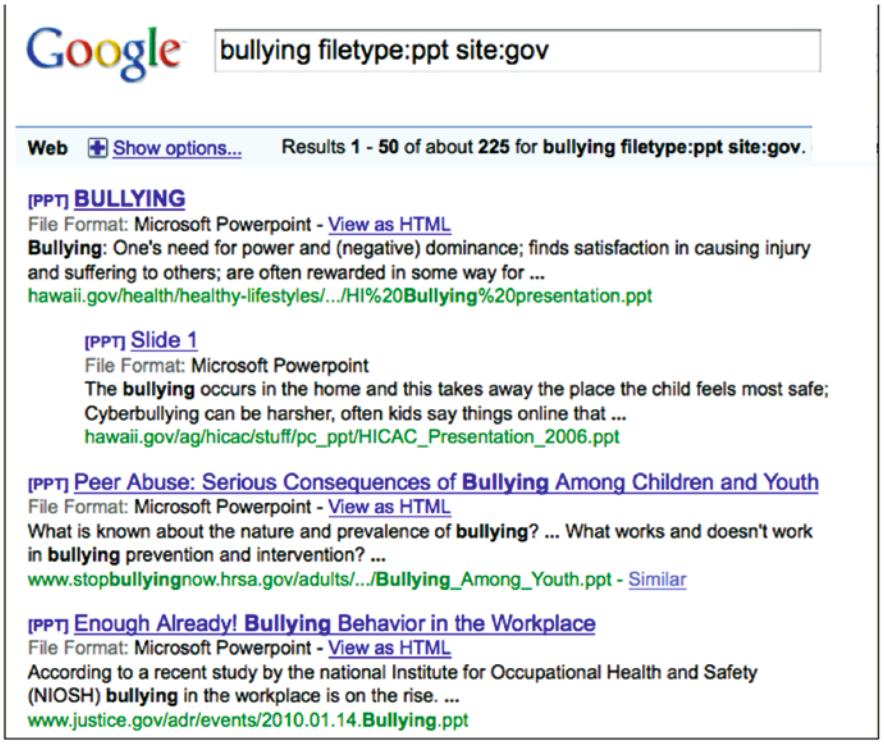
Filtering by File Type

Google and other search engines can find not only websites, but also documents in various formats, including PDF, Powerpoint slideshows, Excel charts, Microsoft Word documents and others.

Powerpoint files (ppt) are rich sources of useful data, distilled down to bullet points. If you are looking for highlights and summaries on a topic, add *filetype:ppt* (no spaces) to your search terms.

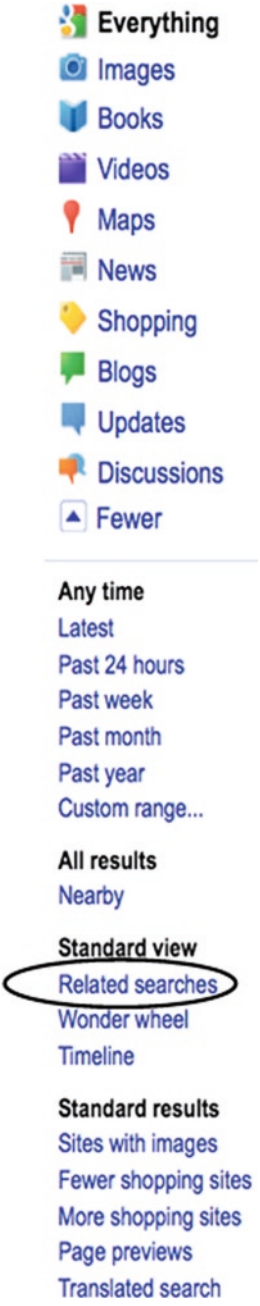
You can combine a domain filter with a filetype filter. For example, to view results on the topic of bullying only on Powerpoint slides from government websites, your search syntax is: *bullying filetype:ppt site:gov*

Your results will look something like this:



To retrieve PDF files, add *filetype:pdf* to your search terms. PDF files are usually official documents, journal articles, tips sheets, guides and brochures. For Word documents, add *filetype:doc* to your search terms. Word documents include forms, fact sheets, reports, etc.

Search Engine Refinements



Major search engines now have options to refine your search results. This section will show some refinements that Google has to offer, but you are also encouraged to explore refinements in Yahoo, Bing and Ask.com

Google's New Sidebar

Recently Google added a sidebar to their main results page, as shown on the left. By clicking on the various options, you can refine your results to show specific media types, page previews and translations. Especially useful is the option to limit your search to a specific time period, which enables you to retrieve only historical information, only the latest information, or anything in between related and similar searches.

Related and Similar Searches

Clicking on "related searches" (circled in the image on the left) opens a results page with suggestions for alternate search terms. If you haven't found exactly what you're looking for, these can give you ideas to broaden your search.

Another way to search for related results is to click on a link that says "Similar" among the list of hits. Clicking on "Similar" yields a page of links with similar content. Not every search result has this option. In the Google screenshot above, "Similar" appears in the last line of the third hit.

Google Scholar

To get results from books, journals and other scholarly works, search Google Scholar (scholar.google.com). You won't have access to the full text of each result – many are only excerpts or summaries. But you may be able to write to the author for a copy of a paper; or you

can ask your local public or academic library to order documents and books for you through interlibrary loan.

In Google Scholar you can refine your search results from a series of drop-down menus, limiting your search to dates and types of articles. There is also an advanced search window, allowing you to specify author, date, subject area, publication, where your keywords appear in the article, and other options.

Other General-Purpose Search Engines

Google and Yahoo are the most well-known general-purpose search engines. Others include Bing, Ask, and AOL, just to mention a few. Each of these search engines indexes and ranks web pages according to their own proprietary algorithms. Thus, each will give you slightly different results for the same search keywords.

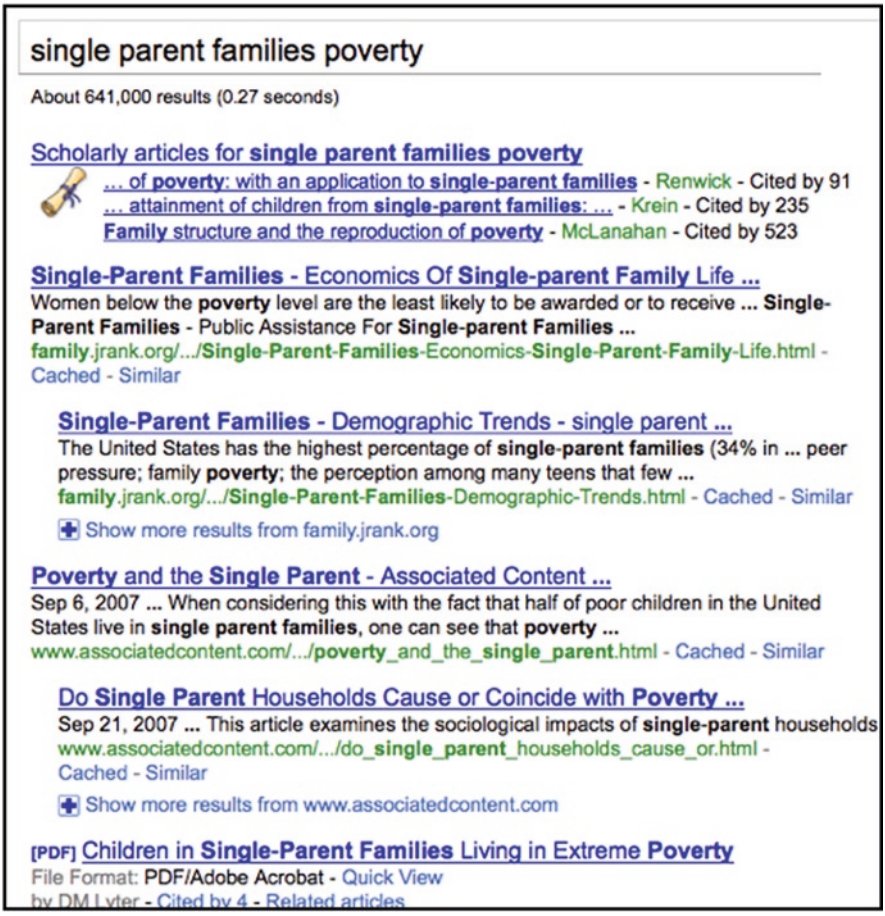
If you want results from multiple search engines, you don't need to run through a separate search process for each one. Instead, use a *metasearch* engine, such as Dogpile.com, which simultaneously searches Google, Yahoo, Bing and Ask. Along with the combined results, Dogpile even offers suggestions for subtopics to find information that is more specific.

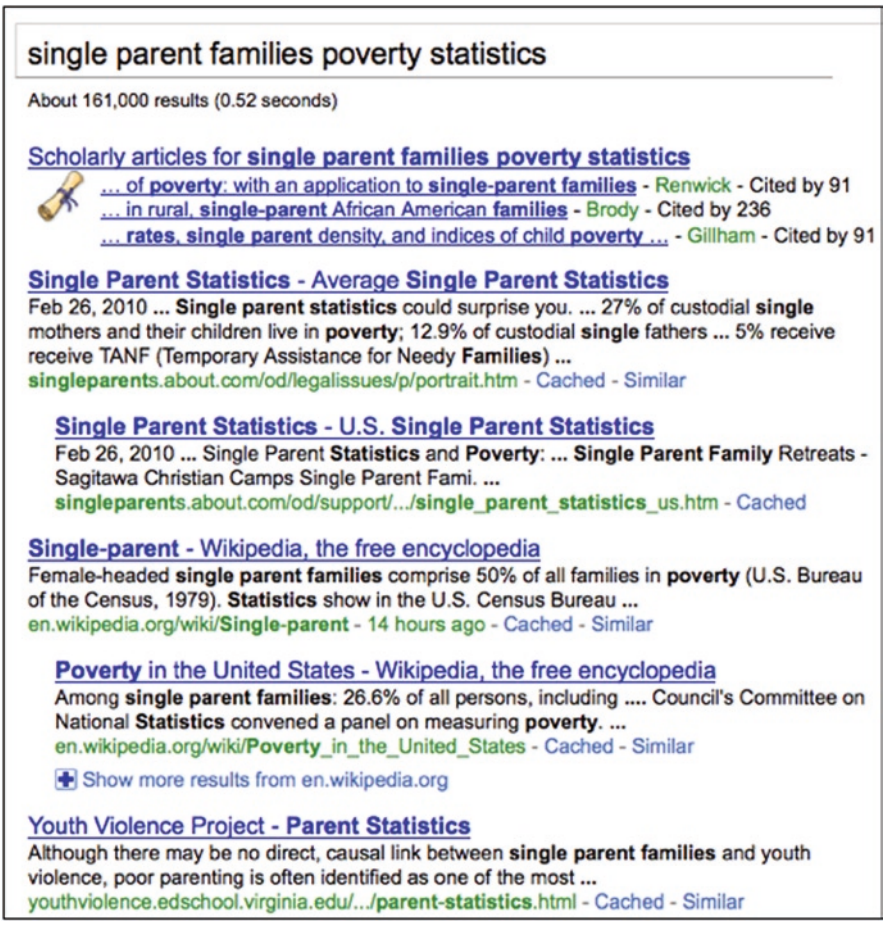
Wedge Words

Your search results are determined by the keywords that you type into a search box. The more precise your keywords, the more relevant your results will be. It's important to specify not only the topic you're searching for, but also the format in which want it.

Earlier you saw how to filter your search by domain and by file type. To add even more specificity, use "wedge words" (a term coined by Internet librarian Marylaine Block, 2001[2]) to pry out very specific formats. Examples of wedge words include: statistics, comparison chart, survey, FAQ, review, research, study, database, demographics and expert. There is no "official" list of wedge words. The idea is to add these types of words to your search, in order to quickly zero in on high-quality, relevant content. Note the difference in the two search results below – one without and one with the word "statistics":

[2]Block, M. (2001, April 6). *Using wedge words.* Retrieved May 5, 2010, from http://marylaine.com/exlibris/xlib94.html


single parent families poverty
About 641,000 results (0.27 seconds)
Scholarly articles for single parent families poverty
... of poverty: with an application to single-parent families - Renwick - Cited by 91
... attainment of children from single-parent families: ... - Krein - Cited by 235
Family structure and the reproduction of poverty - McLanahan - Cited by 523
Single-Parent Families - Economics Of Single-parent Family Life ...
Women below the poverty level are the least likely to be awarded or to receive ... Single-Parent Families - Public Assistance For Single-parent Families ...
family.jrank.org/.../Single-Parent-Families-Economics-Single-Parent-Family-Life.html - Cached - Similar
Single-Parent Families - Demographic Trends - single parent ...
The United States has the highest percentage of single-parent families (34% in ... peer pressure; family poverty; the perception among many teens that few ...
family.jrank.org/.../Single-Parent-Families-Demographic-Trends.html - Cached - Similar
Show more results from family.jrank.org
Poverty and the Single Parent - Associated Content ...
Sep 6, 2007 ... When considering this with the fact that half of poor children in the United States live in single parent families, one can see that poverty ...
www.associatedcontent.com/.../poverty_and_the_single_parent.html - Cached - Similar
Do Single Parent Households Cause or Coincide with Poverty ...
Sep 21, 2007 ... This article examines the sociological impacts of single-parent households
www.associatedcontent.com/.../do_single_parent_households_cause_or.html - Cached - Similar
Show more results from www.associatedcontent.com
[PDF] Children in Single-Parent Families Living in Extreme Poverty
File Format: PDF/Adobe Acrobat - Quick View
by DM Lyter - Cited by 4 - Related articles



More Search Tips

When searching for a specific phrase, put quotation marks around it. This tells the search engine to display links only to web pages containing that exact phrase. To avoid filtering out similar, but useful phrases from your search results, put quotation marks around only the most essential words. Sometimes you'll get better results by having two or three sets of quoted word groupings.

If you want to exclude a certain word from your search results, precede it with a minus sign. Thus, a search for headaches but not migraines would look like this: *headaches -migraine.* To exclude a phrase, enclose the phrase with quotation marks and put a minus sign in front of it. For example: *headaches -migraine -"pain clinic"*

To make sure that your search results *do* include a specific word, precede it with a plus sign. Use this technique when you want the search engine to pay attention to words that it generally ignores, such as *and, the, on, how*, and other commonly used words; For example: +on freud

Specialty Search Resources

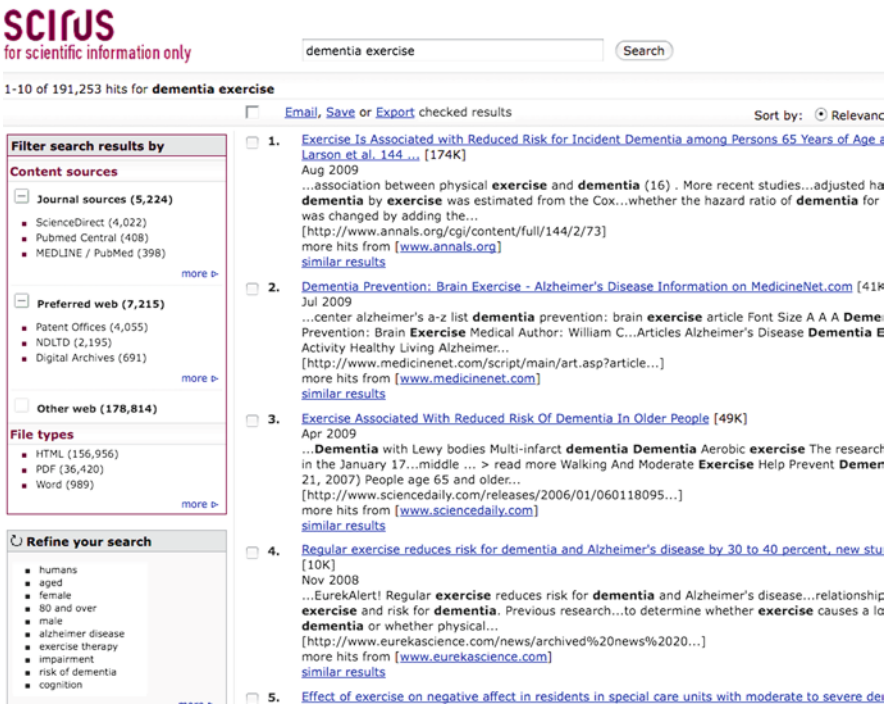
With Google and other general-purpose search engines, you need to set up your search terms carefully, in order to filter out irrelevant commercial websites, blogs, videos, and other user-uploaded content.

It's often much more efficient to go straight to an information hub or specialty search engine. Information hubs typically contain descriptions, FAQs, news and links to related topics. The most widely used information hub is Wikipedia – which is why you'll see a link to a Wikipedia page at the top of many Google search results. While this source is not guaranteed to be accurate (and some serious errors have been uncovered) it can serve as an overview or launching point for your research.

For psychology, some of the top information hubs are the American Psychological Association website (apa.org), PsychCentral (psychcentral.com) and the National Institute of Mental Health (nimh.nih.gov). When you search within those sites, your results are not as comprehensive as you'd get from a general search engine, but they are quite targeted and of high quality.

Most associations are reliable sources of authoritative content. For example, the Juvenile Diabetes Research Foundation (jdrf.org) and the International Dyslexia Association (interdys.org) offer articles, fact sheets, treatment resources and other current information in their respective topic areas. If you are researching a specific medical or psychological condition, or a specific social phenomenon, chances are there's an association that addresses the topic. If there is, you'll find it by adding *association* or *organization* to a Google search query.

For medical searches in general, there are dozens of trustworthy medical websites, including NIH, WebMD and Mayo Clinic. A portal to all of these and more is the Health On The Net (HON) Foundation, healthonnet.org. HON is a non-governmental organization, based in Switzerland, which certifies health and medical websites as authoritative and ethical. It also serves as a meta-search engine for medical information. When you enter your keywords into the search box, your results will include hits from several reliable medical websites at once.



If you're searching for information in biology or other science, try science.gov, the science portal of the US government. From there your search will be submitted to over 40 databases and over 2,000 authoritative websites. Another science search engine is Elsevier's Scirus.com. As shown in the screenshot above, you have several options for narrowing your search – by content source, file type, demographics and more. You can also email and save the results. Results of your scirus.com search are not all full-text documents. If the publishers charge for subscriptions or for individual articles, you won't find them for free (not legally, anyway) online. Sometimes a citation will suffice. If $30 or more per article is beyond your budget, you may be able to get a free reprint from the author.

Trade journals and commercial magazine articles are more readily available at no cost online. Search by keyword at findarticles.com or magportal.com. There you'll find fact-checked articles written by professionals and journalists.

Do you need facts, statistics or other reference data? Refdesk.com and libraryspot.com put thousands of reference pages at your fingertips. Find dictionaries, thesauri, encyclopedias, databases, quotations, military facts, historical information, and data on hundreds of topics.

If you know, from experience, which information hubs and other websites consistently provide the type and quality of content that you need, you can easily create a customized meta-search engine that searches across all these sites at the same time. Set this up at Rollyo.com. Simply open a free account and create a "search roll." Enter the URLs of up to 25 websites you want to include.

For example, let's say you want to search through a collection of psychology-related websites. Your search roll might include apa.org, psychcentral.com, cpa.ca, and other international psychology sites. Then, to search all of these at once, simply enter your keywords into your Rollyo search roll.

News and Press Releases

One of the best ways to get the latest information on research in your field is through news media. Stay current by setting up Google alerts to send you an email or an RSS feed whenever it finds a news story or press release containing the keywords that you specify. Twitter is another source of news (mainly links.) With over 50 million tweets per day,[3] there's a strong chance that your topic is being mentioned. Sign up at Tweetalarm.com to get notified whenever a tweet contains your selected keywords.

News stories are not complete and comprehensive summaries on a topic, but they usually mention at least two experts, whom you can contact for more information. Press releases are often biased or self-serving, so you need to be careful in interpreting the information reported. Academic press release services, such as eurekalert.org, newswise.com and sciencedaily.com are less likely to hype up the stories, than are general press release sites. All of these offer RSS feeds.

A Word About RSS Feeds

RSS ("really simple syndication") technology enables you to have content (called a "feed") delivered to you from multiple websites, without your visiting each site separately. To receive this content you need an RSS reader, such as Google reader. Some email programs and web browsers can be set up to receive RSS feeds as well.

Most news sites and blogs have RSS feeds. Look for the RSS logo similar to that beside the heading above. Getting all your feeds within a single browser window makes it easy to see the latest content from several sources at a glance.

Evaluating the Quality of Information on Websites

How accurate is the information contained on a website? You can't tell just by the site's design and appearance. Many professional-looking websites contain information that is inaccurate, misleading or biased. As a researcher, you want to make sure, to the greatest extent possible, that the content you collect is accurate, objective and up to date.

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[3]Retrieved May 6, 2010 from Twitter Blog: http://blog.twitter.com/2010/02/measuring-tweets.html

Here are some guidelines for evaluating websites:

- *Who owns the website*? Most reputable websites have an "about us" section. If no individual is mentioned there, you can try to find out who owns the domain name by going to whois.net. The domain name owner may be listed as a company or as an individual...or it may be listed as "private," similar to an unpublished telephone number. If a website owner does not want to be identified, that is a clue that the content may not be trustworthy.
- *What is the stated purpose of the site*? Is it to inform? to persuade? to sell something? Most sites ending in .edu and .gov are non-commercial.
- *Who is the author* of the content you are reading, and what are his/her credentials? If you are not familiar with the author, Google the name and see what else s/he has published.
- *How current is the information*? Look for a date of publication.
- *How objective is the content*? Does the author present more than one side of an issue? Are other sources mentioned? Or does all the information seem to reflect the author's own experiences and opinions?
- *Are the links in working order*? Click on a few links on the page. If any lead to a "Not found" page, the information on this site may not be kept current.
- *Who links to this website*? To find out which websites link to the one you're reading, go to Google and enter the following: *link:thatwebpage* – substituting the full URL of the web page for "thatwebpage." In the results look for authoritative websites, such as those ending in .edu, .gov, and .org, or those whose name you recognize as authoritative, such as a major news or medical website. If you see only internal links (i.e., from other pages of the website you're viewing) then be cautious about interpreting the content. Note: you can expect to see a lot of internal links for large websites. But you should see some external links as well.

More information on how to evaluate websites can be found at the Cornell University Library website: www.library.cornell.edu/olinuris/ref/research/webeval.html

A reliable source for evaluating the quality of heath-related news stories is healthnewsreview.org. There, a team of journalists, medical researchers and public health professionals rate health-related news on several criteria, and assign one to five stars.

Get Human Assistance

If you have difficulty finding exactly what you're looking for, contact a librarian. Librarians are information specialists. They often know about special databases and other sources that you have not heard of. Start with the librarian at your local public library.

You can also get help via email from the Library of Congress (loc.gov) or help via email, phone, chat and text from the New York Public Library (nypl.org).

Keeping Track and Organizing All the Content You Collect

Doing online research is kind of like going through an all-you-can-eat buffet line: Load up on whatever looks good, even though you probably won't consume it all. But unlike a buffet line, you never get full. It's possible to continue loading up on information ad infinitum. With online search, it's easy to lose track of what you've collected – because, unlike a buffet, where you can see everything on your plate, it's not that easy to see all your electronic information at once. Your information is locked in files, the names of which don't always reveal what's inside. And sometimes you store your files in places that you've forgotten about.

Fortunately, there are some very good web tools to help you organize the content you collect, so that it is readily accessible from any computer connected to the Internet. Online bookmarking services have been around for several years, but they have added features that make it much easier to find the exact stored content you need at any given moment.

For example, at Diigo.com (pronounced "deego,") when saving web pages, you can assign "tags" (like keywords) to them. Using tags has an advantage over filing web pages in virtual folders. Folders are general categories, while tags are specific. You can assign as many tags as you want to a saved web page. Later, when searching your Diigo account for specific content, type in the relevant tag word or phrase, and all the web pages that you've saved with that tag will be listed.

For example, let's say you've saved an article that discusses various treatments for depression. Your tags might include: depression, ECT, antidepressants, cognitive therapy for depression, exercise and depression, etc. Once stored, you can search for any of those keywords, and that article will show up in the search results, along with other content that you've tagged with the same keyword.

A tag need not include any text from the article or web page. For example, you can tag items of different content with "my thesis" – even though these words are not in the text itself.

If you still prefer folders over tags, Diigo offers that option, as well as full-text search across all bookmarks.

Diigo is more than a bookmarking site. It also has a highlighter and annotation tool. You can highlight portions of a web page while you're reading it, or attach your own notes. When you later open that page, your highlighting or notes will appear just as you left them. For teachers, Diigo provides an Educator account, in which students can share and comment on saved content. A summary of all the Diigo features are in the Help section of the diigo.com website.

Another free tool for organizing your content is Webnotes.net. More of a project manager than a bookmarking site, it provides tools for highlighting and saving web pages, note-taking and collaborating with others. Each project is a folder, containing the content that you collect. Your folders are all listed in the left column of your Webnotes dashboard.

A useful feature of Webnotes is its ability to generate reports from various sources within a project. Also, you are able view only the content that you highlighted – which makes it easier to grab just those parts of web pages that are of interest to you.

Webnotes has a free and a paid version. The free version gives you web page annotation, folders and tags for organizing your content, and a means to share your annotated pages with others. The paid version includes different colors of highlighters, a report generator, and several other features.

A third organizing tool is Zotero.com, a Firefox browser extension. Like Diigo, you can save web pages and assign tags and notes to the content. Zotero does not aggregate highlighted sections from across documents as Diigo does, but it has a very powerful citation manager, which automatically extracts bibliographic information from websites, documents and other online content. It also integrates with Microsoft Word and Open Office, so that you can drag and drop citations into your document as you write.

Storing and retrieving text and other content from Zotero are easy. Store all related items in a "collection" (folder.) Set criteria for a collection, and all items meeting those criteria will automatically be added to it. Later, you can find all related content by searching for tags or full text – even within PDF documents. Teachers and students can also set up groups to collaborate on a research project.

There are dozens of other resources online to help you save and organize your content. Experiment with the three tools described above. One of them should meet your needs… but if not, you can search for others, using techniques you learned in this chapter!

Copyright and Citations

Just because information is free online, does not mean that you can simply copy and paste it into your own work. It is still protected by copyright. However, ideas cannot be copyrighted. Thus, it is legal to read the information you've saved from various sources and express it in your own words.

Copyright law is beyond the scope of this chapter, but readable summaries and links to authoritative sources are available at the George Mason University: http://mason.gmu.edu/~montecin/cpyrght.htm

In your writing you will need to cite the sources from which you've gleaned your information. The Writing Center at Yale University offers guidelines for citing databases, online journals, blogs, Wikipedia entries, emails and more: www.yale.edu/bass/writing/sources/kinds/citeinternet/

Conclusion

You'll get the most out of this chapter if you select one or two strategies at a time, and use them for several searches. You'll eventually get a feel for which strategies work best for you. Just using a fraction of the techniques mentioned in this chapter, you can expect higher quality search results, with less time and effort.

Telemental Health Competencies: Training Examples from a Youth Depression Telemedicine Clinic

Eve-Lynn Nelson, Thao Bui, and Susan Sharp

National and state guidelines specific to telemedicine practice and psychology are on the horizon. In the absence of psychology-specific telemedicine guidelines, psychologists rely on American Psychological Association's (APA) ethics code (APA, 2002) that, "In those emerging areas in which generally recognized standards for preparatory training do not yet exist, psychologists nevertheless take reasonable steps to ensure the *competence* of their work and to protect clients, students, research participants, and others from harm" (Koocher, 2007; Reed, McLaughlin, & Milholland, 2000). Telemental health guidelines from the American Telemedicine Association (Grady, Myers, & Nelson 2009) as well as child telepsychiatry practice parameters (Myers & Cain, 2008) can inform areas of competence in psychology practice over videoconferencing. The authors emphasize three areas of trainee competency through the TeleHelp clinic: (1) *technology competency;* (2) *youth depression clinical competency; and* (3) *outreach competency.*

Telemedicine Overview

The last decades have brought many advances in psychology evaluation and treatment across the lifespan. These advances, however, are tempered by challenges in delivering best practices to rural and other underserved families. As an example, in Kansas most psychologists reside in two population centers (Kansas City and Wichita) while half the population resides in over 100 rural counties. A compelling 99 of 105 counties are designated mental health professional shortage areas (HPSAs) and this need is particularly striking for psychologists with specialized training. The overwhelming majority of mental health specialists work in metropolitan areas while many underserved families live in rural and frontier settings.

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Such mental health shortages are the norm across rural states, with many gaps in care related to high costs of transportation, limited public transportation, mistrust of professionals outside the immediate neighborhood, long waitlists for treatment, and very limited/no specialists available within the region.

Telemedicine is one outreach strategy to bridge this gap between high mental health need and limited access to mental health specialists. *Telemedicine* may be defined as "the use of telecommunications technology for medical diagnostic, monitoring, and therapeutic purposes where distance and/or time separate the patient and health care provider" (Myers & Cain, 2008). The application of telemedicine to mental health specialties, including psychology, psychiatry, social work, psychiatric nursing, and other areas, is termed *telemental health*. The telemedicine technology described in this paper is limited to synchronous videoconferencing for health service delivery.

The consultations described in the paper approximate face-to-face encounters and as such are reimbursed by many insurers including Medicare and most state Medicaid programs. Other health technologies are very important but may have a different focus as adjunct to care or specific to adherence. The encrypted clinical consultations are delivered over high speed internet links that are now cost feasible in most rural settings. Videoconferencing technology allows mental health providers and patients at different locations to interact in real time. Mental health applications are the most common outpatient applications of telemedicine due to high service needs, provider shortages, interactions predominantly based on conversation and observational skill, and minimal technology needs. Review articles (Pesamaa et al., 2004) document telemental health applications across urban and rural areas within the traditional care delivery model for specialists and primary care providers. Almost every psychiatric diagnosis has been seen over telemedicine in settings including schools, daycare facilities, community mental health centers, hospitals, primary care offices, military sites, Veteran Administration centers, nursing homes, reservations, correctional facilities, homes, and other creative service locations. High satisfaction and feasibility is reported across telemental health services within the traditional care model (Grigsby, Brega, & Devore, 2005). Overall, studies have concluded that telemental health is a reliable means of conducting clinical interviews and noted high levels of clinician and client satisfaction. Preliminary evidence from a literature review suggests that telemental health services are cost effective to clients when factoring in reduced travel requirements, time off work, and childcare needs. There is limited data to date concerning clinical outcome across telemedicine services, although pilot work is encouraging (Grady et al., 2009).

TeleHelp Clinic

Youth depression is a significant public health concern with significant morbidity as well as suicide risk. Despite evidence-based guidelines, very few youth receive treatment, particularly in rural areas. Barriers that prevent access to services for youth depression include distance, lack of transportation, poverty and unemployment,

inadequate health insurance coverage, lack of specialists, appointment delays, and stigma. Across our existing telemedicine sites, rural and urban communities reported high need for depression services and thus, we developed an interdisciplinary telemedicine clinic to evaluate and treat youth depression. Real-time videoconferencing is used to bridge the gap between evidence-supported youth depression treatment and limited/no access to specialty mental health providers. The telemental health clinic also offers a unique opportunity to build trainee competencies around not only youth depression intervention, but also broader outreach competencies.

A psychologist and psychiatrist team and their trainees, located at the academic medical center, connect with client and family at telemedicine sites across the state. The model utilized includes a trained site champion/coordinator that assists the family with the technology setup as well as socialization and implementation of the mental health encounter. The program draws referrals from a range of urban and rural telemedicine sites. The most common referral site has been schools. Schools have emerged as an effective partner in overcoming traditional barriers to mental health services in providing comprehensive health services where children spend much of their time and have established relationships and support from trusted school professionals. TeleHelp links the psychologist and child psychiatrist team at the academic medical center with clients at distant telemedicine sites across the state. The program draws referrals from a range of urban and rural telemedicine sites.

From 2007 to 2009, the TeleHelp clinic has completed approximately 50 interdisciplinary intakes and 250 follow-up visits, with approximately 40 trainees participating in the clinic. Clients have presented from 3 years to 18 years in age, with most clients presenting from elementary schools based on the location of telemedicine sites. The ethnicity of patients presenting to the clinic has been approximately half Caucasian patients and half patients across other ethnicities. Trainees have included psychology graduate students, social work students, counseling students, psychiatry fellows, pediatrics residents, medical students, and other trainees. The TeleHelp clinic psychologist implements elements from a cognitive-behavioral treatment protocol for childhood depression that has been previously evaluated in the telemedicine setting (Nelson, Barnard, & Cain, 2003). The client's family and school personnel complete intake paperwork and rating scales before their initial telemedicine visit to assist with diagnosing, treatment planning, and recommendations for treatment and referral. Treatment is collaborative across providers, family, and school personnel and encompasses cognitive-behavioral strategies and medication management. Recommendations cross the child's complex psychosocial world and take individual, academic, and family needs into consideration.

Technology Competency

Trainees are given a brief overview of the technology used, including use of point-to-point, encrypted technologies appropriate for the clinical setting. For example, many trainees have used Skype for their own personal use but the current limitations to using this type of technology for clinical purposes are discussed as part of

the training experience. The team models videoconferencing etiquette, including introducing the trainees to the client at the distant site, scanning the room to show who is in attendance, and asking permission from the client/family for trainee participation in the session. The psychologist and psychiatrist both emphasize maintaining good eye contact and making sure that as professionals, we apply the same good communication skills as in the face-to-face setting.

With recent advances in telemedicine equipment and connectivity, there are minimal delays based on technology. However, the team models the good communication over technology including close attention to turn taking and frequent "check ins" with the client/family about comfort with the telemedicine setting. This includes simply asking "can you hear and see me alright?" and "do you have any questions about meeting over video today?" Trainees observe how clients are socialized to the technology context and reassured that only the team can see them and only they can see the team, like a phone call with a picture rather than like television. Trainees are also engaged in understanding the importance of back-up plans in the event the technology fails.

Trainees learn skills related to providing therapy over videoconferencing from the basics of using the equipment to videoconferencing etiquette. Although providing therapy over videoconferencing relies on the same competencies of providing therapy face-to-face (knowledge and skills in following best practices, etc.), telemental health does pose unique benefits and challenges. With the picture-in-picture function, trainees see what the distant (client side) sees in a smaller window in a corner of the larger display. Thus, trainees have the unique advantage of observing their own eye contact and body language throughout the appointment. This can be valuable training tool for novice therapists. Trainees also learn to control the camera and volume controls. One advantage of the telemedicine system is the ability for the psychologist/psychiatrist to unobtrusively zoom the camera in on the client in order to observe facial expression, tics, gait, or other clinically relevant signs. Trainees learn to accommodate conducting therapy in separate rooms from their clients through using fax machines to distribute educational materials, thought log examples, etc. and to incorporate the distant side's support personnel as needed.

Clinical Competency

The clinical competency is central to supervision in the telemedicine setting. Much of training in this area is the same as in onsite clinics, with an emphasis in understanding and applying evidence-supported approach to treat youth depression. The clinic is unique in having both the psychologist and the psychiatrist available to trainees to understand both approaches in managing youth depression. As in onsite clinics, much attention is devoted to developing relationships with the client and his/her family in order to support both therapy and medication management approaches.

Trainees review the intake and questionnaires used in the clinic (the Behavior Assessment System for Children across parent, teacher, and child as well as related

measures) as part of training in depression evaluation and treatment. The telemedicine setting draws diverse clients that may otherwise not present to traditional clinics and thus the team discussed with trainees how the client's unique environment influences evaluation findings and recommendations in treating youth depression. For example, some rural sites have been particularly hard hit by economic downturns related to farming and this influences understanding community influences on the depression presentation. Similarly, the urban school based clinics have several new immigrant students presenting and the stress of acculturation is an important part of understanding recommendations for support and treatment. In summary, the telemedicine setting brings to the foreground the need to tailor treatment approaches to fit the client and their family's unique cultural and geographic contexts, a very important training lesson from the clinic perspective.

Another component of the telemedicine clinic is increased coaching families in skills rather than the therapist directly applying the skill. For example, the depression clinic often implements parent training in tandem with child strategies. The therapist is not onsite to implement time-out but must coach the parent in following time out procedure based on a clear parenting rationale.

Trainees are also engaged in understanding the importance of pre-established back-up plans in the event the client presents with an immediate safety concern, disclosure of abuse, or other crisis concern. In this event, the psychologist and the telemedicine coordinator assists the client/client family with seeking local crisis services based on well-established telemedicine protocol.

Outreach Competency

The communication technology links together the psychologist and psychiatrist with not only the client, but also others within the client's community. *From the TeleHelp team perspective, this is the key advantage to the technology*. It allows input in the child's evaluation across multiple perspectives, including the child, the child's parents/guardians, the child teachers and other educators, the child's school nurse, the child's case manager, or other community individuals. The parent/guardian has the authority in who participates in TeleHelp visits, but almost always welcome these additional support personnel in developing and implementing the treatment plan. Instead of playing phone tag or other barriers to treatment, parties meet together and work toward a treatment plan based on psychologist and psychiatrist guidance. Meeting in the school or other familiar setting also decreases the stigma that is sometimes associated with mental health concerns, particularly in rural and frontier settings.

While there are advantages to working with this group each with its own unique perspective on the child, there are also challenges in managing the amount of information and an important area to offer support to trainees. As in other outreach settings, trainees learn about the importance of thoughtful, professional communication across the diverse systems of care. Maintaining focus on best depression

treatment options for the child is emphasized. There are increased opportunities for trainees to observe, interact, and understand the therapeutic importance of the client's community (school personnel, case managers, etc.) as telemedicine increases the feasibility for multiple interested parties to convene at a convenient, familiar, local site rather than all traveling to a distant medical center or other specialty location.

On a practical level, TeleHelp trainees observe managing not only the technology, but also the flow of individuals in and out of the therapy room. The psychologist/psychiatrist "directs" meeting together in the telemedicine room and then meeting individually with different participants (client, client family, school representatives, other community representatives) that often participate in telemedicine encounters. The trainees observe this collaboration among the mental health professional and the onsite telemedicine coordinator in making sure the physical space is used to the best advantage and that all standards of confidentiality/privacy are maintained.

On a professional development level, TeleHelp trainees learn the importance of understanding different systems of care. This includes understanding the "different language" and focus at the distant site. This is often the school setting but is at times the primary care or rural clinic settings, each with a different emphasis in the child's care. For example, the trainees often observe discussion around 504 plans or Individualized Education Plans, with a focus on school-related accommodations and supports around depression.

Trainees also have the opportunity to participate in broader community education around youth depression. The TeleHelp clinic developed a DVD for school personnel concerning identifying warning signs of youth depression and understanding treatment options. Using the DVD as a springboard, a subset of trainees either go onsite to the schools present by televideo about youth depression. The TeleHelp team believes this is a particularly good training experience related to outreach competency and hopes to expand the opportunity in the future.

Conclusion

We have described the TeleHelp clinic as one example of telemedicine training opportunities. The telemental health clinic gives opportunities for training about technology, about youth depression intervention with diverse populations, and about outreach. The supervision focuses on training the students in evidence-supported youth depression interventions across diverse populations, rather than technology per se. On the horizon, technology may be further utilized to deliver supervision at a distance to rural and underserved areas. The fields of nursing and medicine have lead telesupervision and telementoring to meet similar access workforce shortages faced by psychology. Program descriptions in mental health suggest that technology-supported supervision offers trainees opportunities to practice in rural settings and to have ongoing supervised support in developing competencies with diverse underserved families (Miller et al., 2003; Reese et al., 2009). Finally, videoconferencing

technology offers exciting new possibilities for psychologists in practice to support each other and trainees in real-time guidance and collaboration across geographic boundaries. In the future, the technology may be a tool to support the life-long learning competencies we aim to instill across trainees.

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How Can Educators LEAD Professionals Through New Technologies that "Connect the Dots" to Quality Care?

Meredith Cary

Don Berwick MD and the Institute for Healthcare Improvement (IHI) have set a high bar for training health professionals, and, now their work needs adapting to new technologies. The IHI Breakthrough Series trained countless teams of health professionals to target a topic area for continuing improvement (IHI, 2003). As a result, their training significantly improved the quality of healthcare, reduced costs, and saved millions of lives. One topic area, that is, new communication technologies could follow the IHI model so educators in the health professions can collaborate to systematically improve clinical prevention and population health. Specifically, clinical educators could share performance-based training in self-management support skills to **LEAD** people to do what works:

Leverage distance learning and new social media technologies to
Engage interprofessional students in a Capstone Project for Clinical Prevention and **P**opulation Health to
Accelerate health consumer demand to do what works, and
Disseminate outcomes on their "peer-reviewed" health information website.

This chapter explains these four major elements that use new communication technologies to meet the high IHI standards. A foundational start to this explanation begins with the area of new technologies and self-care.

Challenges Professionals Share: Maximizing Patients' Self-Care

It's estimated that 80% of healthcare is self-care (Sobel,1995). So, boosting effective self-care at both personal and population levels pivotally bends the cost curve of health-care and improves health for all. Although clinicians are the most trusted catalysts in patients' decisions, too many fail to assist patients to use evidence-based

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practices or resources to bend the cost curve toward containment (Baker, McFall, & Shoham, 2009).

For instance, according to Woods and Jaen (2010), about 70% of smokers have seen a provider in the past year. Yet, two-thirds of those who try to quit do not use proven practices, products, or services that could double or triple the current 3% success rate. Many clinicians don't follow the 5A's model for counseling about quitting smoking, promoted by the 2000 and 2008 Public Health Service *Clinical Practice Guidelines, Treating Tobacco Use and Dependence*:

1. *Ask* about substance use.
2. *Advise* to quit.
3. *Assess* motivation.
4. *Assist* in the quit process.
5. *Arrange* for follow-up.

Clinical education has failed to train the workforce in the most foundational skills needed for chronic care and prevention – self-management support. The critique of current health practices only begins here, and how new technologies figure into this polishing of current practices into best practices is key. First and foremost, educators must train in how to be skillfully "prepared and proactive" to "inform and activate" patients to use best practices and to access proven resources (Schaefer, Miller, Goldstein, & Simmons, 2009). One of those proven resources is new technologies.

In our Web 2.0 world, providers as the most influential evaluators of information need training in how to skillfully offer their health opinions online (Keselman, Logan, Smith, Leroye, & Zeng-Treitlerg, 2008). Increasingly, patients need even more targeted health opinion leadership. Just as millions more enroll in Medicare, a multi-billion-dollar mobile health industry is promising 'care anywhere' with persuasive technologiesfor self-care (Fogg & Eckles, 2007). How will patients make informed choices from among the burgeoning 5,820 medical, health, and fitness applications (apps) for smartphones (MobiHealthNews, 2010)? For that matter, how will busy providers find time to evaluate these apps to recommend the ones that work?

In fact, to continue with the smoking cessation example, the consensus among leaders in tobacco prevention is to leverage direct-to-consumer marketing to increase use of evidence-based practices and resources (Orleans, Maybry, & Abrams, 2010). Using consumer-centered principles derived from the Consumer Demand Initiative creates strategies that "foster a community" and "facilitate transitions" along the journey of smoking cessation (Backinger et al., 2010). Wood and Jaen (2010) recommended that the 5A's be redesigned to help patients "connect the dots" to easily find the best resources that "integrate with their lives." For example, Saucedo & Schroeder (2010) report that more than 15 professional organizations have now adopted the *Ask*, *Advise*, *Refer* approach by dispensing *1-800-Quit-Now* cards to patients.

However, few clinical programs actually use performance-based training to teach students how to improve self-management support skills for patient activation. As well, medical schools struggle to fit community-based training experiences in clinical prevention and population health into already crammed curricula and stressed schedules (Chamberlain et al., 2008; Finkelstein et al., 2008; Kerkering, & Novick, 2008).

Certainly, no inter-professional training taps the collective power, that is,'the wisdom of the *academic* crowd,' to improve self-management support by 'connecting the dots' for patients and the public to use proven resources, locally and online.

Perhaps, easier access for educators to save time, money, and effort may promote sharing training resources. If it's enjoyable or prestigious enough, educators might just want to compete for pride at being the best at improving clinical prevention and health in their communities.

Opportunities We Could Share

For that achievement, educators might create an interprofessional Training-Based Research Network (TBRN) to systematically improve clinical prevention and population health, targeting self-management support for evidence-based resources. The TBRN's Capstone Project could create a culture of interprofessional collaboration for continuous improvement in both training and health outcomes. That is, the Capstone would standardize training and measurement of participatory health leadership skills that would activate patients and the public for improved self-care. Ultimately, university-based interprofessional teams could LEAD their surrounding communities to compete to be the healthiest - and have fun doing it! The American Psychological Association Psychologically Healthy Workplace Award in one example of recent acknowledgement for community advances (http://www.apa.org/news/press/releases/2010/03/workplace-awards.aspx).

Organized by clinical psychologists and health communicators, the TBRN-led Capstone could use performance-based training and measurement in skills for both tracks: Clinical Prevention and Population Health. Adjunctive to their home school curricula, students would access sequential skills-based modules in: Motivational self-management support, consumer-centered health risk communication, and quality improvement of clinical or population-based activation parameters. The Capstone would create or use validated measures to enable comparison of learner competencies, training program effectiveness, and community-based health outcomes.

Training would integrate best practices, such as from Clinical Practice Guidelines and Practice-Based Research Network (PBRN) findings. Such an approach would share the best training talent, technologies, methods, materials and measures. Using a common training platform, the 'community of learners' would train together in simulations to gain basic skill mastery. Then, as supervised trainees, they would serve their communities. More advanced learners would train, mentor, or supervise the less advanced. The most advanced learners would study quality improvement parameters and publish them.

For instance, interprofessional clinical student teams would practice what Woolf et al. (2005) described as the best possible primary care model for promoting self-care. For example, 17 practice-based research network (PBRN) projects augmented the 5A's by referring to their practice-based websites for patient education, decision-making, and community referrals. Hence, Capstone cohorts would strive to continuously improve the centralized TBRN-led website. This health information

and opinion portal would double as a training platform and a public service. Leveraging social media, learner-generated health information would disseminate the best peer-reviewed, science-based interprofessional opinions on health topics, for different populations.

In the Population Health Track, students would use the site to explain best practices using plain language, spotlight science-based resources, as well as study health consumer informatics to improve consumer demand to do what works. In the Clinical Prevention Track, students would use the site to improve patient activation. They would learn how to match their patients' readiness for change and, using *Ask, Advise, and Refer,* they would assist patients to *connect the dots* between the best practices and resources that would *integrate into their lives*.

Each TBRN (likely an academic health center collaborative) could LEAD as the expert of a health topic (e.g., PTSD, Diabetes, Preparedness). To continue the Smoking Cessation example see a prototype at: http://www.webhealthdev.org/?q=topical_portal/35. Or, they might LEAD as the experts for a particular population (e.g., Seniors, Faith-Based Groups, Hispanics). In another example, to see a prototype for the Post-Deployed, visit: http://www.webhealthdev.org/?q=topical_portal/22.

Adjunctively, as a service-learning component to existing home school courses, Capstone training modules would be taken sequentially. First in simulations, students would learn how to communicate their health opinions to shape healthy behavior, clinically and on their training website. Once learners demonstrate basic mastery, they would continue to get feedback from student mentors, to improve their skills and health outcomes while conducting their regular practica or training-based services. The most advanced students would train and practice in quality improvement, using clinical metrics and consumer health informatics, both to feed back to training mentors and to inform the public.

For instance, clinical psychology interns would train less advanced clinical peers in motivational self-management support skills, using a validated training package to mentor clinicians to increase patient activation (Martino et al., 2006). Furthermore, they would use the IHI Toolkit for self-management support (Schaefer, Miller, Goldstein, & Simmons, 2009). After demonstrating basic mastery in simulations, clinical student skill improvement would be continuously measured and mentored, using the *actual* Patient Activation Measure (PAM) in *actual* clinical training (Hibbard & Cunningham, 2008). Fellows would collect this data, using methodologies of the IHI Breakthrough Series for quality improvement (Institute for Healthcare Improvement, 2003). They would publish results both on their social media outlet and in peer reviewed publications, such as the *Journal of Participatory Medicine*.

As well, advanced health communication graduate students would mentor clinical peers in consumer-centered health risk communication, to encourage patients and the public to do what works. For example, once a simulated student posting like *"Ask your doctor about 1-800-QuitNow"* was 'peer-reviewed' by clinical and communication peers, mentors would make it visible on the Smoking Cessation public portal. As well, they would use Breakthrough Series methods to improve parameters such as health literacy and usability. Moreover, they would publish improved consumer behavior as well.

Over time, continuously improving their reach and scope, the Capstone Project conceivably would increase local community involvement for an array of preventive behaviors. Educators, who normally assign hands-on or community-based learning, would increasingly participate. For instance, those who teach PR or health campaign courses might assign students to test strategies to engage the student body to join healthy competitions. Their students might learn how to use social media to motivate sororities to compete to 'reduce Freshman 15' during a semester. Performing Arts students could create videos for YouTube about personal weight loss stories, Visual Arts students might design posters for the competition, and Business students might test strategies for sustainability, such as developing sponsors or branding.

In the long term, even more extensive healthy competitions are conceivable. Capstone cohorts at different schools could compete to LEAD – stretching beyond their campuses. Visit a prototyped example of a competition to fight childhood obesity: http://www.webhealthdev.org/?q=topical_portal/359. In the best case, the Capstone would create an annual intercollegiate competition, branded as the *March Madness for Prevention,* sponsored by the NCAA. And so, leader boards might display school standings for creating communities that have the leanest kids, as well as for basketball.

Potentially then, in the best of all worlds, TBRN-led Capstone Projects would LEAD - provide continuously improving training, community-based resources, and health outcomes for all. Their site would be a peer reviewed reference for finding the best practices and resources, locally and online, for any health topic and population. Participating academic programs and health centers could advertise their patient activation improvement rates and rankings, similar to other promotions (e.g., US News and World Reports Best Hospitals). Finally, their institutionalized health campaigns would offer community-based self-management support, for patients and the general public.

Who Could LEAD First?

Nowhere is the urgency to improve clinical prevention and population health more profoundly felt than in the Department of Defense (DoD). According to their Final Report (2010), the Task Force on the Prevention of Suicide by Members of the Armed Forces recently offered 13 Foundational Recommendations. To prevent suicides, now one in every 36 hours, uppermost among their suggestions were to:

1. Centralize and standardize best practices.
2. Develop skills-based training for behavioral health specialists.
3. Strengthen strategic messages to inspire help-seeking for known and available treatment that works.
4. Determine effectiveness of these prevention efforts.

As well, the Chairman of the Joint Chiefs of Staff, Admiral Michael Mullen (2010) recently charged his best experts to develop a completely new paradigm for health.

Total Force Fitness, this new holistic framework for health, integrates the mind and body within the entire community (Jonas et al., 2010). It includes eight domains:

1. Physical
2. Nutritional
3. Medical
4. Environmental
5. Behavioral
6. Psychological
7. Spiritual
8. Social

As never before, the need for interprofessional collaboration among military and civilian providers is imperative. Many service members tend to access healthcare from civilian providers. If they do seek care for mental health symptoms, they tend to only go to primary care. Therefore, military behavioral health providers, now more likely to be embedded in primary care, also need to train their civilian colleagues in how to work with service members.

On the population health front, the military has begun to take innovative consumer-centered approaches. During summer 2010, the Defense Centers of Excellence (DCoE) and the Defense Advanced Research Projects Agency (DARPA) distributed a Broad Agency Announcement, the Healing Heroes Initiative (HH). The request for contracts is to develop a groundbreaking telehealth platform, based on social networking technology, which would provide a virtual community for service members and their families. The platform will host multiple interactive components, such as avatars who are 'Sim-Coaches' to make it easier for members to "connect the dots" to get help with stigma-related issues, anytime and anywhere.

Thus, this is a fortuitous time for DoD behavioral health specialists to LEAD. They could establish the first TBRN to standardize training of military and civilian providers to help service members find evidence-based services, both face-to-face as well as online. Building on the Healing Heroes platform, they could provide a continuously improving resource such as the prototyped Post-Deployment Health website (http://www.webhealthdev.org/?q=topical_portal/22).

That is, conceivably in a centralized training, clinical psychology interns in the military would learn the skills to improve service member activation to seek evidence-based behavioral health. As their Capstone project, they would train, mentor, and supervise other clinical students in the health professions how to improve patient activation. Finally they would target continuous improvement in clinical prevention and population health, specifically for suicide prevention among the post-deployed.

Why Would Other Psychologists Collaborate?

Generally, graduate clinical psychology programs do not specifically train students 'how to' translate research into practice. In 2009, Begley's *Newsweek* article, "Ignoring the evidence: Why do psychologists reject science?" sparked this theme

reverberating throughout 15 other media outlets. For months, there was no way to effectively address these categorical defamatory claims.

As well, clinicians are bound to be more vulnerable, as consumer ratings, rankings, and rants on the Web become more popular. Now reputations can be devastated in an instant whether or not based on false information. Anyone can say anything malicious, and it can spread virally in minutes. At the very least, to fight media-based slander, it may become essential for clinicians to have social media skills.

More positively, however, the Web enables transparency and accountability in healthcare. Medicare, for instance, sponsors a site where anyone can check on the quality of hospital care (www.HospitalCompare.hhs.gov). No doubt, consumers in both clinical education as well as healthcare, will demand more information. Prospective graduate students (and parents) will expect to see quality parameters when choosing a clinical psychology program. Certainly, as health consumers learn to make better informed decisions about their self-care, they will understandably expect to know more about the competency of clinicians.

Yet currently, no training program, accrediting or licensing board offers consumers any way to evaluate how competent a clinician actually is with treating their issues. In our view, we need to have population-based norms and standards for improving patient activation, training program norms and standards for producing those outcomes, as well as a way to translate that information so that consumers can understand it.

In the case of a clinical Capstone Project, learners would have performance-based, formative and summative standardized evaluations of self-management support skills and patient activation. TBRN's could develop and publicize norms for patient activation and improvement. Students could measure their competency levels against those norms, as could clinical training programs.

How Would We Share Training?

Clinical students regularly seek distance-learning opportunities. The Open School, an interprofessional online learning environment established by the Institute for Healthcare Improvement (IHI), has become known to its students as their *other school*. They attend to gain skills they cannot find at their regular school, like how to be "change agents" using quality improvement.

Clinical skills can be taught at a distance. Martin Seligman, PhD, demonstrated such success when he initiated a training program, *Authentic Happiness Coaching*. By phone and the Web, he engaged classes of over 300 students, having various professional backgrounds from around the world. Also, students met (by phone) in small groups of 10 or so, facilitated by Fellows or trained mentors. That way, students received more individualized attention to process specific coaching skills. Students could meet in real time, or, they accessed archived classes.

New technologies, mostly open-source and free, could enable a world-class training system that blends a synergy of synchronous with asynchronous experiences.

The TBRN-led training would provide internet-based *Simul-teaching* (Pullen, 2006) for larger classes, led by subject matter expert faculty. *Simul-teaching* enables any student with a PC or Mac and internet connection, to attend any actual face-to-face class. It can be experienced with audio and/or video, in real time or just-in-time. The professor can show slides or amplify his ideas on a shared white board. Students from anywhere can participate, such as 'vote' on issues, comment, or ask questions. In fact, professors can view questions from the audience and answer them in the moment. The system stores all kinds of supplemental files, including audios and videos. The newest version of it, MIST/C (i.e., netlab.gmu.edu/MISTC/), seamlessly connects to Moodle, the open source learning management system, which handles required administrative functions, from enrollment to grades.

For smaller classes led by advanced students, phone-over-the-internet would enable video and document sharing. For instance, imagine three students – sharing a free phone line – would practice motivational interviewing together, for performance-based skill training and measurement. Two would practice role-playing the patient and clinician. The third would practice mentoring skills. These vignettes could be recorded for later supervision as well.

Performance-based risk communication skills could be practiced and measured using simulations on the social media site, previously discussed. The site could handle both training simulations, as well as the public portal. Subject matter experts in health risk communication as well as advanced students would facilitate this training, also using Simul-teaching.

Ultimately, the TBRN-led Capstone Project, for clinical psychology students, could be used as the home school's performance-based measure for an equivalent to a Comprehensive Examination. However, it could also be used as well for Continuing Education Units and or performance-based licensure renewal.

Conclusion

Clinical prevention failures have severe consequences – for individuals and populations.

Clinical training needs to bridge the gaps between science, practice, and the public. The proposed centralized TBRN-led Capstone Project for Clinical Prevention and Population Health could standardize and sustain interprofessional training.

Year after year, Capstone cohorts would focus our effort to systematically improve clinical training in self-management skills, as well as actual patient activation. As well, each cohort would improve the TBRN-led website, to drive consumer demand for what works. If educators in the health professions chose to collaborate (and compete) to LEAD people to "connect the dots" to find proven practices and resources – our training-based services might save many millions of lives.

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Ethical Issues in Media Psychology

David Shapiro

Previous chapters have emphasized innovative concepts in the use of new technologies. This chapter will cover ethical and legal issues that apply not only to these new technologies, but to more traditional media presentations as well.

Recently, there has been a highly publicized case in South Florida of a young man who became enraged at a fellow student over a taunting text message. He put on steel-toed boots and attacked the woman in broad daylight at a school, kicking her in the head, nearly killing her and causing severe brain damage. She is now in a vegetative state. A psychologist hired by the defense went on the *Today Show* on national television with the defense attorney for the young man and they spoke about the case. The psychologist gave details of the history and his diagnosis of Posttraumatic Stress Disorder. Presumably, having the defense attorney present legally satisfied the issue of Waiver of Privilege. However, the defendant was a juvenile and, of course, could not give Informed Consent. The attorney of record can (and probably did) consent on the young man's behalf. However, totally aside from the legal issues regarding privilege is the question of what it does to the trial process. Usually, the defense will try to avoid pretrial publicity, as it may bias jurors against their client. Here, the strategy was just the opposite. It may be called an "in-your-face defense." The question of what the prosecution thinks about this has yet to be determined. However, there are some very troubling ethical issues here, quite aside from the legal issues.

The discussion of a client's history and diagnosis on television is quite similar to a book in which the author described his involvement in a number of high-profile forensic cases. The author stated that since it was a matter of public record, he could discuss anything regarding the defendant's history. He proceeded, in one case, to describe the defendant's masturbation fantasies. This was technically correct. It was a matter of public record, in that the report had been filed in Court. The troubling question is whether or not this overrides the ethical issue of taking reasonable steps

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to avoid harming individuals with whom we work (Standard 3). Whether or not the report is a matter of public record, there is little justification for including such a potentially harmful issue as a defendant's masturbation fantasies. The same author talked about psychological tests that he used but no one else used that "proved" malingering. Here, again, this goes beyond the limits of research data that demand that we look at known error rates and the testable hypotheses. Essentially, the author was proving just how clever he was. It made for good amusing reading, but, again, is it ethical? The Code of Ethics requires us to use well-validated techniques and only for the purpose for which they were intended (Standard 9 – Assessment).

We are bound by the ethical statement that we do not misrepresent our data, we do not overstate the certainty of the data and we make clear any reservations we have regarding validity and reliability. The same issue, the assessment of malingering, which frequently becomes a high-profile issue in the media, came to focus in the pronouncements of one psychologist who stated, and he was, in fact, quoted on the front page of a newspaper, that he can determine malingering in the first two minutes of a clinical interview. This, of course, is totally contrary to the literature; he makes psychology look like some kind of soothsaying process (Standard 2). He also stated, for instance, that a sign of malingering was if a defendant states that he or she hears both male and female voices. There is absolutely no research to support this but many people went around citing that as a legitimate research finding. In short, this psychologist's unvalidated techniques assumed an "urban legend" quality.

In another instance, also highly publicized, a psychologist had testified in Court that he believed that a father had sexually abused his son. The judge ruled that there was not enough evidence to support that assertion and ordered that the father's visitation rights be reinstated. When the psychologist emerged from the Courthouse, he was confronted on the Courthouse steps by television cameras and essentially stated that he did not care what the judge said, in his opinion the father had sexually abused the child.

The father then filed a defamation lawsuit against the psychologist and, while the Court ultimately ruled in the psychologist's favor, stating that he was merely repeating what he had already said in Court, we must look at it through the lens of the Ethics Code as to whether or not his making this off-hand statement to television cameras was, in fact, taking reasonable steps to protect individuals with whom we work. It is worth noting that our Ethics Code requires us to protect not only our clients but also others with whom we work (Standard 3).

A certain well-known media figure had given up his license to practice psychology and stated that what he is doing is entertainment, not psychological assessment or psychological intervention. Nevertheless, he presents material with a ring of certainty and he still calls himself "Doctor." From an ethical point of view, we must ask what image of psychology is created. This doctor would, on occasion, overstate the certainty of his opinions. In a case presented to him regarding a disruptive adolescent, the doctor told the family that Jeffrey Dahmer had six of the fifteen characteristics of serial killers and that their son had nine of them. There is, frankly, no scientific data that allows for the making of such a statement and, were this man still a psychologist, he would clearly be in violation of that part of the

Code that requires us to base our data on established scientific principles (Standard 2.04). In such cases, what psychology are we bringing to the people? Certainly not well-controlled science with reservations regarding validity and reliability but rather sensationalistic material masquerading under the guise of science.

I would urge us to go back to the basics, the Code of Ethics. There is, to be sure, a section on media presentations (Standard 5.04) and within Sect. 5 a section dealing with advertising and other public statements. This section prohibits any statement that is "false, fraudulent or misleading."

The Ethics Code impacts on us as media psychologists on virtually a daily basis. Many people just assume that they practice ethically and do not bother to actually read and think about the Ethics Code.

For instance, several years ago at a presentation at the APA convention, a senior psychologist with many years of professional experience spoke about the fact that the APA Code prohibited multiple relationships. The APA Ethics Code does not and never prohibited multiple relationships. It prohibits harmful multiple relationships, ones that could reasonably lead to harm, exploitation, loss of objectivity or loss of effectiveness. Of course, the safest course of action is to avoid all multiple relationships but that is not what the Code said.

The Ethics Code makes it clear that something that is unethical should not, in and of itself, be the basis for a finding of civil liability or whether a contract is enforceable. It defines "reasonable" as the "prevailing professional judgment of psychologists engaged in similar activities, in similar circumstances, given the knowledge the psychologist had or should have had at the time." "Should have had" refers to the prevailing standard of practice at that time in the past.

It would be helpful now to look at some specific standards. 1.01 – If the psychologist learns of misuse or misrepresentation of their work, he or she takes reasonable steps to correct or minimize the misuse or misinterpretation. Especially when giving statements to the media, sound bites may be taken out of context. One should be very careful in giving such interviews. One of my colleagues suggested obtaining a signed consent form from reporters indicating that nothing would be taken out of context. He indicated that the frequency of his interviews dropped off dramatically after that. If one finds that the media has misrepresented statements, it would be important to notify them in writing. Whether they actually acknowledge or change we cannot help, but it is important to document these efforts. Set up parameters ahead of time, tell the media what you will and will not discuss and do not allow questions to "slip over" into areas that you said that you would not discuss.

Until recently, this related to situations where law and ethics came into conflict, such as in the release of confidential records. A psychologist, having made an attempt to follow the Ethics Code, could follow the law and not be in any ethical violation.

Standards 1.02 and 1.03. Of course, these have to do recently with the issue of torture, intensely debated for the past several years. The phrase, "Psychologists may adhere to the arguments of the law, regulations or other governing legal authority," has been replaced by a statement that states that there can be no violation of basic

human rights. The media has consistently distorted APA's position and sadly, we have not done enough to counter these misinterpretations.

Standard 1.04 – Informal resolution of ethical violations. We prefer not to confront people with potential ethical violations unless we are holier than thou ethics police. It is safer and simpler to take the impersonal step of filing a complaint. Yet, the Code requires informal attempts first. I was involved in a case several years ago in which a psychologist, without having interviewed the Unabomber, made diagnostic statements about him that appeared in the APA *Monitor*. I wrote a letter to him expressing my concern and he, in fact, was quite gracious, understanding after the fact that he realized he should not have done this. So, such confrontation does not necessarily result in angry denunciations and threats of reprisal. One point to be considered, however, is that in forensic situations one often may not be able to talk with the other individual if he or she is to be designated as an expert witness, as this could be seen legally as witness tampering. Reporting of ethics violations does not become an obligation and, in fact, is seen as an exception to this standard if one is reviewing the work of another psychologist whose professional conduct is in question. Many psychologists in this tight marketplace are doing just that, filing complaints against opposing expert witnesses when, in fact, the Code strongly suggests that this is inappropriate and could be seen, in and of itself, as a violation of Standard 1.07, the filing of improper complaints, which is discouraged.

Standard 2 – Competence. This is, perhaps, one of the most widespread areas of ethical concern for psychologist in the media. The media generally does not know the different knowledge bases, theoretical orientations and varieties of training that psychologists have. A psychologist is a psychologist is a psychologist according to the media and they will seek out the same psychologist to give an opinion on child-rearing, geriatric psychology or assessment of violent behavior. Therefore, it takes extra vigilance and self-policing for us to talk to the media only in areas in which we have specific expertise. We have to exert these curbs on ourselves because others certainly will not and, in fact, will tend to see us as all things to all people. In the interest of creating more business, many of our colleagues do not, and this can be ethically very risky. For instance, a psychologist whose expertise is in family therapy, without specific training in child abuse, should not be rendering opinions in a case regarding the sequelae of child sexual abuse.

We are urged in Standard 2.01 to practice within the bounds of our competence, based on education, training, supervised experience, consultation, study or professional experience. Of some interest is the parallel to this definition of competence in the definition in the Federal Rules of Evidence of an expert witness. Federal Rules of Evidence, Rule 702, defines an expert as someone who has knowledge, skill, education, experience and training. Put another way, consider whether or not you have enough expertise to testify in Court about something before you decide to give an interview to the media.

Perhaps as a result of many of our colleagues giving off-the-cuff statements about areas in which they have no expertise, we may be faced with members of the media asking us questions we cannot answer. Several years ago, there was a high-profile murder case in an eastern state involving a multiple homicide. I had not

examined the defendant. I received a call from a talk show host who wanted an opinion from me about what kind of personality the defendant had that he could kill his wife and two children. When I replied that it would be ethically inappropriate to talk about someone I had not examined, the interviewer yelled, "What good are you?" and slammed down the phone.

A closely related area is when we are asked by the media to answer a question regarding which there is no scientific, empirical or professional literature.

A typical question, for instance, is "What is the profile of a murderer?" or "What is the psychological profile of a child molester?" Ethically, we should inform the questioner that there is no such thing as profiles of this sort. Sadly, television, movies and newspapers repeatedly create the image that there is some sort of magical specialty called "psychological profiling" and we need to inform the media of the limits of our expertise.

Standard 2.04 – Basis for Scientific and Professional Judgment. On the surface, this standard is deceptively simple. Our work is based upon established scientific and professional knowledge of the discipline. Put simply, we should not be responding to media requests in areas in which there is no substantial scientific and professional knowledge. How often, however, do we see our colleagues doing just the opposite, rendering conclusions and statements in an area where there is no such established knowledge base. We have a strong statement in our Ethics Code to take reasonable steps to avoid harming individuals. Yet, how often in our contact with the media do we intentionally do just that, by making statements about an individual on television, by the psychologist talking about an ongoing case or, by the psychologist who misrepresents the stated literature in reference to malingering? When we allow ourselves to be "edged" into giving statements where we have not thought through all of the implications, we can be doing some very real harm. We must constantly keep these principles in mind, even when the harm is unintentional.

Standard 3.05 – Multiple Relationships. This is, perhaps, one of the most misunderstood sections of the Ethics Code. Some people maintain, as noted before, that all multiple relationships are unethical. This is an extreme and unrealistic position and one that was never part of the Ethics Code, though some believe it was. What the Ethics Code does prohibit is harmful multiple relationships, those that can reasonably lead to exploitation, loss of objectivity or a loss of effectiveness. These three items should be used as screens to help psychologists think through the potential harm. Only if one can firmly state that the multiple relationship in question would not result in any exploitation, loss of objectivity and a loss of effectiveness should they feel comfortable in pursuing it. Some of these can be very subtle. For instance, in one state, Blue Cross/Blue Shield insurance was proposing dropping of mental health coverage from the health insurance of state workers. The state psychological association, of course, was very concerned and its lobbyist, who was also a psychologist, stated that psychologists should discuss this with their patients and enlist their patients' aid in fighting the Bill. He suggested that psychologists urge the patient to testify against the Bill and the psychologists should go along to the Hearing to provide emotional support. Of course, it was important to keep

mental health benefits from being cut off. However, the Ethics Committee pointed out the multiple relationship, the possibility of subtle coercion and the probable loss of confidentiality and suggested some ways that this multiple relationship between therapist and advocate could possibly cause harm. The situation was resolved by a suggestion that the psychologist leave in the waiting room a brochure describing the legislation and if the patient or client chose to discuss it, options could then be examined.

There has recently been a spirited discussion on the Division 46 Listserv regarding therapists bringing their patients onto a talk show to discuss psychotherapy or having a talk show host refer people to certain therapists. Most people believed it was a potentially harmful multiple relationship, though some pointed out that it publicized and made clear to the public what therapy was. While this is a valid point, one must also look at the potential for harm in terms of a subtly coercive relationship, doing something because the therapist wants them to do it.

Not too long ago, I was involved in a rather high-profile case in which a woman was suing a county commissioner for sexual harassment. I had been retained by the county as a defense expert witness. The woman failed to prevail in her legal action, the jury finding insufficient evidence of sexual harassment. The woman and her attorney then decided to try the case on television. It was announced that the attorney, the woman and the woman's therapist would be appearing on the Larry King Show that night. Here is certainly a compound multiple relationship: A therapist representing himself as forensic expert and going on national television to dispute the jury's finding. Of course, when contacted by the Larry King Show, I declined coming on the show and tried to explain to them that it was an impermissible multiple relationship.

Of course, there is some degree of subjectivity in determining whether a particular multiple relationship could reasonably result in harm but recently in the Ethics Code Introduction, "reasonable" was defined as noted above as the prevailing professional judgment of psychologists engaged in similar activities at that point in time given the knowledge the psychologist had or should have had. What does "knowledge the psychologist should have had" mean? It refers, of course, to peer consultation, listserv and consultation with respected colleagues. These all go a long way to determining this point.

Standard 3.07 – When any third party is involved, as in these examples, the media, there has to be a clear, well-defined, carefully crafted informed consent. Informed consent ethically must include a description of the services to be provided, the identities and loyalties of all concerned, the limits of confidentiality and the nature of disclosure. Legally, it must include an assessment of the individual's competency or capacity to render informed consent, a clear description of the fact that it is voluntary, with no coercion involved, and what we call sufficiency of knowledge – the client or patient has been given enough information to make an informed decision on his or her own. Before consenting to any form of media involvement in any case, it would behoove a psychologist to carefully think through these elements of informed consent from both an ethical and a legal point of view. In one case which received a good deal of press coverage, a police officer sued a psychologist for breach of confidentiality.

The police officer had been referred to the psychologist for a fitness for duty evaluation. The psychologist examined him and wrote a letter to his commanding officer saying that he thought there were some difficulties that might interfere with the officer adequately performing his duties. The police officer filed an ethics complaint for breach of confidentiality. The psychologist was dumbfounded, thinking that anyone referred for a fitness for duty exam would know that a report was to go to his commanding officer. He, however, did not make this explicit to the police officer or obtain any type of informed consent to the evaluation. We simply cannot assume that our clients understand these issues.

In another recent case, which also received media attention, a patient presented to a therapist and asked if everything he said would be confidential. The therapist said yes, unless he felt that the patient were dangerous. The patient then confided in the therapist that he had been having sexual relations with his 14-year-old daughter. The therapist, of course, made the mandated report to Child Protective Services. The man was then arrested and charged with child sex abuse. Following his conviction, he filed an ethics complaint against the psychologist for breach of confidentiality. The therapist explained that he had told the patient about the dangerousness exception and felt that child sex abuse was clearly dangerous behavior. The patient obviously did not share that definition of dangerousness. It is essential, in other words, that we are very explicit in our informed consent about these exceptions to confidentiality.

Standard 4.03 – Recording. Any recording of client sessions must be part of the informed consent. Recall for a moment the case of Lyle and Eric Menendez. One of the ethically inappropriate issues was the therapist having a third party in a closet recording the contents of a psychotherapy session without the client's consent. The therapist justified this, of course, in terms of his concern about the Menendez brothers potential for violent behavior. Nevertheless, even when concerned about the potential for violent behavior, any exception to the confidentiality must be part of an informed consent. Similarly, any possible disclosure to a third party has to be documented in the informed consent.

Standard 4.07 – Use of Confidential Information for Didactic Purposes. This standard asks us to strike a balance between providing relevant information to the public and, at the same time, maintaining confidentiality. We need to disguise material enough so that the parties involved cannot recognize themselves and yet convey enough data about the details that it provides important information. If there is legal authorization to do so or there is consent in writing, these do not apply. However, even here, there are ethical constraints. For instance, legal authorization may include matters of public record but one must exercise caution, as noted in the example earlier, where an author discussed a client's masturbation fantasies, reasoning that it was all a matter of public record. One cannot overlook the ethical requirement that we take reasonable steps to avoid harm where it is readily foreseeable. Even written consent can be tricky, as we need to be sure that a client who gives consent in writing is competent to give that consent. On occasion, a patient who is psychotic may give such consent without recognizing the parameters of such consent. Returning to the disguising of information, this needs to be done very

skillfully. One psychologist found himself the subject of a licensing board investigation following his publishing, in a small town newspaper, an account of a case in which he was involved regarding child sex abuse. While he disguised all the names, the geographical area was so small that the alleged abuser said that he could recognize himself in the article.

When we get to Standard 5, Advertising and Other Public Statements, we encounter, perhaps most directly, issues that confront media psychologists on a daily basis. When a psychologist is asked by the media to give statements, unless the psychologist is very careful, the media may try to exaggerate his or her credentials to make for a more impressive presentation. However, the Ethics Code requires us to avoid public statements that are false, fraudulent or misleading. This includes statements dealing with training, experience, competence, degrees, credentials, institutional affiliations or the scientific or clinical basis for the degree of success of one's services. In the following examples, the first two are not fraudulent but are misleading to a point that they would be deemed unethical. I was sent some business cards by a psychologist who was attempting to do some forensic work, while also completing his dissertation. In and of itself, there is nothing wrong with this provided he receives appropriate supervision. However, his business cards read his name, and after that M.S.A.B.D. Forensic Consultant. The A.B.D., of course, meant "all but dissertation" and was clearly not a qualification of any sort, but its placement suggested American Board of something that qualified him to do forensic consulting. This was clearly misleading. In a similar manner, a psychologist put her name with Ph.D. and then under it, Diplomate, American Board of Professional Psychology, without specifying the area in which she had received her Diplomate, then titled her report, "Neuropsychological Evaluation." This was deceptive by omission, for her Diplomate was in Industrial Organizational Psychology, but the implication was that her Diplomate was in Neuropsychology.

This next example, unlike the past two, was actual fraud. Here, a psychologist described himself as Board Eligible in Forensic Psychology. Board Eligible has no meaning in psychology. This psychologist was relying on medical specialties which do have a status called Board Eligibility to deliberately create a fraudulent credential which does not exist. We also have an ethical responsibility to correct misinterpretations when others make them. Recently, when I wrote an endorsement for a book on the book jacket, they listed me as a Diplomate in Clinical and Forensic Psychology. I do not have a Clinical Diplomate, only Forensic. It was too late. It had already been published at the time that I saw it. I notified the publisher in writing and he said he would correct it in the next printing. When doing media presentations, we must be careful to not say anything indicating that a professional relationship has been formed with the recipient. Any time that advice is given, it must be in general terms, specifying the literature or research behind the observation.

When looking at the area of assessment (Standard 9), we must be very careful to not misrepresent the nature of a particular assessment instrument, to make it have a greater degree of certainty than it really does. One psychologist testified that he used the only psychological test that had been objectively validated as a measure of lying and then proceeded to describe the MMPI-2. He further stated that the

MMPI-2 was "an emotional x-ray." These statements were made in the course of a highly publicized trial regarding child sex abuse. We must also be very careful when we find out about people misusing psychological tests and providing advice in the media, especially online, about how to defeat certain psychological tests. For instance, a fathers' rights group, which can be found at *deltabravo.com*, has provided online reproductions of the Rorschach cards, along with what to respond and not respond. Similar websites can be found for other well-known psychological tests, such as the MMPI-2. When psychologists are involved in consultation to such activities, it is clearly unethical and a misuse of assessment data.

In this overview, I have tried to present some of the major ethical areas with which psychologists rendering services in the media must be informed. We need to think through these areas in advance and not wait until we are confronted, as in an example previously given, on the courthouse steps and asked for a response to an ethical issue.

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