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PPA Survey Reveals Best and Worst Health Care Insurers in Pennsylvania

In a survey sent to PPA members earlier this year, psychologists rated insurance companies in terms of access to psychological services, protections of privacy, efficiency, and overall satisfaction with services to patients. On a four-point scale with 4 representing the highest degree of satisfaction with services provided to patients, psychologists rated Highmark as the best with a 3.4. Blue Cross of Northeastern Pennsylvania, Aetna, and Medicare also did well in overall satisfaction ratings of 3.1, 3.0, and 3.0 respectively. The ratings were lower for other companies, and MHNet was ranked far below all others with a ranking of 1.6 (see Figure 1). Expressed another way 94% of psychologists were satisfied or highly satisfied with Highmark, but only 13% of psychologists reported being satisfied or highly satisfied with MHNet. According to Dr. Vincent Bellwoar, chair of the PPA Insurance Committee, "This survey provides important information on the actual coverage patients can expect from their insurer. It will help patients make the best health care coverage choices for their families."

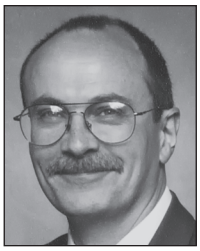
Highmark was also rated highly in terms of patient access to treatment. Respondents were asked, "within the past month, have you or your staff received phone calls from subscribers of ___ complaining of difficulties obtaining an appointment with a psychologist in the health insurer's network?" (Yes or No). Only 16% of psychologists dealing with Highmark reported hearing such complaints. Patient access to services was also measured by asking

Figure 1: Overall Satisfaction with Services to Patients

Continued on page 4

APA Bylaws Revision Is Important to States

Donald McAleer, Psy.D.



Dr. Donald McAleer

In early November, members of APA living in Pennsylvania will receive a ballot regarding a revision of its bylaws related to the structure of the APA Council of Representatives. This bylaws vote has been a long time coming. Our current system for allocating Council representation dates back to the 1960s. For many years members of the Council have sought to resolve a fundamental flaw in the system: the system did not ensure that all of APA's recognized constituencies (states, provinces, territories, and divisions) were guaranteed a vote on the Council while it tried to accommodate for proportional representation at the same time. The Council has made some improvements over the years seeking to remedy the situation. However, the latest incarnation has a flaw that is now coming to fruition. If trends continue in the way members

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Religion and Psychotherapy

Ethical Conflicts and Confluence

Robert M. Gordon, Ph.D., Lowell Hoffman, Ph.D., and Alan Tjeltveit, Ph.D.

Since religious beliefs are part of our definition of internal and external reality, they can become the source of either great conflict or great contentment. Healthy aspects of religious beliefs and practices include positive identification with family and heritage, social support, a source of comfort, meaning, and spiritual connection beyond material existence. Unhealthy reasons for religion include its use as a defense against reality, moral aggression, and splitting people into "the saved" or the demonized. Likewise there are healthy reasons for being an atheist, such as facing reality without magical thinking, and having faith in secular institutions and verifiable knowledge. Unhealthy reasons for atheism include concreteness and cynicism. When religious issues emerge in psychotherapy, we need to attend—carefully and without bias—to both its healthy and pathological elements. Timing and sensitivity are essential.

APA Ethical Principle E, Respect for People's Rights and Dignity, holds that we are to respect all people, including those whose religion is very different from our own. We thus need to be aware of and address any negative effects that religious differences might have on the quality of our work. Religious issues in therapy may produce in psychotherapists strong emotional and cognitive reactions that may be partly unconscious or automatic, including countertransference reactions. For example, when patients consider acting in a manner abhorrent to our most deeply held beliefs, or tell us that they are uncomfortable working with us because of our beliefs, we may react strongly in ways that surprise us, that we don't fully understand. Optimal ethical and clinical responses to such clients involve our becoming aware of these reactions and addressing them effectively.

Because the respect for which Principle E calls must be balanced with the beneficence and nonmaleficence for which Ethical Principle A calls, we may appropriately address pathological beliefs that may be rationalized in the name of religion. We act in ways that benefit others, and don't harm them. Respecting, understanding, and empathizing with different frames of reference does not, however, mean that we should be afraid to question assumptions and rationalizations that lead to harm, hostility, or exploitation of others (recognizing that our approach to religion may shape our understanding of what is helpful and harmful). A psychologist's countertransference reactions may lead not only to an over-reaction to a person's beliefs, but also to an under-reaction based on the fear of being perceived as being biased. Psychologists who are silent about religion may reinforce the stereotype that psychologists are disinterested in and scornful of religious experiences. Problems may also arise when psychologist and patient share the same background—and blind spots.

When psychologists work with clients, they operate within the boundaries of their competence (Ethical Standard 2.01). This

Dr. Robert M. Gordon

Dr. Lowell Hoffman

Dr. Alan Tjeltveit

does not mean that they should refrain from treating someone about whose religion they lack expertise (by one account, there are about 42,000 faith groups in the world). Psychologists may need to increase their knowledge and skills to work effectively with religious clients—by studying a patient's beliefs, consulting experts, or asking the patient. Many patients welcome such questions and see them as an opportunity to help their psychologist appreciate their frame of reference; their reluctance to discuss religion should, however, be respected, especially if religion is not related to their presenting problem. It is crucial that psychologists maintain objectivity, respect, and empathy. If countertransference interferes with effective work, psychologists should seek supervision or refer the patient to a more appropriate psychologist.

Careful assessment of the role of religion in a patient's psychological functioning may be very important. The psychologist should recognize any religiously dynamic countertransference during the assessment phase of treatment and determine whether the psychologist's personal identifications and feelings will be useful or harmful to the treatment process. Assessment conclusions should be drawn with humility and an awareness of the ways in which a psychologist's own approach to religion can lead to misunderstanding the role of religion in particular clients' lives. A sensitively obtained lifespan religious history may be important both with religious and non-religious patients, producing a wealth of helpful information.

Some religious conflicts arise from underlying neurotic conflicts and may be dealt with as such. However, some individuals seek treatment for both psychological and religious issues. These patients may benefit from the expertise of a therapist trained in both psychology and the beliefs and practices of a particular religious tradition. Certain issues may require clarification when therapist and client share a religious perspective: A patient may consciously or unconsciously hope to exploit a perceived shared belief system, expect religious instruction or quasi-pastoral

Continued on page 4

RELIGION AND PSYCHOTHERAPY

Continued from page 3

ministry rather than psychotherapy, or expect moral homogeneity with their psychologist.

Non-religiously identified clinicians can help religiously committed patients when there is no collusion of silence about religion. If clients choose to work with such a psychologist, mutual respect will usually overcome the asymmetry of religious differences. Psychologists, therefore, shouldn't automatically assume that religiously committed patients need to be referred to a religiously identified clinician.

Psychologists who offer psychological services from a particular religious orientation need to fully disclose their approach at the beginning of treatment. Patients who know a psychologist's approach to religion and agree with it are less likely to be influenced in ways they do not want.

In summary, the ethical practice of psychotherapy with respect to religion is not derived from the prevalent illusion of achieving a value-free therapeutic dialogue. Values are embedded in all presuppositions, including those that guide some psychologists to ignore religion. We believe that when psychologists practice in ways that invite the full participation of patients (including their religious sensibilities), respect the patients (including their choices to not address religion), are aware of religious differences, are informed by relevant knowledge (obtained either before or after therapy begins), and strive to benefit patients, the treatment they provide will be both efficacious and ethical.

———————

This article is a summary of the Pennsylvania Psychological Foundation fundraising ethics workshop, "Religion and Psychotherapy: Ethical Conflicts and Confluence," on May 14, 2010, by Robert M. Gordon, Ph.D., Alan Tjeltveit, Ph.D., and Lowell Hoffman, Ph.D.

Early Career Psychologist Award

Dr. Theresa A. Kovacs, of Clarks Summit, right, was the recipient of the Early Career Psychologist Award at the annual convention in June. It was presented by Dr. Michelle Herrigel, chair of the Early Career Psychologist Committee. Dr. Kovacs chairs the Public Education Committee.

BEST AND WORST HEALTH CARE INSURERS

Continued from page 1

psychologists if they strongly disagreed, disagreed, agreed, or strongly agreed with the statement that patients can get an appointment with an in-network psychologist within two weeks. About 82% of the psychologists dealing with Highmark agreed or strongly agreed with that statement, compared to only 46% of the psychologists dealing with CIGNA and 41% of the psychologists dealing with MHNet (see Figure 2).

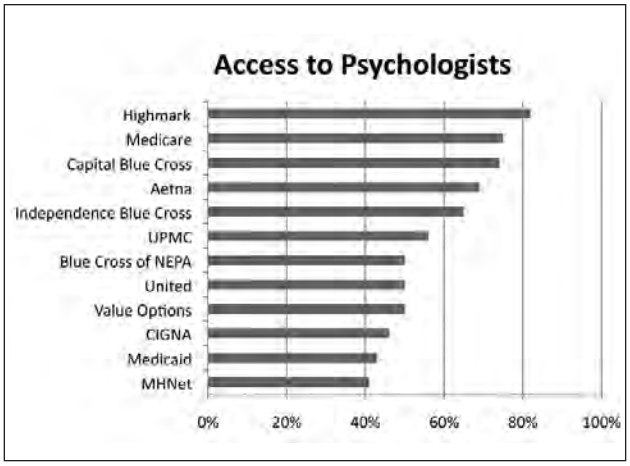


Figure 2: Access to Psychologists

The top insurers in terms of the reasonableness of their policies on ensuring the availability of medically necessary psychotherapy were Highmark, Medicare, and Medicaid. Except for Medicare, most insurers did poorly in terms of their policies towards approving testing and assessment. Among commercial insurers, Highmark rated the best with 54% of respondents agreeing that Highmark often or very often paid for medically necessary assessments. Most insurers were rated high in terms of protecting patient privacy. These and other ratings are summarized in Table 1. Dr. Bellwoar congratulated those insurers "who serve their members well by providing easy access to services and sufficient treatment for their members. We hope this survey will also motivate underperforming insurers to improve."

In spring 2010 the survey was posted on the PPA website using Survey Gizmo, and members of PPA were sent an e-mail asking them to participate in this survey. The survey instrument was adapted, with permission, from the American Psychological Association Practice Organization. Data on the demographics of the respondents in terms of ethnicity, hours providing psychological services, and populations served was similar to data found in previous surveys. A total of 506 psychologists responded to the survey. The results were released to the press on September 22. More detailed information can be found on the PPA website (www.PaPsy.org). It is hoped that insurers will use this information to improve the quality of their behavioral health services or, in the case of several insurers, to continue their good work.

The survey had limitations in its ability to evaluate Medicaid and Medicare. Each of the four Medicaid HMOs was rated separately. However, because of the small number of

respondents for each of the individual Medicaid HMOs, the data for all of the Medicaid HMOs was combined. The questions on Medicare did not distinguish between fee-for-service (traditional) Medicare and Medicare HMOs. Consequently, it is not possible to evaluate the strengths or weaknesses of those different Medicare programs according to this survey.

Surveys of this nature have a limitation in that insurers may offer different products with different benefit structures and sometimes different oversight procedures. For example, it is reported that at least one policy is jointly administered by Blue Cross of Northeastern Pennsylvania and Highmark. Furthermore, it is often difficult for providers to discern the difference between a policy provided by an insurer and a policy administered by an insurer. For example, a large insurer may administer a program for a self-funded company (a company with more than 100 employees which is governed by ERISA) and all of the information given to the patient or provider suggests that this does not differ from other policies issued by that insurer. Many times the policies and their implementation do not differ. However, often they do differ both in terms of their benefits and procedures. So, for example, a large insurer may not require pre-authorizations for outpatient psychotherapy in the policies it issues, but may administer a policy for a large company which does require authorizations.

Dr. Bellwoar congratulated those insurers "who serve their members well by providing easy access to services and sufficient treatment for their members. We hope this survey will also motivate underperforming insurers to improve."

Despite these limitations the differences among insurers appear large and representative of actual differences in their functioning. Also, Pennsylvania data was comparable to a nationwide survey done by the APA Practice Organization that found high ratings for nonprofit Blue Cross/Blue Shield companies, Medicare, and Aetna, and lower ratings for other commercial insurance companies.

Ratings of Insurers

	Access to psychologists[1]	Pt complaint about access[2]	Procedures for therapy[3]	Procedures for testing[4]	Respect privacy[5]	Overall satisfaction[6]
Highmark	82%	16%	97%	54%	94%	3.4
Blue Cross of NEPA	50% (LT 20)	25%	86%	43% (LT 20)	83%	3.1
Aetna	69%	19%	90%	19%	85%	3.0
Medicare	75%	15%	97%	70%	93%	3.0
Capital Blue Cross	74%	35%	89%	34%	83%	2.8
UPMC	56%	18%	83%	40%	88%	2.8
Independence Blue Cross	65%	39%	83%	16%	81%	2.6
Medicaid	43%	32%	96%	38%	74%	2.6
CIGNA	46%	22%	83%	28% (LT 20)	73%	2.6
United	50%	28%	95%	15%	66%	2.5
Value Options	50%	27%	84% (LT 20)	29% (LT 20)	69% (LT 20)	2.5
MHNet	41%	39%	49%	15%	63%	1.6

Table 1: Rating of Insurers

LT 20 means less than 20 respondents in this category, suggesting caution in data interpretation.

[1] The percentage of psychologists who somewhat or strongly agreed with the statement that "patients report that they can get an appointment with an in-network psychologist within 2 weeks."

[2] The percentage of psychologists who answered "yes" to "Within the past month, have you or your staff received phone calls from subscribers of ___ services complaining of difficulties in obtaining an appointment with a psychologist in the health insurer's network?" For column 2 a low score indicates greater satisfaction.

[3] The percentage of psychologists who somewhat or strongly agreed with the statement that _____ pays for psychotherapy services in the number and frequency that is necessary in your professional judgment.

[4] The percentage of psychologists who somewhat or strongly agreed with the statement that _____ pays for assessment and testing services in the number and frequency that is necessary in your professional judgment.

[5] Obtained by averaging the percentage of somewhat or strongly agreed responses across three privacy-related questions. A high score indicates greater respect for patient privacy.

[6] The average of psychologists who answered "somewhat satisfied" or "very satisfied" to "Overall, how satisfied are you with the service _____ provides to patients?" Responses were on a four-point scale with 4 indicating the highest level of satisfaction.

LETTER TO EDITOR

Marketing, Money, and Making It Work

Vincent J. Bellwoar, Ph.D.

Dr. Vincent J. Bellwoar

I thank Dr. Naar for his thoughtful reflections on my article, "Considerations for Financial Success" (*Pennsylvania Psychologist*, September 2009 and June 2010). Psychologists need a healthy dialogue about balancing clinical and financial success, especially given the paucity of business training we receive. It is getting tougher out there. Early career psychologists incur $80,000 of graduate school debt. Managed care organizations have effectively reduced psychologists' incomes while inflation marches on. How do psychologists survive and thrive?

Marketing generates referrals, the bread and butter of a thriving practice. Even with Dr. Phil and *The Sopranos*, what we do is not "common knowledge." Through marketing, we break down the barriers to treatment by normalizing the process. The best marketers are not aloof or snobbish, but warm, compassionate, and grounded. When people approach me at a public gathering (e.g., soccer game or a luncheon after a funeral) about whether they or someone they know would benefit from treatment, I welcome a brief but meaningful discussion. To put them off with, "Call me at my office so we can discuss it" is a missed opportunity—for you and potential clients. Your goal is to avoid any appearance of a 5-minute therapy session while offering an exchange that welcomes them to schedule an appointment. To remain aloof and disengaged is the real disservice.

Why do we hesitate to put a price on time? Physicians now assertively charge for ancillary services such as completing forms, add fees for unpaid copays, and charge "premium" fees for boutique treatment. Assigning a dollar value to the minutes of one's day is no longer limited to lawyers and accountants! When insurers continue to suppress reimbursement rates and refuse to pay for ancillary services, psychologists have three options: conduct a cash-only business (and hope to attract enough business); accept the reality and do nothing (while slowly getting poorer); or start charging assertively for all ancillary services they provide, including no-shows, reports, letters, and phone consultations. If we believe we are "above" other professions and should not be paid for everything we do, we eventually become the underpaid victims of our own elitist thinking.

Is it "business, not personal"? Or "personal, not business"? Why not both? It too gives me a warm and fuzzy feeling to know I helped save someone's marriage. Why not expect this *and* adequate payment? So go ahead, talk to that patient who calls with an emergency. Is this the first or fourth call this month? Does it last 4 or 40 minutes? You decide how to value it. But don't believe your profession requires you to provide free services. If psychologists do not address head-on the increasing difficulty of making a living commensurate with our education and training, we create our own lack of parity. Make 2011 the year that you are both an excellent clinician and a savvy, disciplined businessperson!

APA BYLAWS REVISIONS

Continued from page 1

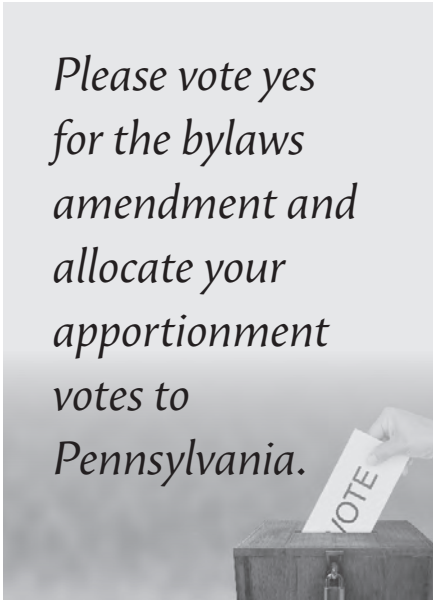
apportion their votes, soon the apportionment vote will not provide a seat for all divisions and states. This bylaws change will correct that.

It is important that the association include all recognized constituencies at the table. Our many voices can only be heard if we are all participants in the discussion, and we will not be able to tap our multitude of talents if we are not all included in making the decisions and conducting the work of the organization.

APA's constituencies come in many sizes. The smallest are the small state, provincial, and territorial associations. These associations represent the interests of professional psychologists within their state, province, or territory. Their involvement in state and federal advocacy is essential to addressing the needs of our entire membership. Some of our greatest legislative initiatives have come in small states. For example, one of the first states to gain prescription privileges has been a small, rural state.

The Caucus of State, Provincial, and Territorial Representatives asks all state association members to express their support of this bylaws change. Please vote for it.

At the same time it remains CRITICAL that members still allocate either all or at least some of their apportionment votes to their state association. In doing so, members will be voting to allocate more seats to the pool representing state interests and which can win more seats for states, territories, or provinces.



¡Viva! Arcadia Wins CSP Honor for Work With Latinos

The winning team from Arcadia University. Not all team members were present for the photo, listed left to right: Oscar Escobar, Cristen Fitzgerald, Jennifer Wiggins, and faculty member Dr. Eleonora Bartoli.

The Community Service Project (CSP) of the Pennsylvania Psychological Association of Graduate Students (PPAGS) challenges individual graduate students or teams of students to develop and provide a service to an underserved population in their immediate area. PPAGS had four CSP entries for 2009–2010.

The winning team, from Arcadia University, developed a Latino Community Project to provide psycho-educational resources and social learning experiences to the Latino population of Center City Philadelphia, during November and December 2009. Approximately 1,000 people at the Mexican Consulate were provided with psycho-educational group sessions about sexual harassment in the workplace. Arcadia University's community service project was completed by Oscar Escobar, Cristen Fitzgerald, Rachel Shor, Brittany Baker, and Jennifer Wiggins. They were supervised by psychologist Sharon Flicker, Ph.D.

The Carlow University community service project was completed by graduate students Diane Snyder and Jennifer Croyle. They were supervised by Robert Reed, Psy.D.

The Indiana University of Pennsylvania community service project was completed by Susan Jefferson, Shelby Bohn, Justin Harms, and Steve Hartman. They were supervised by Kimberely J. Husenits, Psy.D.

The Immaculata University community service project was completed by graduate student Lois Row, under the supervision of Maria Cuddy-Casey, Ph.D.

Pennsylvania Psychological Foundation Education Awards

Nine graduate students were recipients of the Pennsylvania Psychological Foundation Education Awards.

Pictured above, left to right: Betsy E. Feinberg, M.S.Ed, M.S; Aleisa Myles, B.A.; Antoneal N. Swaby, M.Sc.; Toni Rex, Ed.D., Awards Committee Chair; Richard F. Small, Ph.D., PPF President; N. Diny Capland, B.A.; Crystal D. Taylor, M.S.; Joseph E. Beeney, M.S.; and Kasey M. Griffin, M.S. Not pictured: Karen Dias, M.A.; and Joan F. Rowland, MSN.

What Opinions Can Psychologists Give About Persons Whom They Have Never Met?

Samuel Knapp, Ed.D., Director of Professional Affairs
John Gavazzi, Psy.D., Chair, PPA Ethics Committee

What professional opinions can psychologists give about persons whom they have never met? Is it ever appropriate for psychologists to comment on or diagnose a person whom they have never evaluated personally? The APA Ethics Code is not clear on this issue. According to the APA Ethics Code,

> 9.01 (b) Except as noted in 9.01 c, psychologists provide opinions of the psychological characteristics of individuals only after they have conducted an examination of the individuals adequate to support their statements or conclusions. When, despite reasonable efforts, such an examination is not practical, psychologists document the efforts they made and the result of those efforts, clarify the probable impact of their limited information on the reliability and validity of their opinions, and appropriately limit the nature and extent of their conclusions or recommendations.
>
> 9.01 (c) when psychologists conduct a record review or provide consultation or supervision and an individual examination is not warranted or necessary for the opinion, psychologists explain this and the sources of information on which they based their conclusions and recommendations.

These standards never use the word "diagnosis," and just refer to the opinions of the psychological characteristics of an individual. Nonetheless, the wording makes it clear that generally psychologists should not comment on individuals whom they have not personally evaluated. However, this general rule has qualifications as indicated in standard 9.01 above.

Some situations have clear answers. For example, misuse of psychological

Dr. Sam Knapp

Dr. John Gavazzi

knowledge could occur when psychologists on a talk show speak briefly with a caller and then are asked for an opinion. Typically, these communications are brief and the psychologists do not have the time, nor would the venue be appropriate, to do an evaluation "adequate to support their statements or conclusions." The purpose of these talk shows is to give information to the listening or viewing audience, and giving assistance to the caller is a secondary goal. Often the psychologists will give general information about things to look for and say something like, "the information you presented to me just now shows the symptoms commonly found in persons diagnosed with XXX disorder. Such a diagnosis can only be made by a qualified professional after a thorough evaluation...".

Also, psychologists could not give opinions concerning the fitness of a parent for custody of a child without having seen and evaluated that parent and child (or that parent /child relationship) directly. However, psychologists could give opinions on the appropriateness of the methods used by other psychologists who had evaluated the parties involved. The reviewing psychologists could comment on whether the tests used were appropriate for the referral question, whether the questions asked in the interview were relevant, and whether the conclusions were supported by the raw data or research. Similarly, psychologists conducting peer reviews can determine whether the notes and evaluations justify the decision reached by other psychologists.

In addition, psychologists could, and often do, give diagnoses based on information provided by supervisees, even if they have not personally evaluated the patient. In this situation the supervisee is legally the arms and legs of the supervisor and, according to the State Board of Psychology Code of Ethics, the psychologist has an obligation to have face to face contact with the patient if necessary to ensure the adequate delivery of services. So the supervisor has the option and the obligation to inquire more closely with the supervisees or even meet the patients if there are any concerns about the reported diagnosis or treatment plan. In addition, any reports for distribution outside of the professional setting must be "signed by the employee and countersigned as 'reviewed and approved by' the supervisor" (49 Pa Code §41.58 (c) (7)).

In other situations psychologists (and psychiatrists) are asked to provide some type of evaluation for a specific purpose. For example, the Bureau of Disability Determination (BDD) hires consultants who, among other responsibilities, will review the medical records of disability applicants to render an opinion related to the person's ability to perform simple routine work skills under the federal standards. The procedure to determine or define disability has many components. However, the psychologist consultants are only looking at the data generated by others. If the data in the file is insufficient or does not address the individual's ability to perform simple, routine work skills, the psychologist reviewing the claim can ask for additional, highly specific information about work-related functioning, including a full psychological evaluation purchased at the expense of the Social Security Administration. When all of the information is compiled, the psychologist

produces an opinion about the claimant's residual functional capacity as it relates to a psychological condition. More significant, a disability claims adjudicator makes the final decision about the individual's disability claim. BDD and the Social Security Administration have numerous quality review processes to ensure that the work of each psychologist is correct and that proper decision making has been applied. All denial decisions from BDD can be appealed.

Also, according to Pennsylvania's Megan's Law, psychologists may be requested to offer an opinion as to whether a sex offender meets the two criteria to be classified as a sexually violent predator. One of the criteria is the presence of a "mental abnormality or personality disorder that makes the person likely to engage in predatory sexually violent offense" (42 Pa. C. S. §9792). The second is whether the offender has displayed "predatory behavior" as defined by the Act. In answering this question, the psychologist, psychiatrist, or other expert will review documents such as victim statements and records from the police, corrections, mental health, and probation and parole. All offenders are offered the opportunity to participate in an interview, but frequently they choose not to participate. On the surface, providing expert opinions on persons not directly evaluated might be construed to violate at least the spirit of Standard 9.01. However, the Ethics Code notes that opinions can be given when an examination is not practical, such as here when the offender declines to be interviewed. Also, the offender has a right to cross-examine the psychologist or psychiatrist on the stand related to the expert opinion.

Providing opinions about persons not directly seen poses a variety of ethical challenges that must be considered ahead of time.

Therefore, the general rule stands that psychologists ordinarily refrain from giving diagnoses or opinions about persons whom they have not professionally evaluated. However, at this point we are unwilling to say that psychologists can never, under any circumstances, diagnose a patient whom they have never seen, although some ethics experts take a different position. In some circumstances, we believe psychologists can give opinions about the diagnoses, functional limitations, or proclivity to violence about persons whom they have never met. Nonetheless, the ethical problems in these situations will be minimized if mechanisms are in place to challenge the opinion or correct inaccuracies, either by having the psychologist observe the patients seen by a supervisee, or by having a judicial review of the opinions of the psychologist. Whenever opinions are given in the absence of a direct evaluation, psychologists must explain "the probable impact of their limited information on the reliability and validity of their opinions, and appropriately limit the nature and extent of their conclusions or recommendations" (Standard 9.01b).

All of the possibilities, subtleties, and nuances on this topic cannot be addressed in this short article. However, psychologists who give opinions on persons they had not directly evaluated should ask themselves several questions. First, is the available information sufficient to support our statements? Next, if not, can we acquire more data to support the decisions? If more data cannot be obtained, what is the probable impact of the limited information on the reliability and validity of the opinions? What is the impact of such an opinion on the parties involved? Finally, is there a mechanism to correct us if we are wrong? As can be seen, providing opinions about persons not directly seen poses a variety of ethical challenges that must be considered ahead of time.

Reference

Fisher, C. (2003). Decoding the ethics code: A practical guide for psychologists. Thousand Oaks, CA: Sage.

Appreciation goes to Drs. Bruce Mapes, Stephen Ragusea, and members of PPA's Child Custody and Ethics Committees for reviewing an earlier version of this article.

Pennsylvania Psychological Association

2011 Award Nominations Sought

For each nomination you would like to make for the categories below, please prepare a one-page narrative describing the person's contributions and send the information to the following address by the deadline listed.

Pennsylvania Psychological Association
416 Forster Street
Harrisburg, PA 17102-1748

Award for Distinguished Contributions to the Science and/or Profession of Psychology to be given to a Pennsylvania psychologist for outstanding scientific and/or professional achievement in areas of expertise related to psychology, including teaching, research, clinical work, and publications. Deadline for entries is **October 20, 2010**.

Distinguished Service Award to be given to a member of the association for outstanding service to the Pennsylvania Psychological Association. Deadline for entries is **October 20, 2010**.

Public Service Award to be given to a member (individual or organization) of the Pennsylvania community in recognition of a significant contribution to the public welfare consistent with the aims of the association. Deadline for entries is **October 20, 2010**.

Award for Distinguished Contributions to School Psychology: The School Psychology Board nominates a candidate annually for this award. Criteria for nominations include persons who have contributed significant research in the field of child, adolescent, school, or educational psychology; have contributed significant public service to children, families, or schools; have made major contributions to the field of assessment; have made significant contributions in the media; have advocated politically for children, families, or schools; have been a voice advocating for school psychologists in Pennsylvania; and/or have made significant contributions to the Pennsylvania Psychological Association. Deadline for entries is **December 31, 2010**.

Psychology in the Media Award: Members of the Pennsylvania Psychological Association and members of the media in Pennsylvania who have presented psychology and psychological issues to the public are encouraged to apply for the 2011 Psychology in the Media Award. Members who have written newspaper or magazine articles or books, have hosted, reported or produced radio or television shows or commercials about psychology or psychological issues, or have designed psychologically oriented websites are eligible for the award. We are seeking candidates who have had a depth and breadth of involvement in these areas with the media over a period of time. Some of the work must have been published or broadcast during 2010. An application form, which is available at www.PaPsy.org, must accompany all entries for this award. Applicants who have received this award in the past are not eligible. Deadline for entries is **December 31, 2010**.

Early Career Psychologist of the Year Award to be given to a Pennsylvania Early Career Psychologist (ECP) who, in his or her practice as an early career psychologist, is making a significant contribution to the practice of psychology in Pennsylvania. Criteria for the award are available at www.PaPsy.org. Deadline for entries is **January 31, 2011**.

Student Multiculturalism Award to be given to a psychology student who is attending school in Pennsylvania and who produced a distinguished psychology-related work on issues surrounding multiculturalism, diversity, advocacy, and/or social justice. Criteria for the award are available at www.PaPsy.org. Deadline for entries is **January 31, 2011**.

Classifieds

OTHER

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The *Pennsylvania Psychologist* Update is published jointly by the Pennsylvania Psychological Association (PPA) and the Pennsylvania Psychological Foundation in January, February, April, May, July/August, October and November. The *Pennsylvania Psychologist* Quarterly is published in March, June, September and December. Information and publishing deadlines are available from Marti Evans at (717) 232-3817. Articles in the *Pennsylvania Psychologist* represent the opinions of the writers and do not necessarily represent the opinion or consensus of opinion of the governance, members, or staff of PPA. Acceptance of advertising does not imply endorsement.

2010–11 CE Calendar

The following programs are being offered either through co-sponsorship or solely by PPA.

November 4 – 5, 2010
Fall Continuing Education and Ethics Conference
Exton, PA
Marti Evans (717) 232-3817

March 31 – April 1, 2011
Spring Continuing Education and Ethics Conference
Harrisburg, PA
Marti Evans (717) 232-3817

June 15 – 18, 2011
Annual Convention
Harrisburg, PA
Marti Evans (717) 232-3817

For CE programs sponsored by one of the Regional Psychological Associations in Pennsylvania, visit http://www.PaPsy.org/resources/regional.html.

Registration materials and further conference information will be mailed to all members.

If you have additional questions, please contact Marti Evans at the PPA office.

also available at www.PaPsy.org – HOME STUDY CE COURSES

*Introduction to Ethical Decision Making** – NEW!
3 CE Credits

Staying Focused in the Age of Distraction: How Mindfulness, Prayer and Meditation Can Help You Pay Attention to What Really Matters – NEW!
5 CE Credits

*Competence, Advertising, Informed Consent and Other Professional Issues**
3 CE Credits

*Ethics and Professional Growth**
3 CE Credits

*Confidentiality, Record Keeping, Subpoenas, Mandated Reporting and Life Endangering Patients**
3 CE Credits

*Foundations of Ethical Practice**
6 CE Credits

*Ethics and Boundaries**
3 CE Credits

Readings in Multiculturalism
4 CE Credits

*Pennsylvania's Psychology Licensing Law, Regulations and Ethics**
6 CE Credits

***This program qualifies for three contact hours for the ethics requirement as mandated by the Pennsylvania State Board of Psychology.**

For all Home Study CE Courses above contact: Katie Boyer (717) 232-3817, secretary@PaPsy.org.