

The Pennsylvania

Psychologist

December 2010
QUARTERLY

WORLD PSYCHOLOGY



ALSO IN THIS ISSUE

- Dealing with economic uncertainty
- Review of mandated reporting laws
- Cultural considerations in adolescent suicide
- Safeguarding online privacy



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The Wide World of Psychology

Mark A. Hogue, Psy.D.



Dr. Mark A. Hogue

Welcome to the December edition of the *Pennsylvania Psychologist*. I couldn't be more pleased that this edition is devoted to world psychology. Because psychologists have much to offer in the areas of mind, body, spirit, and community, a balance that is essential and universal, I believe psychology has much to offer the world beyond our borders.

Paradoxically, our differences unify us: We are all people who, beyond our genetics, are shaped by culture and learning. Those influences — the nuances of different languages, cultures, and beliefs — create the wonderfully different “flavors” of humanity. Psychologists are the best trained professionals on this planet to deal with the totality of our humanness. We need to study, draw from, and understand these important cultural influences.

As I wrote in September, instead of devoting an entire presidential article on my presidential speech, I decided to “dose you” with portions of my speech throughout the year and to keep you abreast of the seven initiatives I set forth in June.

In my address, I mentioned that the excellence of human performance and the exertion of human will fascinate me. Willfulness is an interesting concept. I believe it is our largest God-given gift. It can be our greatest ally or our worst foe. It all depends on “where it's pointed.” Developmentally, we see willfulness increasingly emerge in the 2- to 3-year-old. It can turn a mild-mannered child into a ferocious force. Willfulness is “perfected” in the adolescent. Dr. James Drane, a former philosophy professor of mine, once defined adolescence as: “psychosis with a good prognosis.” It is the will gone mad, still unfettered by proper engagement, guidance, and inhibition of the frontal cortex.

In fact, I would boldly proclaim that it is exactly the human will that we, as psychologists, are charged with guiding and guarding professionally. The proper engagement of the human will in our clients allows them, in very important ways, to improve their performance in life. A past PPA president, the “mild-mannered” Dr. Stephen Ragusea, also made some bold proclamations. He boldly proclaimed in his presidency, and throughout all public speeches and presentations, that we are the best trained professionals on the planet, bar none. I would certainly agree to this: We are the best trained professionals to understand the *totality of the human condition* than any other trained professionals on the planet.

Historically, when medicine and philosophy split over the “everything must be measured” versus “the whole is more than the sum of its parts” argument, psychology was birthed between the two. It is precisely why many physicians and some experimental psychologists see practicing psychologists as “muddle-headed thinkers” and philosophers charge us with

“selling out” to the medical side. Dr. Mary Lou Zanich, one of my professors at IUP, responded to the tendency to consider psychology a “soft science” memorably. Here is the gist of her remarks:

To measure the temperature of a rock in Arizona is *easy science*. To measure the amount of love or affection people have for their children versus others' love and affection for their children... now, that is *hard science*.

There is easy science and hard science. We have been charged with understanding hard science. No other profession is better trained to understand it and the essence or spirit of humankind, known throughout literature as “the heart” or *will* of humans. We have been formally trained in the “mind,” the “body,” and the “community” or social aspects of humans, but perhaps less formally in the “spirit.” Still, look at the practice of psychology and you will continually see the spirit of humans

The proper engagement of the human will in our clients allows them, in very important ways, to improve their performance in life.

being considered. Every day in our offices, we engage with our clients regarding their will to change or to not change. We encounter the alarming “will-lessness” imposed by different disorders on our clients: encased in the despair of depression, anxiety, obsessions and compulsions, or autism spectrum disorders, people are robbed of their ability to engage their own willfulness. To help them re-engage their self-agency is essentially our job.

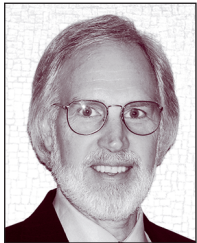
In fact, Perry London (1986) referred to psychologists as a “secular priesthood” (p. 148). He asserts that we engage with people entangled in ethical dilemmas and moral struggles, and those who are entrapped by psychopathology. While he says that it is “an uncomfortable function,” he submits that “it is unavoidable” and “can be best pursued by studying what science may have to say of human nature and its moral limits” (p. xii).

Many of our patients struggle with “doing the right thing” about wellness. They enact damaging and self-defeating behaviors. They become addicted. They become unreasonably angry or distraught. They become engulfed in problems of living and poor choices, and then they lose the freedom to choose well. People mistakenly believe that freedom is the right to choose. A wise pastor I know once said: “Freedom is not the right to choose. Freedom is the ability to choose to do what is right” (Risner, 2009). Psychologists are uniquely trained to engage clients in the “essence” of who they are and who they are

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PPA Helps Members Deal With Economic Uncertainty

Thomas H. DeWall, CAE



Thomas H. DeWall

Many PPA members are facing stressful times in the current economic environment. We know that the income of many of our members is down, or you are working harder and longer for the same income. We are glad to hear reports from some psychologists that incomes appear to be rising. Throughout this recession PPA is continuing to create value for psychologists and is engaging in numerous initiatives to benefit our members.

One of our most important initiatives is advocacy for more enlightened public policy. These changes don't always pay off financially in the short run, but they enhance the field of psychology, benefit psychologists' clients, and expand opportunities for psychologists in the long run. We went through a period of advocacy on major issues from 2007 through 2009, pressing at the state level for restrictions on insurers' use of authorizations, and at the national level for establishment of mental health parity and fair reimbursement under Medicare. More recently we have focused on issues with more long-term benefits, such as mental health courts (enacted in June), psychologists' role in concussion management among high school athletes (pending in the legislature at press time), and ensuring the ability of psychologists to participate in insanity cases. The General Assembly recently enacted legislation establishing procedures for testing newly hired police officers and firefighters for physical and mental fitness in boroughs, first class townships, and third class cities. It specified that the physical exams had to be conducted by physicians and that the psychological exams had to be conducted by psychiatrists or psychologists. Even

though these bills may have less direct impact on the majority of psychologists, they are all part of an important strategy: establishing building blocks, one block at a time, to provide legal recognition for psychologists to practice to the full extent of their scope of practice in any appropriate venue.

A complementary initiative is PPA's Public Education Campaign (PEC), which informs potential consumers of the contributions that psychologists can make. Through the PEC we coordinate our public education efforts with those of APA. For several years we have gone to great lengths in the campaign to help to "make psychology a household word." The Public Education Committee and staffer Marti Evans have arranged to present free "mind-body health" workshops for the public at the annual PPA convention for the last three years, and they are planning to do so again next June. In addition we publish an e-newsletter for the public, "Psychological News You Can Use," that focuses on issues of general concern to a lay audience. We also promote speaking engagements by our members as well as interviews with various media outlets. By educating the public about psychology we complement our advocacy efforts in strengthening the whole field of psychology.

An essential service that we provide our members is professional development. Our members receive the latest information on a wide range of issues at our many CE workshops throughout the year as well as our annual convention. Members receive significant discounts on those activities. Our listserv provides a forum for members to provide consultation to each other in solving a host of practical issues that arise. We have more professional information than ever for our members on our newly designed website, www.PaPsy.org. We utilize Facebook and Twitter and even have our own YouTube channel, www.youtube.com/user/PPAonYT.

Of course, we provide a great deal of useful information the old-fashioned way, via the *Pennsylvania Psychologist*, including the articles in this issue around the theme of World Psychology.

We believe that the range of resources provided is a major reason why PPA members have disciplinary rates from the State Board of Psychology at less than one-third the rate of nonmembers.


Probably our most valuable form of professional development is the ethics education that we provide. I refer to a whole network of activities, including advice on the listserv; ethical dilemmas posted on the electronic bulletin board; articles in the *Pennsylvania Psychologist* and on our website; a low-cost legal consultation plan; and online, home-study, and live continuing education programs. In addition to these resources, much of our professional development on ethics is supplied in the form of consultation with our staff members, Dr. Sam Knapp and Rachael Baturin, and members with expertise in certain specialties and types of practice. Together with the members of the Ethics Committee they field literally thousands of inquiries from our members each year on all aspects of ethics, regulatory, legislative, insurance, and other practice issues. We believe that the range of resources provided is a major reason why PPA members have disciplinary rates from the State Board of Psychology at less than one-third the rate of nonmembers. In fact, since 1998 the State Board of

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EXECUTIVE DIRECTOR'S REPORT

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Psychology has reported 30 psychologists who have been disciplined for serious boundary violations. However, only three of the psychologists, or 10%, were PPA members. So, at least for this particular type of infraction, PPA members are disciplined at less than one-fifth the rate of nonmembers.

In order to provide advocacy, public education, professional development, and other services on behalf of our members, we engage in activities to keep our association strong and solvent. We continue to expend efforts on member recruitment and retention activities, including emphases on early career psychologists, graduate students, and diversity within our membership. We provide direct benefits that help the bottom line, including health insurance availability, a career center on our website, a low-cost merchant credit card program, and many other benefits. Guided by an involved and fiscally responsible Budget and Finance Committee, PPA is stable financially. We have focused on leadership development to help maintain our excellent reputation of forward-thinking and flexible governance. One marker of our success is that we have more than 300 members involved in our various boards, committees, and task forces. I invite all of you to get involved to help continue our tradition of excellence as a premier professional association. 


PRESIDENTIAL PERSPECTIVE

Continued from page 2

becoming, core to the choices they make in their lives. Because I believe we have been “charged” with guarding and promoting healthy willfulness and the ability to make right choices in one’s life, we share certain responsibilities as a profession. These include the ethical delivery of effective therapeutic interventions to help clients regain adequate freedom of thought and self-agency. This “hard science” requires us to conduct our work with principles and ethics, and to take care of ourselves in order to deliver our best performance every time we engage our clients in their life struggles.

Two of my initiatives reflect these responsibilities: appointing a task force for PPA’s Bylaws Revision and asking our Colleague Assistance Committee to look into self-care for psychologists. These roughly fall under the rubric of “spirit” in my yearly theme of Celebrating Human Performance in Mind, Body, Spirit, and Community.

1. **Bylaws Revision Task Force:** Our bylaws are the foundation and “spirit” by which this organization operates. A bylaws provision mandates that every 10 years, the bylaws be reviewed and revised as needed to reflect the operations of this organization. Dr. Donald McAleer has agreed to chair this task force for the year.
2. **Self-Care:** Dr. Eric Affsprung, our Internal Affairs Board chair and chair of the Colleague Assistance Committee, suggested that this committee expand its efforts to proactively assist Pennsylvania psychologists. Good ethical care of our clients begins with good self-care. Dr. Affsprung offered that the “focus would be on the importance of psychologists practicing good, proactive, preventative self-care and also the importance of all of us (e.g., PPA members) taking care of one another, as a community.” I have asked him to study self-care in PPA members and to make recommendations on how we can improve our performance and ensure excellence in the care of others and ourselves.

In future articles, I will highlight and report on the progress of other initiatives for the year. Thank you all for your support of this great organization. I am honored to serve as your president as we continue to have PPA remain at the forefront in moving our profession forward. Enjoy this edition focused on world psychology!! 

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Risner, Jack. (2009, Feb. 15). Sermon series: A new degree of freedom. Unpublished manuscript.

A Special Thanks to Our Sustaining Members

As you know, members are billed for their annual dues based on the quarter in which they joined. For the first quarter of our fiscal year (July 1 to September 30) we had 39 Sustaining Members. That means that they contributed a minimum of an extra \$100 over and above their regular dues. Please watch for the notice that comes with your dues statement and respond generously. For more information on the Sustaining Membership program, please visit the PPA website, www.PaPsy.org. If your membership renewal is due in the current quarter (October 1 to December 31) you can make your contribution with your dues check or make it online. **We raised \$3,900 in the first quarter** with this effort – a good start!

In return for this level of membership PPA will provide:

- Special mention in the *Pennsylvania Psychologist* and on our website
- Special acknowledgement at the PPA convention
- A free Sustaining Membership wall certificate
- *PPA Membership Directory* – Buy one get one free! One for home and one for the office – or one for the office and one for a gift.

As a member of PPA, you know the importance of our association. PPA has a unique role in advocacy on behalf of the field of psychology and in providing direct benefits to members. One of the ways we keep our professional organization strong and productive is to support it financially, and this is one good way to do it. 

Review of Mandated Reporting Laws and Permitted Disclosures of Patient Information

Samuel Knapp, Ed.D., Director of Professional Affairs
 Rachael L. Baturin, MPH, J.D., Professional Affairs Associate
 Allan M. Tepper, J.D., Psy.D., PPA Legal Consultation Plan

In certain situations, Pennsylvania law requires psychologists to report confidential patient or non-patient information to public officials. These mandated reporting situations include suspected child abuse, suspected elder abuse, potential harm to third parties, impaired drivers, impaired psychologists, unethical conduct by other psychologists, and medical errors.

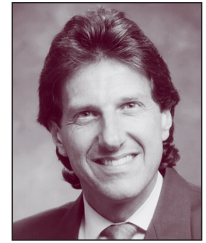
In Pennsylvania there are also situations where psychologists have discretion in reporting information. These situations include certain instances of child abuse and elder abuse. However, Pennsylvania law prohibits the release of information without



Dr. Samuel Knapp



Rachael L. Baturin



Dr. Allan M. Tepper

patient consent or a court order, such as when patients reveal past crimes, a history of domestic abuse, or a patient's HIV status. The information disclosure situations are governed by statute and case law and are summarized in the following charts:

Mandated Disclosures

TYPE	SITUATIONS	OTHER COMMENTS
Suspected Child Abuse ¹	statutory duty: 31 Pa. C. S. §6301 et seq. child comes before you in your professional capacity or is served by your agency Report abuse by caretaker or any adult.	threshold for reporting is "reason to suspect" four types: emotional, physical, sexual, and neglect child must be under 18 "perpetrators" defined by state law penalties for failure to report, immunity for good-faith reporting any sexual activity for a child under 13; sexual activity for children 13, 14, and 15 if the partner is 4 or more years older
Duty to Protect by Warning	duty created by <i>Emerich</i> , 720 A. 2d 1032 (PA 1998) imminent danger of substantial physical harm to identifiable third party	Pennsylvania version of <i>Tarasoff</i> does not apply to state licensed drug and alcohol facilities
Impaired Drivers	statutory duty, 75 Pa C. S. §1518; see also, 67 PA Code §83.1 professional relationship with patient who because of mental defect cannot drive safely	mandated to report to Pennsylvania Department of Transportation immunity for good-faith reports does not apply to state licensed drug and alcohol facilities

¹ School employees have special provisions that require them to report when they learn of physical or sexual abuse of students by other school employees.

LEGAL COLUMN

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TYPE	SITUATIONS	OTHER COMMENTS
Elder Abuse	<p>statutory duty 35 Pa. C. S. §10225 et seq.</p> <p>mandatory for employees of nursing, personal care, and domiciliary care homes; adult day care centers; home health care; and DPW funded facilities such as community residential facilities, homes and family-living homes for persons with mental retardation, intermediate care facilities, and state mental hospitals</p> <p>discretionary for other health care providers</p>	<p>“Elders” refers to adults 60 or older.</p> <p>applies to neglect, sexual exploitation or harassment, physical abuse involving serious injury, financial exploitation, suspicious death, abandonment</p> <p>penalties for failure to report; immunity for good-faith reporting</p>
Impaired Professionals	<p>statutory duty: 63 P. S. §1218</p> <p>awareness of impaired psychologist</p> <p>does not apply to psychologists in treatment or known to be in treatment</p>	<p>“Impairment:” when an individual persists in providing professional services at a substandard level because of drug addiction, physical or mental illness.</p> <p>mandated to report to impaired professional program; penalties for failure to report; immunity for reports</p>
Unethical Behavior of Colleagues ²	<p>based on APA Ethics Code (incorporated by reference into State Board of Psychology Ethics Code; 49 PA Code §41.61 (3) (e))</p>	<p>must report unethical behavior of colleague if (1) confidentiality rights are protected, (2) there is serious threat of harm to patient, and (3) informal efforts to resolve problem are not appropriate or effective</p>
Serious Medical Errors	<p>statutory duty: Act 13 of 2003</p> <p>applies to employees of hospitals</p>	<p>Incidents (“could have injured patient”) and serious events (“resulted in death or . . . unanticipated injury requiring additional health care services”) are defined in state law; report must be made to hospital and/or to Pennsylvania Department of Health.</p> <p>protections under Whistleblower Act and from retaliation</p>

Discretionary Disclosures³

TYPE	SITUATIONS	OTHER COMMENTS
Elder Abuse	<p>statutory 35 Pa. C. S. §10225 et seq.</p> <p>professional services delivered to an older adult outside facilities mentioned in mandated reporting section</p>	<p>same standards for elder abuse as under mandated reporting law</p>

²The regulations of the State Board of Psychology in 7 (i) of its Ethics Code conflict the APA Ethics Code, which is incorporated into the State Board of Psychology Ethics Code by reference in 3 (e). However, non-binding discussion by Board members suggests that they would follow the APA Ethics Code. The State Board is in process of revising these regulations.

³These discretionary disclosures must be read in light of the *Emerich* decision. It is possible, for example, that a “discretionary” report of elder abuse or child abuse may be mandated by the *Emerich* decision, although not by the reporting law itself.

⁴The regulations of the State Board of Psychology restrict disclosure to “professional workers or public authorities.” However, case law in other jurisdictions and statutory law in the Mental Health Procedures Act suggest that disclosures to family members are permitted under unusual circumstances when necessary to protect the patient from imminent danger of serious self-harm and other effective options to prevent the harm are not available.

TYPE	SITUATIONS	OTHER COMMENTS
Danger of serious harm to self	State Board of Psychology Regulations; 49 PA Code §41.61 (b) (1)	Patient presents "clear and imminent danger to an individual or society. . ." ⁴
Child Abuse	31 Pa. C. S. §6301 Any person may report suspected child abuse, even if they are not required to do so.	same standards for child abuse as under mandated reporting laws Case law provides immunity for discretionary reports for mandated reporters the same as for mandated reports.
vulnerable adults ⁵	Act 70 of 2010 will go into effect in 2011 – permits reporting of crimes against vulnerable persons	

May Not Disclose Unilaterally⁶

TYPE	SITUATIONS	OTHER COMMENTS
Patient is HIV positive	patient poses danger of infection to identifiable third party	State law prohibits disclosure of HIV information without patient consent or a court order. Physicians may, but are not required to, disclose HIV status to identifiable third party. Anyone may petition a court to release this information.
Patient has committed a serious crime in the past	requires patient release or court order	
Patient victim of crime, including spouse abuse (unless falls under vulnerable person statute)	requires patient release or a court order	

⁵ This law was just enacted on October 7, 2010, and will go into effect in 2011. More information will be reported in the *Pennsylvania Psychologist*.

⁶ These are situations when psychologists often ask if they are mandated to report, when, in fact, they are not mandated or permitted to report.

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- ♦ Information on PPAGS, PPA's student organization
- ♦ Members-only password: keystone

Psychologists Recognized as Evaluators of Firefighters and Police Officers

Over the years PPA has promoted legislation that would expand the services that psychologists are permitted to provide within the scope of their license. Often these changes occur through highly visible bills that involve years of work, such as the bill that led to psychologists getting included under Medicare, or the bills that ensure limited mental health parity.

However, in every session of the state legislature, PPA works to secure the passage of less visible bills that nonetheless benefit psychologists, even in minor ways. The General Assembly, in its recently concluded session, passed a series of bills that amend local government codes, including those pertaining to third class cities, first class townships, towns, and

boroughs, to require physical and psychological examinations for candidates for police officers and firefighters after a conditional offer of employment has been made. These bills were passed to bring the local government codes into compliance with the federal Americans with Disabilities Act, the Pennsylvania Human Relations Act, and several court decisions. Of importance to our association, the required psychological evaluations must be conducted by either a psychologist or a psychiatrist.

The Commonwealth of Pennsylvania has 53 third class cities, 92 first class townships, 958 boroughs, and one incorporated town (Bloomsburg).

The package of bills included four House bills introduced by Reps. Robert

Freeman (D-Northampton), chair of the House Local Government Committee, David R. Millard (R-Columbia), and Chris Ross (R-Chester). They have been signed by Governor Rendell as Acts 75 through 78 of 2010. Two Senate bills comprise the remainder, both introduced by Sen. Robert D. Robbins (R-Mercer), chair of the General Assembly's research agency known as the Local Government Commission. Those bills were signed into law by the Governor on October 27 as Acts 91 and 92.

Over the last 2 decades in Pennsylvania bills have passed or rules have been adopted that would allow psychologists to evaluate impaired drivers, testify as

Continued on next page

Concussion Management Bill Runs Out of Time

PPA strongly supported a bill in the Pennsylvania General Assembly that would have taken several steps to protect student athletes who suffered head concussions. House Bill 2728, introduced by Rep. Timothy P. Briggs (D-Montgomery) was passed by the state House of Representatives on September 28 by a vote of 169-29, and referred to the Senate Public Health and Welfare Committee on October 12. However, the Senate failed to bring the bill to a vote before adjourning for the year. The Senate Education Committee had passed a companion bill, SB 1241, introduced by Sen. Patrick M. Browne (R-Lehigh), but that bill also failed to get a vote by the full Senate. We expect this legislation to be re-introduced early in 2011.


Of primary concern to PPA was the language describing the credentials of the health care professionals who were authorized to determine whether a student suffering a concussion was able to return to play. After going through many iterations, the version that passed the

House stated, "The student shall not return to participation until the student is evaluated and cleared for return to participation in writing by a licensed or certified health care practitioner whose scope of practice includes the management and evaluation of concussions." In contrast, some legislators had wanted to require that this professional be a physician. Our association was able to provide convincing evidence that this provision had to be broad enough to include psychologists. Since many psychologists, including neuropsychologists, have this expertise and, in fact, have developed many of the procedures for evaluating concussions, we believe that the language that was passed by the House is most protective of student athletes.

Better education about concussions was at the heart of this legislation. House Bill 2728 would have required the state Departments of Health and Education to develop guidelines and other relevant materials related to the nature and risk of head injuries. Schools were to be

encouraged to hold informational meetings on this topic prior to the start of each athletic season. Students participating in an athletic activity, and the student's parent or guardian, would have to annually sign and return an acknowledgement of receipt of a head injury information sheet.

Under the legislation, students who exhibited signs or symptoms of a concussion or head injury while participating in an athletic activity would be required to be removed from play. They could not be returned to play until cleared by a health care practitioner as described above. Finally, coaches would be required to complete a concussion management certification training course once every 3 years. Any coach failing to comply would have been subject to penalties, including suspension from coaching.

PPA had issued a legislative alert on this issue in September and had a good response by our members. We urge all members to respond again in 2011 when similar legislation is in play. 

The Bill Box

Selected Bills in the Pennsylvania General Assembly of Interest to Psychologists

As of November 15, 2010


Bill No.	Description and Prime Sponsor	PPA Position	Senate Action	House Action
SB 383	Promotes establishment of "problem solving courts," including for mental health and addictions - Sen. Jane C. Orié (R-Allegheny)	For	Passed, 6/3/09, 49-0. Removed House amendment & passed, 5/5/10, 49-0	Amended and passed, 3/23/10, 196-0. Passed Senate version, 5/25/10, 194-0. Signed by Governor, 6/3/10, as Act 30
SB 1241 HB 2728	Provides for management of head injuries among high school athletes and evaluation by psychologist or other provider - Sen. Patrick M. Browne (R-Lehigh) - Rep. Tim Briggs (D-Montgomery)	For	SB 1241 In Approp. Committee. HB 2728 in Public Health & Welfare	Passed 9/28/10, 169-29
HB 1	Expands state adultBasic program to cover more people and add prescription drugs and behavioral health - Rep. Todd A. Eachus (D-Luzerne)	For	In Banking and Insurance Committee	Passed 6/29/09, 104-96
HB 215 SB 1017	Restricts insurance companies' retroactive denial of reimbursement - Rep. Stephen E. Barrar (R-Delaware Co.) - Sen. David G. Argall (R-Schuylkill)	For	In Banking and Insurance Committee	Passed by Insurance Committee, 6/30/09; in Appropriations Committee
HB 1250	Establishes a "practice act" for social workers, marriage and family therapists, and professional counselors; provisions intruding on psychology practice amended out - Rep. Marc J. Gergely (D-Allegheny)	Neutral	In Consumer Protection & Professional Licensure Committee	Passed 3/9/10, 185-11
HB 1639	Comprehensively revises child custody laws; establishes 16 factors for courts to consider in custody cases - Rep. Kathy Manderino (D-Philadelphia)	For	Amended and passed, 10/13/10, 49-0	Passed 6/14/10, 191-0. Concurred in Senate amendments, 11/15/10, 196-0
HB 2496	Authorizes psychologists to testify in court on the determination of insanity - Rep. Kathy Manderino (D-Philadelphia)	For	None	In Judiciary Committee

Information on any bill can be obtained from <http://www.legis.state.pa.us/WU01/LI/BI/billroom.htm>

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expert witnesses in civil trials, testify in the sentencing of those convicted of drug or alcohol offenses, evaluate adults for guardianship proceedings, assess sexual offenders, diagnose persons with mental retardation for purposes of placement in

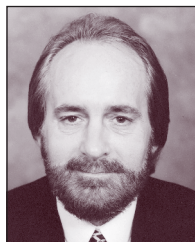
intermediate care facilities, act as reviewers for managed care companies, or be recognized by the State Boards of Medicine and Nursing to treat impaired physicians or nurses. None of these individual changes, in and of themselves, has had a tremendous impact on the incomes or practices of psychologists. However,

they incrementally expand the situations where psychologists can serve the community, help distinguish psychologists from other mental health professionals, and set precedents that make it easier to remove other barriers to the practice of psychology. 



Gateways and Getaways to International Psychology

Frank Farley, Ph.D.



Dr. Frank Farley

If you are interested in getting actively involved in international psychology, or merely learning more about it, you can read books and journals on the topic, go online to

relevant websites, join international psychological associations or the Division of International Psychology of APA, or pack a bag and head to psychological conferences outside the U.S.

In this article I will elaborate on all the foregoing suggestions. While not exhaustive, the information provided should give you a flavor of international resources and activities.

Psychology in the U.S. has been criticized as being too insular and self-involved, referencing overwhelmingly our own work, ideas, and accomplishments rather than that of other nations. While this criticism may have been more apt in earlier years, it remains true even now. Some would say, "Sure, there was Freud and his followers, and Piaget, and a small handful of others, but contemporary therapies, assessments, psychological science, and educational-psychological interventions that get attention in contemporary psychology are primarily home-grown." But there is a big world out there of psychological ideas, science, and practice if we set aside our ethnocentrism. So, how does one access all that?

Books and Journals

Highly recommended is M.J. Stevens & D. Wedding (Eds.). (2004). *Handbook of international psychology*. New York: Brunner-Routledge.

There are many good English-language journals that will provide a flavor of work being done in a number of nations or cross-nationally:

- *Applied Psychology* (published by the International Association of Applied Psychology);

- *Journal of Cross-Cultural Psychology*;
- *International Journal of Psychology*;
- *Interamerican Journal of Psychology* (in English and Spanish, covers the Americas).

Newsletters

Informative newsletters include:

- *The International Psychologist* (published by the International Council of Psychologists);
- *Psychology International* (published by the APA Office of International Affairs);
- *International Psychology Bulletin* (APA Division 52);
- *Interamerican Psychology: ISP Newsletter* (published by the Interamerican Society of Psychology);
- *The European Psychologist* (published by the European Federation of Psychologists' Associations).

Websites

The website of APA's Division of International Psychology (Division 52) is good (<http://www.apa.org/division52>), as is APA's Office of International Affairs (<http://www.apa.org/international/index.aspx>). The APA Office publishes a newsletter (see above) and maintains a directory of more than 80 national psychological associations from Afghanistan to Zimbabwe, including e-mail address, phone or fax, mailing address, and contact person where known. It also has a directory of dozens of international and regional associations. The APA Office also maintains a calendar of international conventions and meetings. Other useful websites include the International Association of Applied Psychology, (<http://www.iaapsy.org/>); International Council of Psychologists (<http://icpweb.org/>); Interamerican Society of Psychologists (<http://www.sipsych.org/english/home.htm>); and European Federation of Psychologists' Associations (<http://www.efpa.eu/>).

International Psychological Associations

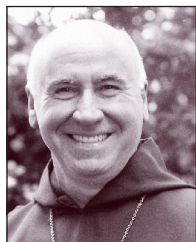
- **The International Association of Applied Psychology (IAAP)**, which has a convention in a different country every 4 years, showcases some of the best ideas and work from around the world. Annual member dues are \$60 (\$10 for students), for which you receive a journal (print and online) and a newsletter. IAAP comprises 17 divisions, including the Division of Psychological Assessment and Evaluation, Division of Clinical and Community Psychology, and Division of Health Psychology. Their conferences are a superb way of learning about psychology in other countries and meeting international colleagues.
- **International Council of Psychologists (ICP)**, meets every year in a different country. It publishes a newsletter (see above). Its annual dues for U.S. residents are \$115. It has a very welcoming conference with a breadth of other nations represented. ICP has a unique voluntary program of members offering free accommodation in their homes for foreign ICP members travelling in their country.
- **Interamerican Society of Psychology (SIP)**. SIP meets every two years in a different country in our hemisphere. In 2011, it will meet in Colombia. Last year it met in Guatemala. Annual dues for U.S. residents are \$75 (students \$40), which includes its journal (see above).
- **APA's Division of International Psychology (Div. 52)**. If you are an APA member, it will cost \$30 to join Div. 52 (students \$15). You can join as a non-APA member for \$28. Division 52 puts on a fine international program at the annual APA

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Psychology in Asia: A Personal Perspective

Brother Bernard Seif, SMC, Ed.D., DNM



Brother Bernard Seif

When Western people think about the clinical practice of psychology, or about coursework in psychology, their thoughts typically range from the research and theories of Skinner's behaviorism to Freud's psychoanalytic model and all the ground between. While Asia may have been introduced to psychology through Western models, Eastern cultures have added their influences. Having traveled to many parts of Asia over the last 20 years, most of what I will write about will be drawn from personal observations and experiences. The rich and varied ancient Asian countries and cultures have their own unique flavors, but since most of my visits to Asia have been to Hong Kong and Mainland China, I will allow those regions to inform my thoughts.

Mainland China introduced psychology to its vast population in the early 1900s through Chinese students who studied with Western educators such as experimental psychologist Wilhelm Wundt. By the 1960s, psychological approaches deemed antiquated or useless were discarded in favor of programs viewed as practical and helpful for the development of the people and the country. During the Cultural Revolution (1966-1979), psychology fell out of favor, but was revived after that era. Today it is taught in many Chinese universities (Chinese Embassy website, 2004).

Hong Kong, controlled by the British for a century and a half (1842 to 1997), has been more deeply influenced by Western culture than Mainland China. Psychology is taught and practiced there, and the Hong Kong Psychological Society offers a professional registration to psychological practitioners, much like the professional credentialing offered in the United States before licensure laws were adopted.

In 1999, I was invited to give several workshops to mental health professionals in Hong Kong. Most who attended were social workers, the apparent majority among mental health professionals in Asia. China struggles with a serious addiction problem, much of it manifested as gambling. This behavior may be underpinned by the Asian emphasis on luck, chance, and fate. A second powerful cultural influence, "saving face," complicated intervention for the first: Trying to introduce the twelve-step program of self-disclosure within a group was a real struggle for me. One does not embarrass anyone else or let oneself be embarrassed – that is "losing face." This aspect of Chinese culture militates against self-disclosure, therapeutic or otherwise, which is difficult enough even without an injunction.

There is also a strong interdependent bond, a kind of social reserve, among Asian groups. For example, it would be unusual for a group of friends or relatives walking down a street to interact with others who are not part of their group. Also, if the members of the group need to buy tickets for a bus or a movie, for example, everyone in the group gives money and instructions to one person, who then purchases the tickets as the group representative.

While many Asians are bright and well educated in Western subjects including modern psychology, an ancient Asian psychology is also deeply embedded in the culture, of which saving face and group interdependence are but two examples. Western psychology has its unique philosophical roots, as does Asian psychology. These foundational Asian philosophies are drawn from Confucianism, with its strong emphasis on filial piety, Taoism, and Buddhism, and they pervade the Asian psyche and profoundly affect the way one treats other people (Tien-Lun Sun, 2008).

Traditional (as well as pre-Cultural Revolution classical) Chinese medicine does not split soma and psyche the way Western science does. Hence specific positive and negative emotions are

linked to specific organs, e.g., liver and gall bladder are associated with anger or kindness. While a modern holistic practitioner might easily delight in such a view, Chinese understanding of the self is far broader than Western notions:

In attempting to gain an understanding of Chinese emotions, it would be pertinent to bear in mind that the Chinese culture is characterized by its collectivistic nature, authority-orientation, and other-orientation. The Chinese construal of self tends to be interdependent, and therefore the cognitive appraisal of events, the vocal and facial expressions of emotions, the emotional behavior, and the role of cognitive mediators must be considered within a *relational* context (Tien-Lun Sun, p. 175). (*italics added*)

One must understand the Asian view and experience of emotion in order to do good psychological research and/or psychotherapy there. The same holds true for bodily health: "From the physiological point of view, it is clearly stated in *The Yellow Emperor's Classic of Internal Medicine* that emotional excess is injurious to one's physical health" (Tien-Lun Sun, p. 175).

The discipline of psychology in Asia, if Hong Kong and Mainland China can be used as a measuring stick, is clearly making progress. Barriers to cross-cultural East-West experiences in psychology not only include the need to learn Mandarin, Cantonese, or another of the smaller but myriad dialects; the psyche of an entire people needs to be understood, which is perhaps an even greater task. One might view the union of Eastern and Western cultures as like the two hemispheres of one brain, each necessary to the whole.

Psychologist John Banmen's work with immigrant Asians in Vancouver, as well as in a number of Asian countries, provides an excellent example of East-West bridging through the discipline of psychology. He builds upon Virginia Satir's family therapy model and offers Asians on both sides of the Pacific Ocean a way to

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A Taste of Psychology in South America

Jacqueline B. Sallade, Ed.D.



Dr. Jacqueline B. Sallade

When I visited South America last February, I interviewed an Argentine psychiatrist friend of a friend, who offered the insight that psychoanalysis ruled

among the approaches employed by mental health practitioners there. Her confidence in that assertion was so definite that I was intrigued. What about cognitive approaches? Behavioral techniques? Other therapies? And, of course, South America is so big and diverse that it is impossible to generalize. So, with the help of my colleague Dr. Juris Draguns, of cross-cultural psychology fame, I looked at some literature and sampled a few professors and clinicians with first-hand knowledge of a few countries in South America, and we came up with the following observations.

First, although psychology has been around in South American countries such as Argentina since the end of the 19th century, it has not been recognized as a full-fledged and respected profession until the 1950s or, in Brazil, the 1960s. Relatively few doctoral-level psychologists are found in South America. Most have only 5 years of university training, the equivalent of a master's degree. These psychologists have done some sort of internship or apprenticeship, its length varying by country: in Brazil, 2 years, and elsewhere, 1 to 2. Licensure is granted after graduation or after internship. Journals, ethical laws and regulations, and associations are modeled on ours or on those of our European counterparts. Most South American psychology uses the U.S. as its main model, but Argentina has been heavily influenced by French and Spanish psychology, and Venezuela by Swiss and British psychology.

Many psychologists have been educated in the U.S. or Europe and read English-language journals as well as their own. The majority of South American psychologists are middle- and

upper-class urban women. Psychology is seen, especially in Brazil, as primarily a women's profession. Psychologists are relatively well paid – though not by our standards – and highly respected. In Brazil, the average clinical psychologist's salary in an agency averages \$10-\$20 per hour.

Brazil is a fairly chauvinistic culture and its psychological materials are limited and unsophisticated, but what it lacks in hard knowledge, it makes up for with an open, friendly, social attitude that defies textbook theories and results in informal, warm clinical work. The clinical psychologist in Brazil functions as a loving guide, intuitively using all her skills and understanding of the early influences and development of a person, and often “wings it” in terms of what happens in the session, rather than adhering to classical psychoanalytical structure. Music therapy and guided imagery, often combined, are popular in special educational and psychiatric institutions. Also, besides psychoanalysis, Brazilian psychologists look at people with a biopsychological perspective, too.

In South America, psychometrics are especially employed in educational and school psychology, just as in the U.S. In Argentina, political regimes skeptical of psychoanalysis accepted psychometrics well, and they remain a tool of guidance clinics and schools. In fact, in Uruguay, psychology grew out of its first association with special education, including related psychometrics, in the 1960s, and later incorporated psychodrama into its common clinical procedures.

Colombia maintains a close relationship with the U.S. and Europe, and places psychologists in hospitals, clinics, the military, and schools. There are proportionally more Ph.D. psychologists there than in other South American countries, and many of them have been educated in the U.S. However, Colombian psychologists are particularly careful to take into account the variety of native cultures, including priests and shamans, and their mores, customs, family structures, rituals and beliefs. In fact, in South America,

each country has its ethnicities, races, and cultures, too, which psychologists recognize. For example, in Colombia, psychologists integrate music therapy into clinical practice, using aboriginal influences along with humanistic and transpersonal approaches, especially for drug addicts and chronic schizophrenics, diverting from the still predominant analytic methods (Dos Santos, 2005).

Argentina is a little different from the rest of South America. The psychology literature is older there and mostly in Spanish, starting with data from late 19th century experimental labs. In the 1980s, psychologists and psychiatrists were finally allowed to practice psychotherapy. However, officially psychologists still “assisted” psychiatrists and other physicians until recently, when their reputation and independence grew exponentially. Now, psychologists are licensed and have expanded their roles: more than 90% are in clinical practice, including in the schools. The primary approach remains psychoanalysis, including play therapy with children, though neuroscience is gaining respect, too. Music therapy and psychodrama are also practiced, mainly in institutions. Cognitive methods exist mostly to do brief, economical therapy, especially with phobias, panic disorder, and OCD. However, as in many countries worldwide, the poor are underserved in Argentina (Guterman-Erich, 2009).

Chile patterns itself after Argentina, perhaps because it has undergone similar periods of dictatorship followed by democracy. Although psychoanalysis dominates, and all therapies are interpreted through that lens, there is some variety, though not well funded, including music therapy with brain-injured or geriatric patients. However, perhaps the most respect for creative psychotherapy, such as music and art therapies, happens in Peru. It will be interesting to see what forms psychology takes and what other perspectives gain popularity in South America over the next decade (Fish, 1996).

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Doctor-Patient Relationships Around the World

Jeffrey L. Sternlieb, Ph.D., jsternlieb@comcast.net



Dr. Jeffrey L. Sternlieb

There seemed to be, at least to me, a mystique to doing work on an international stage. It was foreign (literally and figuratively), exotic, and mysterious. I imagined that the level or quality of work needed to be superior to what I did here in Pennsylvania, and confronted professional unknowns and uncertainties. One thing *did* become certain: under such circumstances, I came face to face with myself, learned a lot, and have had great opportunities to grow and to expand my horizons.

For me, being involved internationally started out as anything but a journey: I was sent to a training program by my employer to learn skills in leading a particular type of group process called “Balint,” designed to help family medicine residents to better understand their most challenging patient interactions (Balint, 1957). I didn’t expect to become fascinated by the process and stimulated to learn more. Although at first I couldn’t imagine attending more than one of these trainings, I realized quickly that there was so much more to learn. Before I knew it, I had attended two more intense experiential trainings, entered a credentialing process, chosen a supervisor, and begun videotaping my groups – the ideal way to learn from one’s experience.

What was so appealing to me was being able to explore doctor-patient relationships in a group environment safe from emotional intrusion and the competition that often occurs in groups. Balint treats all relationships as sacred, and hence worthy of respectful consideration regardless of diagnosis. The focus is the emotional experience and needs of both individuals, and the process builds respectful relationships among group members over time. It considers the universal experiences of two people meeting: one wounded and seeking help, the other also wounded, but in different

ways, and the goal of creating a healing experience.

What followed still amazes me. In a matter of a few short years, I was invited to join the governing council of the American Balint Society, encouraged to write about my experiences of the process, and then invited to present these ideas to a gathering of the International Balint Federation’s board. While I was nervous about my presentation, having spent a little time in a small group of family doctors from Holland, Denmark, and Germany, presenting and discussing challenging patient cases, helped ease my entry into this larger group of people who spoke German, Dutch, Spanish, Portuguese, Swedish, Finnish, French, Romanian, Hebrew, and Danish. And, oh, by the way, they all spoke English! What a wake up call! I felt so humbled and inadequate, not because of a lack of intellect or psychological knowledge about relationships, but because I had to confront my entitlement: All of these professionals were speaking my language, and I didn’t have to learn theirs. I didn’t create this situation, but I participate in it. I feel a sense of indebtedness: By some quirk of history, English is the lingua franca, and I am a beneficiary to something I did not earn. I have written before about white privilege (Sternlieb, 2005); this is American privilege.

I have now attended three International Balint Federation (IBF) events: in Chicago, where I was invited to present a paper; in Romania in September 2009, to attend the 16th International Balint Congress after a paper I submitted was accepted for presentation and publication in the proceedings; and most recently a Balint Weekend (of Renewal and Reflection) in Oxford, U.K. In Oxford, I was asked to co-lead a group with a physician from the U.K. In our group were three physicians-in-training from Iceland, a psychiatrist from Denmark, a physician from Germany, one from Ireland, and two British family physicians. Working on the challenges of healing relationships on an international stage is no longer exotic or mysterious.

The challenges of doctor-patient relationships are universal. While it is cool to have international presentations and publications on my résumé, the real bonuses are working on issues that transcend territorial differences, exploring them authentically, discovering different cultures where life is lived very differently from the privileged ways I have become accustomed to, and developing relationships with like-minded people whose work complements, challenges, and expands my own.

One of the most moving experiences I have had in this international work occurred at the end of the Balint Congress in Romania. Unbeknownst to me, there is a tradition at alternate-year Congresses that representatives from each country perform a song representing their country or culture. Our table of U.S. attendees was neither enthusiastic about singing nor unanimous about what to sing if we were somehow coaxed into participating. Every other country had already performed spiritedly. Reluctantly, we rose together – eight of us, many first timers – and, led by a fearless osteopath from Sebastapol, CA, stood front and center. Our fearless leader then told the transformational story behind the writing of “Amazing Grace,” and we launched into its verses. Before we knew it, the entire Congress of more than 165 people, moved by the story, rose spontaneously to stand arm in arm in an enormous circle, singing the chorus with us and sharing a unifying moment that brought tears to my eyes! I cannot imagine this occurring at my other professional conventions.

In closing, I’d like to issue an announcement and invitation: The 17th International Balint Congress will be held September 7-11, 2011, in PHILADELPHIA! This is the first time since 1994 that this event will be held in our country. The theme is “The Heart of Patient-Centered Care,” and the call for papers is on the website of the IBF and the website of the Congress. Regardless of whether you

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Out of Danger, Into Displacement: Seeking Refuge in the U.S.

Takako Suzuki, Ph.D.



Dr. Takako Suzuki

According to the United Nations High Commissioner's Global Trends Report on Refugees (2010), 43.3 million people worldwide were displaced

forcibly due to socio-political/economic instabilities and natural disasters in 2009 alone. Of these, 15.2 million are refugees, nearly a million are asylum seekers, and 27.1 million are internally displaced (those forced to flee their homes who remain within their country's borders). These numbers are growing.

Sudden displacement engenders uncertainty and danger. Many refugees have been tortured (Bemak, Chung, & Pedersen, 2003). They need relief, but instead spend months — and sometimes years — in camps before they are resettled. Poverty, health problems, and lack of personal dignity accompany their wait for safe haven in a new land (*Refugee Journey*, 2010).

In 2009, of the 112,400 refugees resettled in 19 countries, 79,900 entered this one. Additionally, the U.S. received 250,000 asylum applications between 2005 and 2009 (UNHCR, 2009). Asylum seekers are those seeking international protection whose status has not yet been determined. Twenty-seven percent of asylum seekers are children. Single men constitute the large majority of those seeking protection in the industrialized world.

Host countries protect those who do not return to their homelands due to threat of persecution and other human rights violations, and determine their eligibility for refugee status. During this process, mental health professionals often assess psychological effects of torture, prepare affidavits for the asylum process, and provide written documentation for submission to immigration courts (Gangsei & Deutsch, 2007). Asylum-seekers claiming to be torture survivors must disclose in detail their experiences

of torture and its devastating consequences. Although extremely difficult for most torture survivors, who would prefer never to speak of their trauma, Gangsei and Deutsch assert that full disclosure of experiences and feelings is necessary not only for assessment but for healing.

When refugees are granted a stay in a new land, they must adjust to profound changes to adapt to the culture of their strange, new countries (see Pre/Post Arrival Checklist). This would be challenging for anyone, but displaced people have already endured many losses: community, loved ones, social status, self-esteem, loss of parental authority, familial structure and control, and cultural identity.

Adult male refugees often lose traditional provider roles, authority, and respect because they are underemployed. Professionals may take menial jobs. Women may have to take jobs, challenging their traditional gender roles and status. Such changes often result in marital conflict and altered family dynamics. One common consequence is "increase[d] risk of domestic violence as men attempt to reestablish their authority and power" (Sue & Sue, 2008). These issues differ from those of other immigrants because "the cultural dynamics as well as the sociopolitical and historical backgrounds of various refugee groups present unique characteristics... traceable to respective cultures of origin and culture of resettlement" (Bemak et al., 2003, p. 2). Clinicians must understand that, unlike other immigrants, refugees migrate involuntarily and are far more likely to have experienced severe pre-migration trauma.

As a result of these differences, refugees are particularly vulnerable to depression, anxiety, post-traumatic stress disorder, somatization, and suicide (e.g., Bemak et al., 2003). Older refugees, sexually assaulted women, and youth who witnessed or participated in violence are at high risk for mental health disorders. Many refugees have serious health

concerns linked to traumatic escape and refugee camp stresses, including malnutrition, hearing loss, diarrhea, dental degeneration, TB, meningitis, sexual dysfunction, hepatitis, neurological dysfunction, or HIV/AIDS.

Pennsylvania is home to many displaced people. Refugees from more than 30 countries have resettled to this state in recent decades. In the six months between October 2009 and April 2010 alone, 1,684 refugees arrived here (<http://www.refugeesinpa.org/RefugeeResettlementProgram/CurrentStats.html>).

Chiny Ky, a Cambodian genocide survivor who lived for 4 years as a Khmer Rouge captive and slave, then in refugee camps for a year in Thailand before arriving in the United States in 1980 to resettle in Philadelphia, shares his observations.

Cambodian refugees' challenges begin with new living arrangements. Inner-city homes with several locks on their doors represent a world completely alien from traditional village life. Cambodian food, climate, language, and culture all differ from that of Philadelphia. Refugees must find a means to make a living. Chiny managed to get into higher education, becoming a math teacher. He then became a liaison for Cambodian refugee children, helping them stay in school and learn Cambodian culture. He refers sadly to the many "lost" Cambodian children who drop out of school and join gangs, seeking group identity and safety. Chiny notes that in refugee families, little communication can occur between children and parents who work long hours, often at more than one job. Children raise themselves, learning the language of the new culture, while parents continue in their native tongue. In the absence of contact and communication, misunderstanding and disrespect are common in intergenerational relationships. Parents avoid discussing their traumatic pasts, believing others cannot understand (Gangsei & Deutsch, 2007); children fail to care. No foundation

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Character and Characters in Yiddish

Edward Zuckerman, Ph.D.



Dr. Edward Zuckerman

Some commonly used words are originally Yiddish and kept their meanings when adopted into English: kosher, nosh, bagel, and non-food words like chutzpah, kibitz, and schlep. Yiddish is widely seen as a dialect of German but with large numbers of words of Russian, Lithuanian, Slovakian, Polish, and Hebrew origin. It is a trove of descriptors for variations among individuals, but just as Yiddish is disappearing, so too may these types be fading from linguistic distinction, so below I've offered some examples. This is not a list about disorders or psychopathology, or about Jews as persons, although it reflects the experiences of European Jews. Neither is this a companion to DSM-IV's Axis II or its list of "culture-bound syndromes"). It is not about pathology at all, only about human variety and a culture whose skill at naming may have shaped and been shaped by its survival.

Relevant theory

The Sapir-Whorf Hypothesis argues that a culture's experience shapes its language and that the language in turn shapes its users' perceptions and experience. For example, according to urban legend, Eskimos (the proper term "Inuit" was not used here) had 25 words for snow but we, of temperate climes, had only a few because Eskimos needed such differentiations to survive and we did not. A more current formulation, based on accurate data, suggests that while the availability of terms and concepts does certainly assist some perceptions, it is not exclusive. We can make discernments beyond the ones offered by our familiar terms. Yet, some meaning must be lost because words are embedded in a culture that cannot be transmitted. Despite these limitations, the following personality names are offered to enrich readers' perceptual range. The list and definitions are lightly adapted from Leo Rosten's delightful *Joys of Yiddish*.

First, Jews admire certain traits. For example, a chochem (KHAW-khem) is a clever, wise, and learned person. A maven (MAY-vin) is an expert, a good judge, a connoisseur. Those held in high regard, of impeccable repute, and large responsibility are called balbatim (bol-BOT-im) because they are quiet, respectable, and well mannered. Of note, there is a special word for a woman of remarkable energy, talent, and competence, who gets a lot done, swiftly and well: a berye (BERR-yeh).


A philosophical bent of the Jewish spirit is the extensive use of irony: words of praise can be used sarcastically to convey their opposite. For example, a bandit or bonditt (bon-DITT) is clever and resourceful, so clever that he or she is beguiling, and by extension, can be mischievous. The word for thief, ganef (GON-iff), is also applied to a tricky person, a prankster, and then, by extension, to an ingenious child. Like a maven, a bal-malocha (bahl-m'LUK-kheh) is an expert but is also used sarcastically for the mal-adroit and inexperienced. Technically, kokhlefl (KOKH-lef-fl) is a long, wooden cooking spoon. Because it sticks its nose in and stirs the pot, those who are busybodies, or who butt in are thus labeled. It can also have a positive connotation as a live wire, go-getter, organizer, promoter, or activist who "stirs things up" and, by extension, can be applied to a bright, energetic toddler.

Jews greatly value learning and especially book learning. A chochem must be clever and wise but also a learned person. Gaon (GUY-awn), technically the head of a Talmudic academy, also means a genius. Some limitations of this kind of learning are also recognized: The word for a Lithuanian Jew, Litvak (LIT-vok), values erudition but implies some pedantry. Litvaks are seen as learned, but also skeptical, shrewd, and clever (of course this is to the eye of a Galitzianer, a Jew from Galicia). In distinction, a batlen (BOT-l'n) is without a trade or livelihood, and is seen as lazy for being unemployed. But he could be so because he is a misfit with intellectual pretensions and half-baked ideas. He is related to the luftmensch

(LOOFT-mensch; literally, "air man") whose head is in the clouds. They are impractical but optimistic, dreamy, sensitive, and poetic who, when they work, do so *ad libitum*. At the other end are those who have succeeded, the *nouveau riche* who are called, in mixed Yiddish and English or "Yinglish," alrightniks. The word balebos (bol-eh-BAWSS) means the head of a house and, by extension, the owner of business, a manager, even an authority. Others who succeed are makher (MOKH-ers), influential people connected to the power structure who can make things happen. Jews are obligated to charity and have many social organizations to carry out this work. Makher would also describe a leader in such an organization. However the possibility of disappointment and loss is ever-present in Jewish culture, so one must be on guard against the k'nacker (K'NOK-r), a big shot who shows off, boasts and is cocky; the bluffer (BLUFF-er) who bluffs, deceives, or exaggerates with hot air and hyperbole; and his 'relative' the fayfer or fifer (FIE-fer) who brags in a loud, shrill, and aggressive or ill-mannered way.

Some cautions

This essay into language psychology and history is greatly diminished because I am not a Yiddish speaker and have to depend on the writings of Leo Rosten (*The Joys of Yiddish*, *The New Joys of Yiddish*) and Michael Wex (*Born to Kvetch*), both delightful reads. I have found hundreds of words and offer only a few here.

Finally, dear reader, please consider this essay an invitation: Share with all of us what your language offers about character and characters. 

Resources

- Pullum, G. (1991). *The great Eskimo vocabulary hoax and other irreverent essays on the study of language*. Chicago: University of Chicago Press.
- Rosten, L. (1968). *The joys of Yiddish*. New York: Crown.
- Wex, M. (2006). *Born to kvetch: Yiddish language and culture in all of its moods*. New York: Harper Perennial.

GATEWAYS AND GETAWAYS...

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Convention, and has a useful newsletter (see above), announce-only listserv, and a website (see above).

National Psychological Associations

Dozens of countries have their own national psychological associations that host annual conventions. As mentioned above, the APA Office of International Affairs maintains a list of these associations.

Frank Farley was born and raised in Canada, and received a Ph.D. from the Institute of Psychiatry, University of London, England. He is L.H. Carnell Professor at Temple University, Philadelphia. He is a former president of APA, as well as its Division of International Psychology (Div. 52), former president of the International Council of Psychologists and the International Facet Theory Association, former member of the National Research Council/National Academy of Sciences, U.S. National Committee for the International Union of Psychological Sciences, former Board Member of the International Society for the Study of Individual Differences, and is currently U.S. National Representative to the Interamerican Society of Psychology. 📧

PSYCHOLOGY IN ASIA...

Continued from page 11

develop healthier nuclear and extended family relationships (Banmen, 2007).

Asia and America have much to offer one another. An attitude of sharing and mutual respect, values which lie at the heart of psychology, is perhaps the most important ingredient for empowering all people of good will. Psychology has much to offer both East and West. 📧

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A TASTE OF PSYCHOLOGY...

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DOCTOR-PATIENT RELATIONSHIPS...

Continued from page 13

submit a paper, this will be a wonderful opportunity to get to know like-minded professionals from around the world. You will not only hear a plenary and papers being presented, but you can also participate in a Balint group and present a case of your own if you wish. This conference may offer the same intimacy we experience in our small groups as well as the opportunity to begin your own exploration of our work on an international stage. 📧

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OUT OF DANGER...

Continued from page 14

exists for children's cultural and personal identity.

Racial tension among Black and South Asian high school students pervades South Philadelphia High School and its community. It is this author's opinion that these noxious relationships were spawned and exacerbated largely due to lack of parental involvement in schooling. The school system did little to address conflicts until they became riotous and public. Chiny worries that adults are alienated and turn to gambling and alcohol use to ease homesickness and lack of control in the family. To reintegrate, Chiny believes that these adults must discuss memories

of their past lives. By doing so, he believes these survivors could transcend their hardships and take pride in their resilience, lending support and sharing an emerging identity and positive view of a new future for themselves and their children. Chiny attributes a healthy relationship with his daughter, now in college, to communicating about his past. A regular guest speaker in the author's diversity class, Chiny says the more he talks about his experiences, the more he feels healed and whole.

What can psychologists do? Psychologists can volunteer to assess asylum seekers. We can get training to treat refugee populations and assist through local refugee resettlement agencies. We can teach English to older refugees and listen to their stories. We can earn their trust, infuse personal pride, and promote constructive communication in their families and community. We can do all of these things, if only we will. And in doing so, we can learn from these courageous people, and share with them our own appreciation of their remarkable resilience. 📧

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From “Seeing” to “Treating”

Esmael Darman, Graduate Student, Chestnut Hill College



Esmael Darman

Dozens of women, men, and children line both sides of the corridor, waiting for a general practitioner. Some adults complain of fever, lack of appetite, stomachache, high blood pressure, cough, or diarrhea. However, the complaints of others are vague: headache every now and then, back pain without any history of trauma or bone disease, pounding heart, sensitivity to crowds and noise, hot flashes, and so forth. This population appears in most medical clinics run either by the government or non-governmental organizations in Afghanistan. Some even show up in hospital emergency rooms. And what are they prescribed? Usually analgesics such as ibuprofen or acetaminophen, known there as “paracetamol,” for a week or two. And what happens? These patients show up again and again with similar symptoms.

More than 3 decades of war has shattered the infrastructures of Afghanistan, among them the health system. Many health care professionals have left the country; others struggle to get by in inadequate facilities with severely limited resources. War has hobbled the younger generation’s efforts to acquire higher education and improve life. The result: Afghanistan needs thousands of doctors to address the demand of an increasing young population as well as its returning refugees and internally displaced persons. And when it comes to mental health, the situation is even worse. There are too few psychiatrists and psychologists, and the latter actually have only a bachelor’s degree in psychology and are not trained in clinical work.

The majority of public clinics offer basic medical services by one doctor and a couple of nurses during the day, so the workload is high. Beyond their walls, too few health care professionals with too few resources struggle to address the increasing demands. Recent statistics (BBC World Service, Persian, 2010)

indicate that more than 60 percent of Afghans suffer from “mental problems” — unsurprising, given all the traumas and challenges the people have been through so far, when even in a post-industrial economy like Japan, the cost of suicides and depression have been estimated at \$32 billion in the past year (BBC World Service, 2010). Afghanistan’s capital, Kabul, is served by only one psychiatric hospital and a few government, private, and semi-private clinics. Other major cities also lack facilities. This highlights the dire need for facilities and for training as many mental health professionals as possible, a considerable commitment of time and money. However, a less costly intervention may also help.


The more clients, the less the time one has to spend with them individually, which affects quality of treatment. Afghans’ cultural, historical, and individual pride may account for their impatience with learning and expecting others to value them appropriately. This, added to the time pressures on medical personnel, can increase frustration and burnout, further alienating doctors from patients and causing more misunderstanding and misdiagnosis, particularly with patients who suffer from a mental disorder. Is there a way to minimize the miscommunication and streamline the workload? I believe there is: Improve the quality of doctor-patient relationships. Psychologists and physicians in other cultures may understand the benefit of rapport on patients having a medical condition or a mental disorder or both, but Afghan health care professionals lack training in developing and maintaining professional relationships with patients beyond a brief review of the Hippocratic Oath.

Described by Steward and Gilbert (2005), improving the doctor-patient relationship requires effectively engaging at both the cognitive level (the doctor will learn more about the patient), and the emotional level (the doctor will feel the patient’s pain and suffering). In terms of time spent with each patient, this change would be front-loaded: While it might initially mean spending more time

More than 3 decades of war has shattered the infrastructures of Afghanistan, among them the health system.

actively listening to each patient, it permits the professional to distinguish those with possible mental disorders from those with a medical condition so the former can be referred to a mental health center for appropriate treatment.

A high percentage of those who seek treatment in medical clinics in other countries have a psychological disorder. Afghanistan is no exception. Because mental disorders are strongly stigmatized there, Afghans may not seek treatment at all, or if they do, medical clinics may be the first place they turn to. As a result, physicians at these clinics are most likely to be the “front line” for mental health patients, and their referral authority may undercut the stigma of going first to a mental health clinic.

Were the doctor-patient relationship to be improved, Afghan physicians could interrupt the cycle of vague somatic complaints obscuring a mental health issue and being treated by an unending round of analgesic prescriptions; treatment would be improved; and physicians would be freer to treat acute and chronic medical diseases. A nation traumatized by conflict and serious challenges needs comfort and care as a cornerstone for its treatment. 

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Thanks to Our Members Who Help to Make Psychology a Household Word

Marti Evans, APA Public Education Campaign Coordinator for Pennsylvania

The vision of the American Psychological Association's current Public Education Campaign focus, *For a Healthy Mind and Body...Talk to a Psychologist*, is to help the public recognize the health benefits of caring for both mind and body. Recent studies and media reports conducted by APA have shown that more people than ever realize that physical health and mental health are intertwined and that psychologists are at the forefront of this public awareness.

More and more PPA members have become active in our Public Education Campaign and have let us know about their outreach activities to the public. We thank them for helping to "make psychology a household word" in Pennsylvania.

During the 2010 Annual Convention, a series of 14 free mind-body health workshops for the public were held on June 16 and 17 at the Hilton Harrisburg. The workshop presenters included:

Stephanie Dobroski, Tanisha Drummond, Alison Paules, Cathy Petchel, Julia Rovinsky, Diane Snyder, and Drs. Judith Blau, Melinda Brown, Judith Coché, Michael Crabtree, Kaila Dickstein, Ann Durshaw, Barbara Golden, Vincent Morello, Gerald O'Brien, David Palmiter, Robert Reed, and Dea Silbertrust.

The members of the E-Newsletter Committee continue to make psychology a household word by publishing PPA's free quarterly electronic newsletter for the public, "Psychological News You Can Use." Pennsylvania is the only state psychological association with an e-newsletter for the public. **Lt. Col. John Dowling (USAR), and Drs. Aaron Brinen, Beatrice Chakraborty, Michael Crabtree, B. Janet Hibbs, David Leaman, Marolyn Morford, Carol Salacka, Pauline Wallin, and David Yusko** contributed articles for the June and September 2010 issues. The e-newsletter editor is **Dorothy Ashman.**

Dr. David Rogers has coordinated interviews this year with PPA members on *WITF Smart Talk Radio* in Harrisburg: **Drs. Jay Carter** (May 12 on Bipolar Disorder), **Theresa Kovacs** (June 24 on summer vacation and family stress), and **David Palmiter** (September 9 on suicide prevention).

Dr. Hue-Sun Ahn organized a Mental Health Screening Day (depression, bipolar, GAD, PTSD, eating disorders, alcohol abuse) on the campus of the College of New Jersey on October 7. They had 19 people attend in person and over 290 completed the online screenings from the college's website.

In May, **Dr. Judith Blau** presented "Is This Relationship Good for Me?" to 40 people at Delaware Valley College in Doylestown.

Dr. Helen Coons discussed "Behind the Bedroom Door: Sex and Intimacy Uncovered" on April 22 with 40 participants of the Living Beyond Breast Cancer group in Conshohocken.

Harrisburg-area child psychologist, **Melinda Eash**, was interviewed by *WHP-TV Channel 21* in Harrisburg in May on "Discipline vs. Child Abuse."

Bala Cynwyd psychologist, **Dr. Jonathan Grayson**, was interviewed for an article in the *Body and Mind* section of the *Patriot-News*, "OCD: Anxiety Controls Lives of Sufferers," on June 6.

Dr. Mark Hogue was interviewed by *WSEE-TV Channel 35* in Erie on April 29 on behavioral issues following concussions.

Dr. Pater Langman, KidsPeace Director of Psychology, has been interviewed more than 100 times by newspapers, and radio and television stations on numerous child and adolescent issues, including "Why Kids Kill: Inside the Minds of School Shooters" which is also the title of his new book published

in 2009. On September 30 he was interviewed by *WDIY Radio* in Bethlehem on suicide prevention and by *CBS-TV* in Grand Rapids, Michigan, on March 25 on why kids kill.

Lancaster-area psychologists, **Kim Rosenberg** and **Dr. Nicholas Martino Jr.**, were interviewed for an article, "Divorce Is Contagious," in the *Lancaster New Era* on July 25.

We are very grateful for the efforts of all PPA members who do an interview or presentation, or produce written work that educates the public about psychological issues and services psychologists offer.

Dr. Donald McAleer discussed behaviors exhibited in Alzheimer's and other dementias to 15 family members of residents of Saint Mary's Home of Erie on April 20.

On January 26 during the Early Childhood Educators Conference at Penn State University, **Dr. Marolyn Morford** presented "God, Sex, and Germs: Obsessive Compulsive Disorder in Children."

Dr. Michele Novotni was interviewed by *USA Today* for an article on June 30, "ADHD Kids Must Manage Symptoms When They Get Jobs."

To commemorate National Depression Screening Day on October 7, **Dr. David Palmiter**, chair of PPA's Communications Board, and his psychology students coordinated free mental health screenings for over 200 community members in the Scranton area.

Dr. Steven Pashko presented a series of three 2-hour workshops on October 27, November 3, and November 10. The series was titled "Stages of Meditation" and was held in Havertown with 20 people attending.

Dr. Nicole Quinlan participated in several roundtable discussions on *WKOK Radio* in Danville (August 22 on childhood obesity and July 11 on the effects of the obesity epidemic on adults and children).

In September an article by **Dr. Elaine Rodino** of State College, "Is Your City in the Bedbug Top 10?" was posted on <http://www.rodale.com/getting-rid-bedbugs>.

Dr. David Rogers of Hershey Psychological Services has presented numerous workshops to the Pennsylvania State Police, FBI, and other law enforcement agencies, including "Internet Addiction" on June 8 to 35 state police officers and "Adolescent Needs and Development" on June 14 to 20 state police cadets.

Harrisburg-area psychologist, **Dr. Wayne Schmoyer**, was interviewed for an article in the *Body and Mind* section of the *Patriot-News*, "5 Questions about How to Protect a Child's Self-esteem," on June 6.

Brother Bernard Seif spoke about mind-body meditation on October 15 and 16 to more than 200 participants at the Building Bridges of Integration for Traditional Chinese Medicine Conference in Chantilly, Virginia.

Dr. Matt Shollenberger is the co-producer and co-host of a regular show on *BCTV* (Berks Community Television) in Reading, "Talking Mental Health." He also appeared on a radio show in Dallas, Texas, on May 22 on "The Psychology of Plastic Surgery."

Forty members of the Lower Merion Synagogue in Bala Cynwyd heard **Dr. Katherine Shrager** present "Food, Body Image, and Eating Disorders in the Orthodox Community" on June 22.

Kathryn Vennie of Hawley did a presentation, "Coping with Divorce," to 10 members of the Pennsylvania State Police member assistance team on May 21. She also participated in Wayne Memorial Hospital's Health Partnership Fair with an exhibit on mind-body health on July 30.

Dr. James Vizza of Windber Medical Center did a presentation on September 21 on resilience to 25 members of the support group for laparoscopic banding patients.


Dr. Pauline Wallin writes a column, "on your mind . . . with Pauline Wallin" for the *Body and Mind* magazine published by the *Patriot-News* in Harrisburg six times each year. Recent topics have included, "Strategy of 'Doing' and 'Thinking' Shakes Feelings of Helplessness," "Happiness in Our Appearance," and "Exercise Tones the Mind, Too." A recipient of PPA's Psychology in the Media Award in 2002 and 2005, Dr. Wallin continues to actively reach out to the media nationally and internationally to help make psychology and psychologists a household word.

The founder of Life Counseling Services in Paoli, **Dr. Tom Whiteman**, was featured in an article in the *Philadelphia Inquirer* on July 26 about his faith-based support group for business executives, Convene. The group meets each month for a full day of prayer and faith-based seminars on business issues.

Submissions

If you have done a presentation about psychology and mind-body health to a community or business group, please let us know about it so your activities can be recognized in our next "Thanks to Our Members" article for the June issue of the *Pennsylvania Psychologist*. Kindly send the following information about your presentation(s) to Marti Evans at mevans@PaPsy.org:

- Your name
- Title of your presentation
- Name of the group
- Date of presentation
- Location of presentation (city/state)
- Number of people present

Also, if you have authored a book or CD, have been interviewed by a reporter for a magazine or newspaper article, or a radio or television program, please send us the details! We hope to see **your** name in our next article. 

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- ♦ PPA Online Psychologist Locator – a free listing on www.PaPsy.org – click Psychologist Locator
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- ♦ Ethical/ Legal/Practice Consultation – contact PPA at 717-232-3817
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- ♦ Home study courses, offered to members at a discounted rate – check CE calendar
- ♦ An e-newsletter, "Continuing Education News" – great information for your clients
- ♦ *Membership Directory and Handbook*
- ♦ Act 48 credits submitted to PDE free for member School Psychologists
- ♦ Pennsylvania State Employees Credit Union – call 717-234-8484 or 800-237-7328
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Education in India

Gail R. Karafin, Ed.D., School Psychology Board Chair, gkarafin@yahoo.com



Dr. Gail R. Karafin

In May 2010, I had the great pleasure of visiting India. With a population of 1.17 billion people, India is about one-third the size of the U.S. and is home to more than three times our population.

Despite its relatively small size, India's terrain varies from the Himalayan Mountains to river valleys, port cities, beaches, and deserts in the west. Its population is diverse, comprising more than 2,000 ethnic groups and many religions, according to the U.S. Department of State. There is a variety of languages and dialects, although the official languages are Hindi and English. Politically India is a federal republic of 28 states and multiple political parties.

Education in ancient India was first provided to children of nobility by monastic orders under the supervision of a guru. The curriculum in these schools was generally determined by tasks associated with the social strata or castes of the society: the *Brahmin*, or priest class, studied religion and philosophy; the *Kshatriya*, or warrior class, trained in warfare; the *Vaishya*, or business class, learned trades; and the *Sudra*, or farmer/laborer class, received no formal education. With the arrival of the British and colonialism, the Western system of education was adopted, and a number of primary, secondary, and tertiary schools arose.

Currently, Indian education is regulated by curriculum-governing bodies that oversee public education policies. The majority of Indian children are educated in "government" elementary schools. Primary education serves children from 6 to 14 years of age. Although the government has banned child labor to protect children from unsafe working conditions, education is not compulsory. Even with free education and a ban on child labor, school attendance is inconsistent due to economic disparity and social conditions. In addition, massive gaps in programming, including high student-teacher ratios, shortages of infrastructure, and insufficient teacher training, impede the system.

Secondary education serves students 14-18 years of age. However, only one-third of pupils in that age group attended secondary school in early 2000. The secondary school system focuses on profession-based training to help students attain skills for a vocation.

Because public education has a reputation for poor quality, 27% of Indian children are educated in private schools. Private schools cover all government-required curricula and offer extracurricular activities as well. Pupil-teacher ratios in private schools (1:31) are half those of public (1:63 students). However, private schools are reportedly difficult to open, because multiple licenses are required from a number of Indian authorities, a legality that could take years to achieve.

The wide diversity of languages in India has given rise to the formation of linguistic states that recognize regional languages. In January 2000, India released *The National Curriculum Framework for School Education: A Discussion Document*. It recognized Indian education in three languages: the home language of the region, English, and Hindi. The 1991 Indian Census counted 216 mother tongues, and by combining many mother tongues, 114 languages were derived. Considerable controversy exists in government schools regarding the primary language for instruction. Generally, in grades 1-4, the child's mother tongue is used, and in 5th grade, the student chooses second and third languages. In secondary schools, three languages are compulsory.

India reportedly has 40-80 million people with disabilities, 30% of whom are estimated to be children below the age of 14. According to a UN report on Human Rights, 90% of disabled children in India do not receive any education. The Indian government has promised to include disabled children in its educational programs, ranging from segregation to full inclusion in a mainstream classroom. More than 3,000 special schools exist in India today serving those with hearing, visual, intellectual, and mobility impairments. More than 50,000 children with disabilities are enrolled in the Integrated

Education for Disabled Children, a government sponsored program. Although the government promotes inclusion of children with special needs, the system faces challenges in identifying these children and providing programs for them, especially in rural areas. A large part of the Indian population holds a philosophical belief in "karma," in which disability is considered to be punishment for sins of a previous life.

Corporal punishment, originally adopted from the British, is still practiced in Indian schools, despite much opposition. The Indian government has attempted to ban corporal punishment through India's Right to Education bill, which guarantees universal education and bans corporal punishment. However, this bill has been pending for more than a decade. The Indian Supreme Court ordered a ban on corporal punishment in 2000, but enforcement has been weak and has been implemented in only 17 of the 28 states. Educators say they resort to physical punishments because of the inherent problems of India's public education system, specifically the immense challenge of maintaining control of huge classrooms of unruly children.

Educating women has become a priority in India. Conservative cultural attitudes prevent some girls from attending school. The number of literate Indian women was between 2% and 5% during the British Raj, until the formation of the Republic of India in 1947. Concerted efforts increased female literacy from 15.3% in 1961 to 28.5% in 1981. In 1986 the National Policy on Education restructured education within the social framework of each state, promoting education for girls as necessary for democracy and the improvement of women's condition. By 2001, the literacy rate for women exceeded 50%. Since 1947 the Indian government has provided incentives for girls' attendance, including free meals, books, and uniforms. Many private schools offer free tuition for up to two girls per family. Low attendance has been linked to poverty and dependence on girls for housework and sibling day care. Although the

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Adolescent Suicide: Cultural Considerations for School Psychologists

Catherine Rabadi, B.A., and Marie C. McGrath, Ph.D.

Suicide is now the third most common cause of death among 15- to 24-year-olds in the United States (Goldston et al., 2008). The Pennsylvania Department of Health (2009) reports that 382 children and adolescents between the ages of 10 and 19 committed suicide between 2002 and 2006; however, since these data represent only those child and adolescent deaths officially attributed to suicide on death certificates, rather than to other types of injury, it is likely these numbers underestimate the scope of youth suicide in Pennsylvania.

Research suggests that the rate of suicide attempts varies among ethnic and cultural groups. The Centers for Disease Control and Prevention's 2009 Youth Risk Behavior Surveillance Survey (CDC, 2010), which examined the rates at which respondents attempted suicide in the 12 months prior to data collection, found that adolescents in five self-identified ethnic minority groups attempted suicide at rates above the overall attempt rate of 6.3% (American Indian or Alaska Native, 10.0%; Black or African American, 7.9%; Hispanic or Latino, 8.1%; Native Hawaiian or Other Pacific Islander, 11.9%; and Multiple Race, 12.4%); only Asian American (4.0%) and White/Non-Hispanic (5.0%) respondents reported attempt rates below the overall rate.

Culture-Specific Risk and Protective Factors

Research examining adolescent suicidality has identified a number of risk factors for suicide, including previous suicide attempts by adolescents or their family members, friends, or acquaintances; mental health or substance abuse issues; family dysfunction and/or abuse; social difficulties; and sexual orientation-related stressors. However, relatively few studies have examined specific ways in which racial and ethnic factors may also impact risk. Goldston et al. (2008) hypothesized that differences in rates of suicidality and suicidal ideation among racial and ethnic groups may be due to differences in risk and protective factors, help-seeking behaviors, and/or cultural contexts across



Catherine Rabadi



Dr. Marie C. McGrath

those groups. Specific risk factors reported by Goldston et al. that may disproportionately or differentially affect racially and ethnically diverse populations include the following:

- Racism or discrimination may lead to hopelessness, increased substance abuse, and depression, all of which increase an individual's risk for suicide.
- Social and environmental factors that lead to higher rates of poverty for an ethnically or racially diverse group (e.g., lack of educational or employment opportunities) than for the population at large may be associated with increased mental health difficulties, as well as reduced availability of family, social, and professional support.
- Acculturative stress, experienced by individuals attempting to balance their own racial or ethnic minority identity and values with those of the majority group, is associated with higher levels of depression and lower levels of self-esteem in adolescents. Acculturative stress can be experienced by individuals born into racial or ethnic minority communities within the United States, as well as by those who emigrate from other countries.
- Fear of "losing face" or difficulty meeting family expectations can cause individuals to experience high levels of emotional distress following failures that may seem relatively trivial or insignificant to those from cultural backgrounds that place less value on these concepts.
- Stigma associated with the use of medical models of healing in general, or with mental health treatment in particular, may prevent adolescents

and/or their parents from seeking professional help.

Goldston et al. also identified several protective factors that may differentially impact racially and ethnically diverse populations:

- Religiosity, or the extent to which one holds religious beliefs and/or participates in religious practices, is generally thought to be a protective factor for suicide. Most faith traditions discourage suicide; additionally, levels of connection to, and social support received from, church communities appear to be negatively correlated with levels of depression and suicide attempts.
- Research on family size consistently suggests that both immediate and extended family sizes are larger for culturally and ethnically diverse families. While research suggests that larger family size is generally associated with lower levels of depression and/or suicide attempts, the extent to which family size alone impacts suicide risk for adolescents in particular remains unclear; some studies have suggested that larger families are associated with reduced risk, while others have found positive correlations between family size and other risk factors for adolescent suicide, such as drug abuse or depression. Protective effects related to quality, rather than quantity, of family relationships have been consistently supported by research.

What Can School Psychologists Do?

Increasingly, schools are implementing comprehensive suicide prevention programs. These programs generally incorporate several key components, including: training students and staff to recognize warning signs and risk factors of suicide; screening for suicidal ideation among students; and intervening with students who show signs of suicidal ideation (Cigularov, Chen, Thurber,

Continued on page 22

PPA Wants YOU: Call for Nominations

Steven R. Cohen, Ph.D.



Dr. Steven R. Cohen

It is that time of year again – PPA is looking for nominations for the Board of Directors for the 2011 elections. The following positions will be on the ballot: president (a 3-year commitment – as

president-elect, president, and past president), treasurer, Communications Board chair, Internal Affairs Board chair, and School Psychology Board chair. These are 2-year commitments (except the president) and people can serve for two consecutive terms.

Current committee chairs, regional psychological association leaders, and other psychology organizations' leaders are well prepared for board positions. To learn more about each position, head to the PPA website at www.PaPsy.org/members_only/governance. Enter the username *papsy* and the password *key-stone*. For General Assembly member job descriptions click "GA Job Descriptions." Then please nominate yourself or a colleague using the form on the governance page.

Questions? Write to me as chair of the Nominations and Elections Committee, at stevencohenphd@verizon.net. Our future depends on our leadership!

Last year was our second year doing electronic voting, and the success of this method means we will hold elections electronically from now on. It saves PPA precious dollars and it is greener. People who do not have an e-mail address will still be sent paper ballots. Please watch for further announcements this winter and spring. 📧

EDUCATION IN INDIA

Continued from page 20

official minimum marriage age is 18 for girls, many are married much earlier.

According to the U.S. Department of State, the overall literacy rate in India is 61%. 📧

Acknowledgment

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ADOLESCENT SUICIDE...

Continued from page 21

& Stallones, 2008). In a recent review of comprehensive suicide prevention programs designed for use in schools, Rabadi (2010) found that all programs reviewed stressed the importance of recognizing general risk factors; however, few of the programs reviewed had been validated for use with racially and ethnically diverse populations. Similarly, few programs explicitly addressed the impact of these cultural factors on suicide risk in particular, or on mental health in general.

Therefore, school-based practitioners cannot assume that the use of comprehensive suicide prevention programs alone will permit identification and intervention with racially and ethnically diverse students at risk for suicide. Rather, school psychologists must be aware not only of these general risk factors, but also of the risk and protective factors specific to the backgrounds and traditions of the students in the schools where they work, as well as the ways in which intersections between general and culture-specific risk factors (e.g., within the racially and/or ethnically diverse LGBTQ student population), may potentially impact these students. Incorporating this knowledge into practice and staying current with the research base in this area as it grows will help school psychologists to implement suicide prevention tools and techniques in a culturally competent manner. 📧

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Safeguarding Privacy in a Nosy World

Edward Zuckerman, Ph.D., edzuckerman@mac.com



Dr. Ed Zuckerman

A major advantage of Internet communication is its ability to work around the usual barriers between people, such as ageism, lookism, distance, and expense when exploring new personal relationships, and time, language, and cost when expanding knowledge and skills. Even the unconventionality of one's interests is not a handicap on the Internet: among billions of users, even the most unusual interests are represented. If you can type, speak, or use a mouse, the vast majority of human knowledge is available to you. But there are those who do not want such open access, sometimes for legitimate reasons: it can compromise law enforcement and protection of trade secrets. While it can augment whistleblowing on harmful or illegal activities, it can also serve oppressors – political, military, religious, economic, or otherwise.

“Who are you and what are you doing on your computer?” Do you feel comfortable answering this question, no matter who asks it, no matter what you are doing on the Internet, even when communicating with people who think as you do? We can be entirely upstanding and still have information and relationships we legitimately wish to keep private.

The first level of protection is the use of passwords for computers, files, and folders to limit access. Equivalent to locking your car or house, these are still breakable by guessing, “social engineering,” dictionary and brute force attacks, or circumvention. However necessary, generally protective, and inexpensive, passwords are often not used to best advantage (i.e., using eight characters or more, changing them regularly, varying their case) because of their operational burdens. Still, upgrading passwords is a simple and needed protection of your privacy.

The second level of protection is encryption: applying a “key” (a set of

transformations such as exchanging each letter for another) to a “plaintext” (readable) document to make it into “cryptotext” (senseless to a reader). HIPAA all but requires these for protected health information, and use on every computer should be standard. Inexpensive programs are available; they are relatively easy to set up and work automatically. Look into your operating system (Windows or Mac OSX) for the most available option or buy a “vault” program. Off-line storage of your files over the Internet always includes good encryption but won't protect your computer. Two-key methods for communication (not for storage) are safe. While they require separate programs, at least you can encrypt your e-mail address book for privacy.

A good place to start on encryption is with www.pgp.com. I will offer more on this program since I greatly admire Phil Zimmermann (see his site: www.philzimmermann.com) because he made secure communications possible in the 1980s to protect grassroots political organizations and human rights campaigners worldwide. For his efforts, he was criminally investigated for years by our government for exporting a “munition” – the encryption software he called “PGP,” for “Pretty Good Privacy.” The suit was dropped in 1996, but by then, dozens of similar programs were readily available. PGP is the most widely used encryption program for two reasons: it is effective and it is free. You can download a “trial” version from <http://www.pgp.com/downloads/desktoptrial/index.html>, called “PGP Desktop Trial Software,” and it will never expire – a commitment of Phil's, despite incorporation of the software into a more complex and well supported commercial product. You can also buy PGP 10 Desktop Whole Disk Encryption (\$149) or a suite of features (for secure e-mail and IM, as well as storage) called Desktop Professional for \$239. Phil has continued to protect human rights for 30 years and to develop additional products such as Zfone for secure Internet calling, such as using Skype.

Who can learn where on the Internet you have gone and what you have read? Your browser keeps a history in an easily accessible cache. Your ISP (Internet Service Provider, such as Verizon, Comcast, or AOL) knows, and our government has gotten such information easily under the Patriot Act. Hackers can access the cache on your computer and the e-mail addresses you store. When you go from site to site on the Internet and from page to page on the Web, your server, by storing each address (URL) on its hard disks, can track the flow. These logs are semi-permanent and accessible to staff of the ISP and law enforcement. What you want for a third level of privacy is anonymous browsing capability.

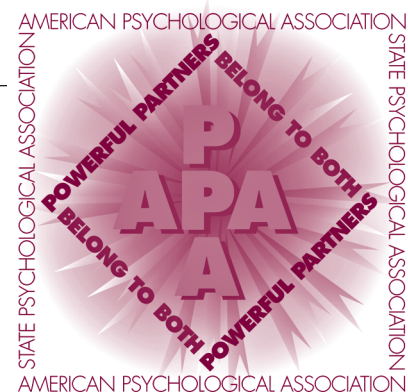
Best known, best tested, and most available is Tor (www.torproject.com). From its website: “Tor protects you by bouncing your communications around a distributed network of relays run by volunteers all around the world: it prevents somebody watching your Internet connection from learning what sites you visit, and it prevents the sites you visit from learning your physical location. Tor works with many of your existing applications, including web browsers, instant messaging clients, remote login, and other applications based on the TCP protocol.”

Lest you worry about whether use of Tor might brand you as a suspicious character, consider this from the website: “Who Uses Tor? People like you and your family use Tor to protect themselves, their children, and their dignity while using the Internet. Businesses use Tor to research competition and keep strategies confidential, facilitating internal accountability. Activists use Tor to anonymously report abuses from danger zones. Whistleblowers use Tor to safely report on corruption. Journalists and the media use Tor to protect their research and sources online. Militaries and law enforcement use Tor to protect their communications, investigations, and intelligence-gathering online.”

Continued on page 25

Welcome New Members

We offer a massive, monumental, mighty welcome to the following new members who joined the association between August 1 and October 31, 2010!



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Kenneth E. Curran, Ph.D.
Broomall, PA

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Atglen, PA

Abe Zubarev, M.A., M.Ed.
Philadelphia, PA

Pennsylvania Psychological Association 2011 Award Nominations Sought

Several PPA committees are still seeking nominees for awards for 2011. 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 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**. 

PSYCH TECH

Continued from page 23

In this world, many governments are not as benign as ours. To see data on this, go to <https://www.sesawe.net/>, which describes government efforts to block citizenry from Internet access in order to suppress dissent and further governmental control. However, there are tools to bypass this government censorship. Among them, "Psiphon ...

help(s) Internet users securely bypass the content-filtering systems used to censor the Internet by governments in... China, North Korea, Iran, Myanmar, Saudi Arabia, United Arab Emirates, Vietnam, Pakistan and others." Psiphon is not a piece of software you can simply download. "The idea is to get [citizens in free countries like ours] to install this on their computer, and then deliver the location of that circumventor to people in filtered countries by the means they know to be

the most secure. What we're trying to build is a network of trust among people who know each other, rather than a large tech network that people can just tap into." Any volunteers? 

The author has no ties, financial or otherwise, to the makers of the products reviewed.

CE Questions for This Issue

The articles selected for one CE credit in this issue of the *Pennsylvania Psychologist* are sponsored by the Pennsylvania Psychological Association. PPA is approved by the American Psychological Association to sponsor continuing education for psychologists. PPA maintains responsibility for this program and its content. The regulations of the Pennsylvania State Board of Psychology permit psychologists to earn up to 15 credits per renewal period through home study continuing education. If you have more than 30 continuing education credits for this renewal period, then you may carry over up to 10 credits of continuing education into the next renewal period.

You may complete the test at home and return the answer sheet to the PPA office. Passing the test requires a score of at least 70%. If you fail, you may complete the test again at no additional cost. We do not allow more than two attempts at the test.

Complete the response form at the end of this exam, making certain to match your answers to the assigned question numbers. For each question there is only one right answer. Be sure to fill in your name and address, and sign your form. Allow 3 to 6 weeks for notification of your results. If you successfully complete the test, we will mail a confirmation letter to you. The response form must be submitted to the PPA office on or before December 31, 2012.

Return the completed form with your CE registration fee (made payable to PPA) for \$20 for members (\$35 for non-members) and mail to:

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

Learning objectives: The articles in this issue will enable readers to (1) assess and explain current issues in professional psychology, and (2) describe and act on new developments in Pennsylvania that affect the provision of psychological services.

DeWall

1. PPA's resources for professional development on ethics include:
 - a. articles in the *Pennsylvania Psychologist* and on the website
 - b. continuing education in several types of formats
 - c. consultation with staff members and other psychologists with special expertise
 - d. all of the above

Knapp, Baturin & Tepper

2. Which of the following is true about mandated reporting laws in Pennsylvania? Psychologists must report any:
 - a. impaired psychologists who come to them for treatment
 - b. medical errors if they are an employee of a hospital
 - c. patient who is HIV positive and refusing to get treatment
 - d. patient who is a victim of domestic abuse, unless that patient is a vulnerable adult

3. Dr. Jones has a patient who confessed to killing a man several years ago. He was never arrested for this crime. According to Pennsylvania law, Dr. Jones:
 - a. must reveal this information to police
 - b. may only reveal the information to the police if the victim were a vulnerable adult
 - c. may not reveal the information to police
 - d. should base his decision on discretionary reporting provisions in Pennsylvania law

Seif

4. Saving face is:
 - a. an empathic response
 - b. helpful in psychotherapy
 - c. not embarrassing anyone or being embarrassed
 - d. only valued in Nepal

Sallade

5. Native cultures, including shamans, are especially recognized in
 - a. Colombia
 - b. Argentina
 - c. Brazil
 - d. Venezuela

Sternlieb

6. Which is NOT a benefit identified by this author in working internationally?
 - a. assisting with issues that are universal
 - b. exposure to other cultures
 - c. promoting the English language and U.S. culture in other lands
 - d. sharing and encouraging a sense of unity
 - e. the opportunity to travel
7. The nature of doctor-patient relationships in other countries and cultures:
 - a. requires learning the language to understand and discuss
 - b. cannot be helpfully discussed among providers from different cultures
 - c. has more similarities than differences across all cultures
 - d. is a function of the health care system in each country

Suzuki

8. For refugees, talking about one's traumatic past may help in what ways?
 - a. It assists with assessment.
 - b. Survivors can begin to appreciate their resilience.
 - c. Other family members can gather a sense of identity.
 - d. It may help with individual healing.
 - e. all of the above.
9. What can psychologists do to help?
 - a. assess displaced people to determine their eligibility for refugee status
 - b. recommend interrogation tactics in camps
 - c. capitalize on the opportunity to learn a new language

- d. listen, infuse pride, and promote family communication
- e. a and b
- f. a and d

Karafin

10. India's official position on corporal punishment is:
- a. Corporal punishment is acceptable and needed to maintain discipline.
 - b. Corporal punishment is forbidden and against the law.
 - c. Corporal punishment is banned through India's Right to Education bill, but enforcement has been weak.

- d. Corporal punishment is associated with higher literacy rates.

Rabadi & McGrath

11. What factor is not described as a contributor to increased suicide rates among ethnic and racial minority adolescents?
- a. experiencing racism or discrimination
 - b. poverty
 - c. stresses associated with acculturation
 - d. greater access to lethal weapons
 - e. stigma associated with seeking help

Upcoming Themes

The themes for the special section in the next three quarterly issues of the *Pennsylvania Psychologist* are as follows:

♦ March 2011

PPA Annual Convention: *Celebrating human performance in mind, body, spirit, and community*. Mini-theme: *Disabilities*

♦ June 2011

Suicide

♦ September 2011

Genders and Therapy

PPA members with particular interest and/or expertise in these areas are welcome to contact our editor, Dr. Andrea Nelken, at nelken.andrea@gmail.com to discuss authoring an article on one of those themes.

Continuing Education Answer Sheet The *Pennsylvania Psychologist*, December 2010

Please circle the letter corresponding to the correct answer for each question.

- | | | | | | | | | | |
|----|---|---|---|-----|-----|---|---|---|-------|
| 1. | a | b | c | d | 7. | a | b | c | d |
| 2. | a | b | c | d | 8. | a | b | c | d e |
| 3. | a | b | c | d | 9. | a | b | c | d e f |
| 4. | a | b | c | d | 10. | a | b | c | d |
| 5. | a | b | c | d | 11. | a | b | c | d e |
| 6. | a | b | c | d e | | | | | |

Satisfaction Rating

Overall, I found this issue of the *Pennsylvania Psychologist*

Was relevant to my interests	5	4	3	2	1	Not relevant
Increased knowledge of topics	5	4	3	2	1	Not informative
Was excellent	5	4	3	2	1	Poor

Comments or suggestions for future issues _____

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2011 CE Calendar

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

March 31 – April 1, 2011

*Spring Continuing Education
and Ethics Conference*
Harrisburg, PA
Marti Evans (717) 232-3817

June 15 – 18, 2011

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Harrisburg, PA
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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.

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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
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