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The Pennsylvania
Psychologist

July/August 2011 • UPDATE

Bill Introduced on Insanity Determinations

Rep. Glen R. Grell

On April 28 state Representative Glen R. Grell (R-Cumberland) introduced House Bill 1405. This bill would permit judges to admit the testimony of psychologists on the initial determination of insanity in criminal cases when done in conjunction with determinations of competency to stand trial. Currently Pennsylvania law restricts that authority to psychiatrists. Pennsylvanians will benefit when the courts have the discretion of accepting testimony from a wider range of qualified professionals. It is estimated that perhaps as many as 100 psychologists in Pennsylvania have proficiency in forensic psychology and could be available to offer such opinions.[1]

House Bill 1405 is strongly bipartisan, with 25 Republican and 24 Democratic cosponsors. It has been referred to the House Judiciary Committee, chaired by Rep. Ronald S. Marsico (R-Dauphin). PPA is hopeful that Rep. Marsico will schedule the bill for consideration in the committee when the General Assembly returns from its summer recess.

Nothing in this bill would alter the standards for an insanity defense in Pennsylvania. Insanity determinations are rare and constitute less than 1% of all homicides,[2] although attorneys will often seek private evaluations to

1 This estimate is based on a survey by the Association of State and Provincial Psychology Boards, which found that about 4% of psychologists had a proficiency in forensic work, thus allowing us to extrapolate that 4% of the 5,000 + licensed psychologists in Pennsylvania have a similar proficiency. However, many of them may have proficiencies restricted to forensic areas other than insanity determinations.

2 This figure is widely cited, although data for Pennsylvania could not be found.

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Scientists and Practitioners Share Ownership of Quality Research

Samuel Knapp, EdD, ABPP, Director of Professional Affairs

Dr. Sam Knapp

It is common for psychologists to bemoan the gap between psychologist-scientists and psychologist-practitioners. However, dedicated psychologist-scientists and practitioners in State College, Pennsylvania, working through the Practice-Research Network (PRN) of PPA, have been collaborating for almost 10 years on psychotherapy research projects. Their work together is unique in that the practitioner psychologists are equal partners with the scientist psychologists in producing their research. A major study from PPA's PRN recently appeared in *Psychotherapy: Theory, Research, Practice, and Training*. A third study is currently underway.

In the most recently published study, 13 treating psychologists, representing several different theoretical orientations, gathered descriptions from 121 clients concerning the events in therapy that were particularly helpful or hindering for them (Castonguay, Boswell, et al., 2010). Researchers then rated more than 1,500 responses according to content. The patients reported that the most helpful events were those that improved self-awareness, improved problem-clarification, or increased problem-solving skills. The psychologists reported that the most helpful events were those that improved self-awareness, strengthened the alliance, or improved problem-clarification. Hindering events were less frequently reported, but poor fit between therapist and client, therapist omissions, and digressions were most often cited.

Of course, these results, like the results of all psychotherapy studies, need to be interpreted in light of the overall literature on patient outcomes and psychotherapy processes. Nonetheless, it highlighted the benefits of promoting self-awareness, problem-clarification, problem-solving, and patient relationships, and the opportunities lost when therapists fail to address important issues or digress from patient needs.

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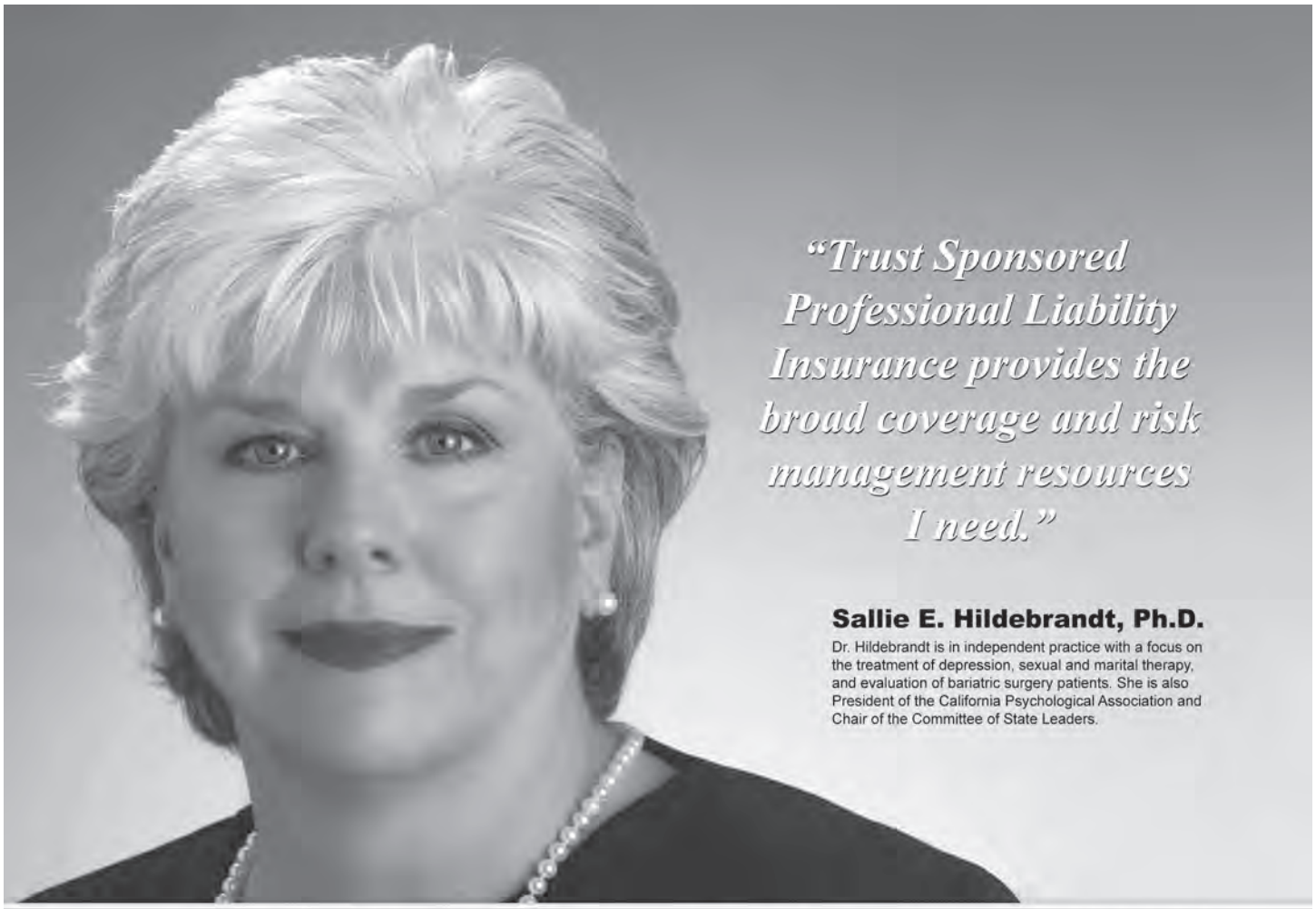

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Emergency or On-Call Coverage: What Standards Should Psychologists Follow?

What obligations do psychologists have to provide 24-hour coverage? Should all psychologists be on call, or have someone on call, at all times? A psychologist with a small private practice (such as an average of six patients per week) may wonder about the desirability of having 24-hour coverage because the number of patients she sees does not appear to justify the inconvenience of maintaining an on-call schedule.

Of course, some insurers may require on-call coverage as a condition of being on their panel. Other than that contractual requirement, however, psychologists should ask themselves whether the continuum of services they provide (including after-hours or on-call coverage) are appropriate to the needs of their clients, and whether their on-call procedures are clearly conveyed to clients as part of the informed consent process.

The need for emergency coverage varies according to the caseload and setting of services. For example, one psychologist works exclusively for several nursing homes. In the event that a patient has a life-endangering emergency, the nursing staff is available and could intervene immediately. Although the nursing staff has her home phone number, she does not feel she needs to be constantly available for the nursing home.

Another psychologist offers life coaching and career assessment and only occasionally treats a patient with an adjustment disorder or problem in living. She carefully screens out all people who have major depression or other more serious mental disorders. Given that she limits her clientele and provides few health care services, it is unlikely that patients would need emergency services. Nonetheless, some clients may expect emergency coverage so she carefully explains the limits of her services as part of the informed consent process and even includes the county emergency number on the message on her answering machine.

Nonetheless, psychologists who treat patients with a variety of serious mental illnesses, such as major depression, eating disorders (anorexia, bulimia), bipolar disorders, or serious personality disorders can expect that some of their patients will have emergencies and need to contact them outside of regular office hours. In addition to meeting patient needs, emergency coverage reduces legal liability. The failure to provide emergency access for these patients with serious illnesses who need a quick response could be considered abandonment, a form of professionally negligent conduct.

Psychologists who offer off-hours coverage vary on how they provide access. Some psychologists employ answering services who take messages and call them if the patient indicates there is an emergency. Another psychologist uses a commercial voice mail system that transfers to her cell phone when the patient follows the instructions on the voice system and presses #911. In each of these situations the delay in reaching the patient is so minimal that it is unlikely to be a problem. Other psychologists who have small caseloads or mixed caseloads (only a few of their clients are likely to need emergency services) sometimes will give their home phone numbers or cell phone numbers to those patients likely to need those emergency services.

Psychologists who work for groups may be better able to spread around the burden of emergency coverage. One group practice rotates emergency coverage among the different therapists in the practice. Another group has arranged for a local hospital to handle emergency calls. Whatever decisions are made about emergency services need to be communicated clearly to the patients as part of the informed consent process.

What to Do With a Drunken Patient?

Samuel Knapp, EdD, ABPP, Director of Professional Affairs

How should psychologists respond if they have a patient who has been drinking and who intends to drive home after a therapy appointment? After reasonable efforts to dissuade the patient from driving have failed, does the psychologist have an obligation to warn the police about the potential danger? Alternatively, does confidentiality prevent the psychologist from doing so?

This dilemma arises intermittently for practicing psychologists. Of course, psychologists have a legal duty to report impaired drivers to the Pennsylvania Department of Transportation (Baturin, Knapp, & Tepper, 2003). However, this requirement does not help resolve the immediate safety issue. Nuances in the interpretation of this mandated reporting law are covered in the article cited above on that topic on the PPA website.

In dealing with the immediate problem of a drunken patient who wants to drive home, much of the decision-making of the psychologist will account for situational factors. The extent of the patient's impairment from alcohol may be difficult to determine. This may be similar to evaluating pornography, in that it can be hard to define, but easy to recognize. In many cases, individual psychologists may observe the same patient and differ in their interpretation of their degree of impairment. I know of no rule of thumb or quick evaluation tool for

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WHAT TO DO WITH A DRUNKEN PATIENT?

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psychologists to rely upon. However, in many other cases, everyone would agree that staggering, slurred speech, affect, and other behaviors would indicate that this person is too drunk to drive.

Psychologists should try to dissuade an impaired patient from driving, and consider options such as getting a taxi for the patient, calling a relative or friend to drive the patient, or other alternatives. Another option might be to inform them that you will call the police if they drive away from your office drunk. Furthermore, this behavior needs to be a part of the calculation in a decision to notify the Department of Motor Vehicles concerning their competency to drive.

The true dilemma arises when a patient you determine to be too drunk to drive insists upon driving anyway. What are the ethical or legal obligations that you have? Are you legally liable if the patient harms others?

In discussions with different psychologists on this exact question, I have learned that several psychologists have called the police on a drunken patient who insisted upon driving home from a therapy session, and no complaints were filed against them. Others have worked with patients who were too cognitively impaired with neuropsychological problems and have similarly notified the police.

There is not, to my knowledge, any court case in Pennsylvania that deals specifically with the legal liability of psychologists in these situations. However, the regulations of the State Board of Psychology permit such disclosures "when there is clear and imminent danger to an individual or to society, and then only to appropriate professional workers or public authorities" (49 Pa. Code §41.61, Principle 5 (b) (1)). I think this can be interpreted to justify notifying the police when a patient is too drunk to drive. In addition, when there is ambiguity in laws or regulations, psychologists should interpret them in light of overarching ethical principles that, in this case, would mean notifying the police if we thought a driver was dangerous to the public. Safety trumps privacy and we do need to live with ourselves. Of course, drug and alcohol facilities in Pennsylvania are governed by special federal and state regulations that have a stricter level of confidentiality.

Reference

Baturin, R., Knapp, S., & Tepper, A. (2003, November). Legal and practical issues related to the treatment of impaired drivers. *Pennsylvania Psychologist*, 5-6.

Special Program at the American Psychological Association's Annual Meeting
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2:00 PM - 3:50 PM
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Selling Products to Patients

Samuel Knapp, EdD, ABPP, Director of Professional Affairs

What ethical considerations should psychologists consider prior to selling products to patients? Several variables factor into this discussion, including whether the psychologist profits from the transaction or whether the product is intrinsic, incidental, or unrelated to therapy.

Consider this situation:

> A psychologist sells a well-respected self-help book on panic disorders to her panic-disorder patient as an adjunctive tool in therapy. The book costs $12 at the local bookstore and the psychologist offers to sell it to the patient at cost. This psychologist, who is skilled in treating panic disorders, keeps several in stock as she receives an average of one referral for a panic disorder a month.

To place this example in context, the psychologist gives patients the option of purchasing it online to avoid the appearance that she was profiting from these sales. However, often the patients delayed in purchasing the books when she gave them the option of purchasing them online, thus delaying the progress of therapy. Consequently, she addressed this issue by noting her use of bibliotherapy in her informed consent procedures that also stated that she expected the clients to have read the assigned book very early in treatment. Her patients tended to appreciate the bibliotherapy when the psychologist explained in detail how it would be relevant to their particular treatment goals.

Consider this other situation:

> A psychologist wants to sell a relaxation tape or CD to her patients. The psychologist creates, produces, and sells the CDs, tapes, and podcasts for $50 per audio program. She made 10 audio sessions for $300. If she sells six programs, she will break even. However, if she sells fewer than that, she will lose money.

This psychologist uses relaxation as a primary treatment for some patients and as an adjunctive treatment for many other patients. However, a patient recently accused her of hawking her wares because this patient did not believe that relaxation would help her. In any event, the patient claimed, the cost of the audio recordings should be included in the overall cost of treatment. This misunderstanding could have been addressed ahead of time if the psychologist noted the use of relaxation and audio recordings in her informed consent procedures and had carefully given the rationale as to why this intervention was a value to this particular patient. Knowing that a few patients do not respond well to relaxation techniques, it might have helped if the psychologist had allowed patients to return the recordings if they were not helpful.

Consider this third example:

> A psychologist planned to sell nutritional supplements to her patients. According to her plan, she would buy them wholesale for about $20 per unit and sell them for $25 per unit. She justifies the plan in that the patients do not have to travel to the stores to purchase them, and she has to invest money and time in purchasing them. Furthermore, she notes that patients benefit from her expertise in knowing about the benefits of these supplements. She plans to offer to sell them to all of her patients regardless of their condition because everyone can benefit from good physical health and an improved immune system.

When she ran her proposal by her consultation group, her peers asked several questions. Group members questioned whether psychologists should be selling nutritional supplements at all, believing that the sale of such items should be restricted to other health professionals such as nutritionists or physicians. Others noted that the plan was to sell this product generically to all patients regardless of their individual treatment goals, and that the markup in price gave an appearance of profiteering on the part of the psychologist, although that was not her intent.

When considering whether to sell products to patients, psychologists should consider whether the product is intrinsic, incidental, or unrelated to therapy. Certainly selling a self-help book on anxiety or a relaxation tape for a patient with an anxiety disorder appears intrinsic to therapy. However, psychologists who sell the same products to every patient may create a perception that the products are being promoted for the profit of the psychologist and not for the benefit of the patient. Psychologists may disagree concerning whether psychologists should be selling nutritional supplements at all. At the least, however, psychologists who claim benefits from nutritional supplements should be able to substantiate their claims with scientific evidence and explain why it benefits a particular patient. Finally, some patients may feel pressure to purchase items unrelated to therapy, just to please the psychologist, even if they have no interest in the product. Efforts should be made to empower patients to decline such offers, especially when the product is incidental to therapy or when alternatives are available.

Our recommendations are that if psychologists offer products to patients they sell them at cost or less; sell only items related to the treatment goals of a particular patient; include the possible use and costs of products in the informed consent process; and ensure that patients understand the relationship of the product to their treatment.

BILL INTRODUCED ON INSANITY DETERMINATIONS

Continued from page 1

determine if a reasonable basis exists for their clients to claim insanity. Recognizing psychologists as evaluators of the insanity defense is consistent with the scope of practice of psychologists and the recognition of psychologists in a variety of forensic areas. For example, psychologists are recognized in Pennsylvania:

- along with physicians and dentists, allowed to testify in civil suits according to Pennsylvania's Rules of Civil Procedure (R.C.P. Rule 4010);
- along with physicians and optometrists, able to evaluate persons suspected of being impaired drivers (75 Pa. C.S.A. §1519);
- along with physicians, able to diagnose children who have been emotionally abused, and to serve on the Sexual Offenders Assessment Board (42 Pa. C.S.A., §9791 et seq.);
- to evaluate individuals for purposes of authorizing a permit to carry lethal weapons (22 Pa. C.S.A. §41 et seq.); and in other places in Pennsylvania law.

Even the current Pennsylvania insanity statute permits defendants to summon an "other expert" (such as a psychologist) to testify on their behalf. It makes little sense for the court to allow a psychologist expert to testify for the defense, but not allow a psychologist expert to testify for the prosecution in the initial determination of insanity.[3]

3 Section 404 (b) "Opinion Evidence on Mental Condition. At a hearing under Section 403 or upon trial, a psychiatrist appointed by the court may be called as a witness by the attorney for the Commonwealth or by the defendant and each party may also summon any other psychiatrist or *other expert* to testify."

SCIENTISTS AND PRACTITIONERS SHARE OWNERSHIP...

Continued from page 1

A companion article reported on interviews with the participating psychologists concerning their experiences with this study (Castonguay, Nelson, et al., 2010). In their candid responses in structured interviews, the treating psychologists reported benefiting from their participation in the study in terms of improving services to particular patients, learning more about psychotherapy research, and contributing to the advancement of knowledge in the profession. However, they noted that, at times, the protocol did become burdensome because it was one additional set of responsibilities that they had to fit into a busy clinical day.

These articles demonstrated the potential of PRNs to reduce the gap between psychological researchers and practitioners and to advance ecologically valid research. The PRN researchers and practitioners worked collaboratively and avoided "empirical imperialism." In other words, the information about effective psychotherapy flowed from practitioner to scientist, as well as from scientist to practitioner. In PPA's PRN, practitioners, in partnership with researchers, determined the research questions, design, and procedures. The researchers described the methodological advantages or disadvantages of certain designs or procedures, but the practitioners determined the final structures after considering the potential benefit of the research, the realities of day-to-day practice, the impact on the psychologist-patient relationship, and other practical factors. In other words, the researchers acted as highly informed consultants to the practitioners resulting in "shared ownership" of the research project.

Dr. Louis Castonguay, professor of psychology at the Pennsylvania State University, was the lead investigator in both articles. Dr. Neal Hemmelstein, a psychologist in practice with the Child, Adult, and Family Psychological Center in State College, is chair of PPA's Practice-Research Network. Dr. Thomas Borkovec, a retired professor of psychology at Penn State, and Dr. Stephen Ragusea, now of Key West, FL, were deeply involved in forming the PRN about 10 years ago.

These studies were funded in part by the Pennsylvania Psychological Association and the Committee for the Advancement of Professional Practice of the American Psychological Association. As this article goes to print, I just learned that this latest article received the Distinguished Research Publication Award from APA's Division 29.

References

Castonguay, L., Boswell, J., et al. (2010). Helpful and harmful events in psychotherapy: A Practice Research Network Study. *Psychotherapy: Theory, Research, Practice, Training, 47*, 317-344.

Castonguay, L., Nelson, D., et al. (2010). Psychotherapists, researchers or both? A qualitative analysis of psychotherapists' experiences in a practice research network. *Psychotherapy: Theory, Research, Practice, Training, 47*, 345-354.

This article appeared in the journal *Advance* and is being reprinted with permission of the Association for the Advancement of Psychology.

Member News

Dr. Louis Castonguay and other leaders of PPA's Practice-Research Network received the following congratulatory letter from Dr. Elizabeth Nutt Williams, president of APA's Division 29 (Psychotherapy).

> "I hope you are well. I wanted to give you my congratulations on being awarded the Distinguished Research Publications Award this year from Division 29 for your work in Psychotherapy:
>
> **Castonguay, L. G., Boswell, J. F., Baker, S., Boutselis, M. A., Chiswick, N. R., Hemmelstein, N. A., ... Grosse Holtforth, M. (2010). Helpful and hindering events in psychotherapy: A practice research network study. *Psychotherapy: Theory, Research, Practice, Training, 47*, 327-344.**
>
> "I think your work on the PRN will be extremely valuable to the field. Congratulations again to you and all of your co-authors."

Classifieds

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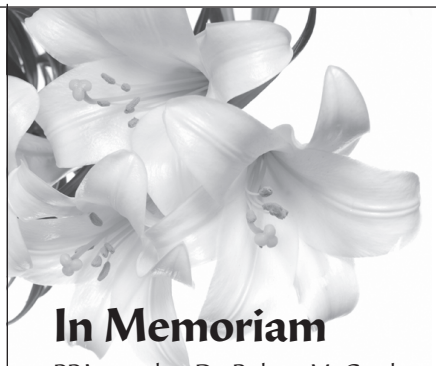
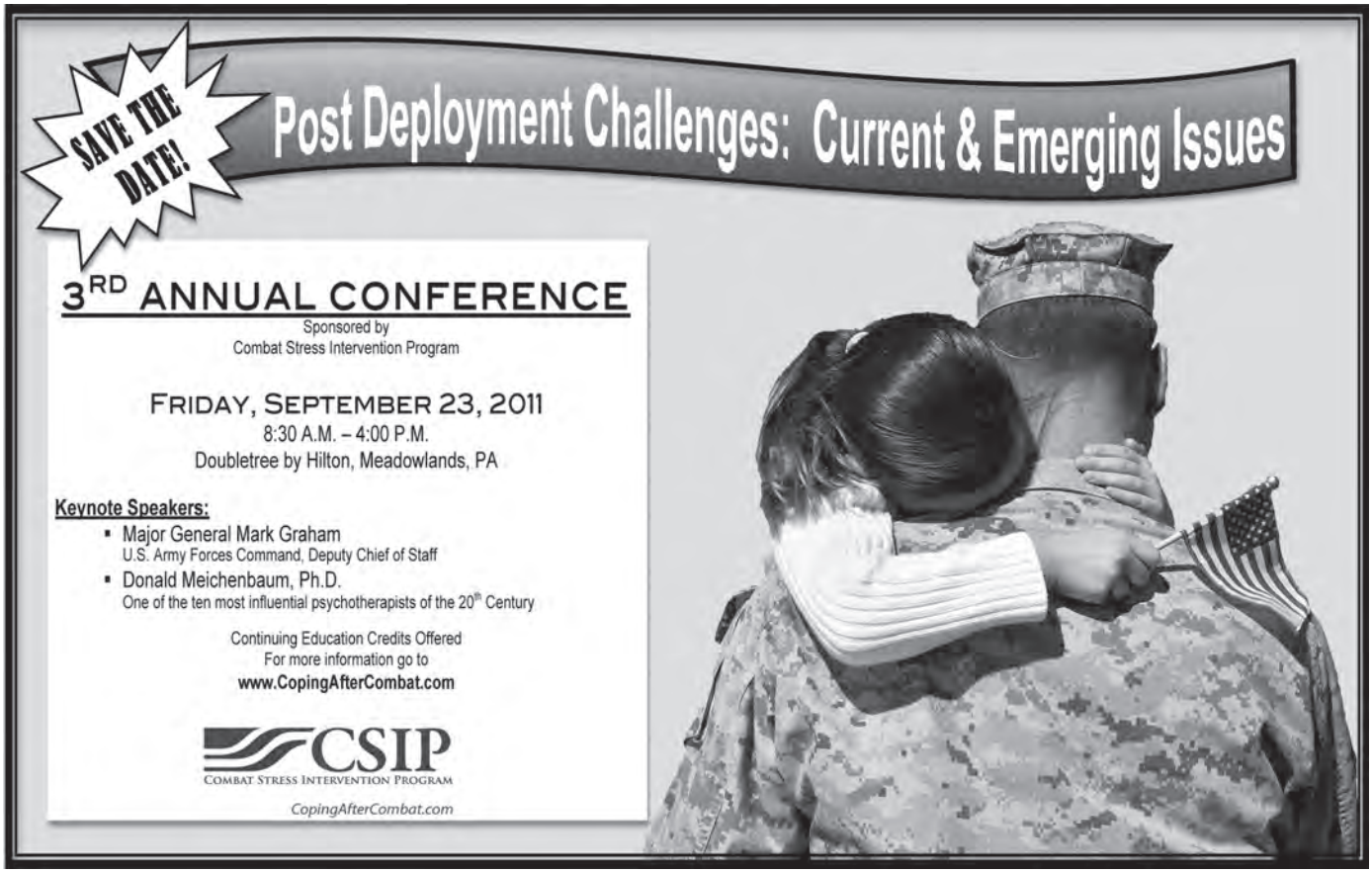


In Memoriam

PPA member Dr. Robert M. Gordon informed the *Pennsylvania Psychologist* of the following unfortunate news:

"My very dear friend and office mate, **Dr. Vera Hornstein**, died in a car accident on May 6th. Dr. Hornstein received her masters degree and Ph.D. from the Ferkauf Graduate School of Psychology, Yeshiva University, New York. She worked as a neuropsychologist at the Good Shepherd Rehabilitation Hospital, and has been in private practice along with me for the past 18 years in Allentown, practicing psychotherapy and neuropsychological assessments. She was not only a talented psychologist, but the warmest and most caring person I have ever met."

Dr. Hornstein had been a member of PPA since 1995.



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2011/12 CE Calendar

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

October 28, 2011
A Day of Ethics Education
by Dr. Samuel Knapp
Doubletree Hotel
Monroeville, PA
Marti Evans (717) 232-3817

November 3 – 4, 2011
Fall Continuing Education and Ethics Conference
Exton, PA
Marti Evans (717) 232-3817

March 1 – 2, 2012
Spring Continuing Education and Ethics Conference
Lancaster, PA
Marti Evans (717) 232-3817

For CE programs sponsored by one of the Regional Psychological Associations in Pennsylvania, visit http://papsy.org/collaboration-communication/regional-psychological-associations.html.

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

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

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