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Safety in Youth Sports Act Signed Into Law

A Behind-the-Scenes Account of a Legislative Success

Samuel Knapp, EdD, ABPP, Director of Professional Affairs

As has been noted in previous articles, after a two-year effort, the Pennsylvania General Assembly passed Senate Bill 200 (the Safety in Youth Sports Act), which would ensure proper screening and return-to-play decisions for high school athletes suspected of getting head concussions. Typically bills take several years (or even decades) before they gain the acceptance of a majority of legislators. This bill, in legislative time, moved quickly in that it was passed less than two years after it was originally introduced. Its passage, although fast in legislative time, represented much effort on behalf of its prime sponsors, Rep. Timothy P. Briggs (D-Montgomery) and Patrick M. Browne (R-Lehigh), and advocacy groups such as PPA.

Last legislative session, in 2010, a previous version of this bill had passed the Pennsylvania House of Representatives, but failed to pass the Pennsylvania Senate. During the debate in the House of Representatives, some legislators had expressed concern that the language of the bill gave too much authority to neuropsychologists; others were concerned that it

Governor Corbett signed the Safety in Youth Sports Act on November 14. He was flanked by Representative Timothy P. Briggs (left) and Senator Patrick M. Browne (right). PPA was represented by our lobbyist, Susan Shanaman, and Dr. Sam Knapp (second and third from the right, back row). Other stakeholders represented the Department of Education, athletic trainers, physical therapists, the NFL, and other organizations.

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Effective Billing Practices

Pay Attention and Communicate

Dr. Vince Bellwoar

Dr. Vince Bellwoar is co-owner of Springfield Psychological Associates, a private company in Delaware and Chester County, which has almost 80 therapists and deals primarily with commercial insurance companies. He also chairs PPA's Insurance and Managed Care Committee. Dr. Bellwoar has agreed to share his insights into common billing and collection problems faced by psychologists in private practice.

Dr. Samuel Knapp: Your company collects most of its bills. How do you reduce unpaid bills?

Dr. Vince Bellwoar: First, we invested in a good computerized billing software program. Second, we learned all of the bells and whistles that the program had to offer. For example, we learned to generate reports that informed us where to focus our collection efforts. The next step was taking the leap to bill electronically. Our most recent significant step occurred two years ago when we began to post

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Raising Your Tech IQ With Everyday Internet Technologies

Brad Norford, PhD, Chair, Committee on Technology Implementation

Dr. Brad Norford

"Would you please establish a Skype meeting date for the committee with Doodle and request that everyone post any updates in advance onto the Wiki?" What would be your reaction to this request in a group or committee in which you participate? Would you think, "What?! Someone else will need to take care of that. I don't have time to figure those things out." Alternatively, you could decide to access the PPA Tech Corner on the PPA website and learn how to do this in no time.

The Committee on Technology Implementation (CTI) is here to help nudge the membership and our PPA committees further into the technologies of the 21st Century. Remember when e-mail seemed confusing and you were not sure that it would be worth the effort? There are many comparable, readily accessible technologies of much benefit to our work as professionals that are only being utilized by a minority of our membership.

PPA committees and the use of technologies: One of the essential missions of CTI is to bolster the use of technologies in the work of the committees for purposes of greater efficiency and to keep PPA leadership up with the technology curve. Last year CTI members investigated some of these technologies and then wrote columns, distributed information via e-mail with links to how-to videos, and presented at the 2011 Annual Convention. This year CTI will be taking an approach to accomplish this that involves all PPA members by offering an opportunity to increase everyone's comfort level with newer technologies in the hopes of more willing adaptation to their usage when committee, work, and personal situations present.

Technology-of-the-Month: CTI will roll out a different technology each month and send one or two e-mails to the membership inviting them to familiarize themselves via the how-to videos and other learning devices introduced by PPA members. A sampling of the basic technologies you could have in your repertoire by the 2012 Annual Convention by way of the technology-of-the-month might also include creating a blog, using cloud storage, creating a YouTube video, creating a podcast, using technology securely, utilizing smartphone apps designed for psychologists, etc.

Not ready for all of this right now? Not a problem. All of the tech information will be stored in a user-friendly, readily accessible format in the members-only section on the PPA website to view when the time comes that you need it. For instance, suppose you do not have a need to learn about Skype now. Then next September your anxious high school patient moves across Pennsylvania to college and asks if you can Skype a couple of sessions while he/she is transitioning to support in the new location. You can quickly tap the PPA website and be ready to go in no time without revealing that you are too old to learn Skype.

Will this really be user-friendly?
Try it today:

- Go to www.PaPsy.org
- Enter your username (your 4-digit PPA number)
- Enter your password (your Lastname, with first letter capitalized)
- Click on the members-only tab
- Click on PPA Tech Corner

Already have these basic technologies in your repertoire? A few members of CTI are assigned to continue to investigate newer and more advanced technologies and to bring them to PPA and the membership. These also will be introduced by e-mail with a link to the Tech Corner for anyone to view.

Want to be a star? CTI would welcome any member to join the committee or to make a freelance YouTube video along the lines of the ones in the tech corner on the website. If applicable, CTI will send it to the general membership and/or place it on the webpage.

Best wishes in your electronic future!

EFFECTIVE BILLING PRACTICES

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EOBs back into our system electronically. Each step cost money, but as with most things involving information technology, if you watch your costs and do your homework, your investment will quickly pay off.

Dr. Knapp: What do you tell patients before they start therapy concerning their obligations to pay their bills?

Dr. Bellwoar: These days, most patients know they have a copay, co-insurance, or deductible. We typically look up this information as we are scheduling them and let them know what their portion is. I feel it is our obligation to make sure that our employees get paid for their hard work. Therefore, we expect patients to pay their copay at time of treatment. Also, because of the way insurance contracts are written, it would be a breach of contract not to collect copays.

To those who struggle with collections from the insurer I would say this: learn quickly from your mistakes and set up a system that will significantly reduce these errors.

Dr. Knapp: I understand that your practice uses credit cards. What advice would you give psychologists concerning the use of credit cards?

Dr. Bellwoar: We initially were reluctant to do so because of the processing fees. But when I compared this to bank fees for processing checks, I realized we were paying one way or another. The biggest factor was realizing that such a high percentage of consumers pay with a credit card. While patients may not have enough cash on them, or they may have forgotten their check, everyone has a credit card. Never hesitate to get your money up front! The amount of time, energy and money it requires to collect old monies quickly makes it a losing battle. You might also want to check into the different costs between a debit and credit card. For us, we encourage debit cards up to a certain amount; then we ask for credit cards.

Dr. Knapp: What are some of the most common problems you run across when it comes to getting bills paid and how do you handle them?

Dr. Bellwoar: About 85% of overdue monies are patient balances and only 15% are insurance monies. As copays, co-insurance, and deductibles increase, the patient percentage will increase even more. It is important to make it as easy as possible to let the patient pay.

Dr. Knapp: Like other practitioners, I am sure that there are times where you have given up trying to get paid by an insurer. What threshold or standards do you set for deciding that it is time to stop pursuing a claim?

Dr. Bellwoar: When it becomes clear that it is our error. For example, when authorizations were in place, we would not get paid because we missed getting an authorization. This was extremely frustrating because authorizations have little or nothing to do with clinical quality; they were just a convenient means not to pay a provider who performed treatment in good faith. We realized that by directing our outrage (with PPA's assistance) in the political realm, we could effect change. Back to your question: we have tenacious billers who are well-schooled in getting paid. Of the 0.5% of insurance claims that don't get paid, most are because the patient lost their insurance and neither we nor the insurer knew until sessions were already conducted. The harsh reality is that patients should always be aware of their coverage (or lack thereof). Of course, there is another important but separate issue of whether the insurer needs to do a better job of knowing when a subscriber is about to lose coverage. To those who struggle with collections from the insurer I would say this: learn quickly from your mistakes and set up a system that will significantly reduce these errors.

Dr. Knapp: When, if ever, do you use collection agencies for unpaid bills?

Dr. Bellwoar: We do for balances that have been outstanding for more than four months. During that time we have sent collection letters to the patient and, if they are still in treatment, it becomes a therapeutic issue. That is, the therapist discusses the need for patients to be responsible for their end of the agreement. Depending on the amount of the balance and the reason it accumulated, we will work with the patient on a payment plan. Regarding collection agencies, we have two concerns. First, most charge 25% to 40% of the collected fee. Second, we are reluctant to send to a collection agency those charges for a "non-service" like a no-show or late cancellation fee. Finally, at some point one should just write it off versus pursing it. It can end up being "negative advertising" in the community. It is a balance between wanting to get paid for your hard work and not being viewed as a money-hungry doctor bent on getting every last penny. We collect 98.5% of all charges and that is good enough.

Dr. Knapp: Do you – or how do you – bill patients for non-therapy related services, such as attending a meeting at a school for a child client?

Dr. Bellwoar: We bill at a rate commensurate with our average therapy rate, broken down in 15-minute increments. Obviously, patients are told of the potential charges before any services are provided so that they can make an informed choice.

Dr. Knapp: Although you do not have a forensic practice, I am sure some patients will request your involvement in some forensic issue. What are your office policies concerning billing for forensic services?

Dr. Bellwoar: We refer custody evaluations out to experts in this specialty. We also tell patients that our goal is to treat, not evaluate for legal purposes. We make sure that in divorce cases or cases that seem headed for a divorce, both parents of children under the age of 14 sign an agreement that keeps the therapist out of the custody disagreement.

SAFETY IN YOUTH SPORTS ACT

Continued from page 1

would result in an unfunded mandate on the schools; and still others worried that it would increase liability for school districts. Nonetheless, Representative Briggs argued strongly on behalf of the bill ("We need their brains to be fit enough not just to get back into the game, but to get back into learning;" Briggs, 2010, p. 1349) and especially for the need for neuropsychologists to be included in the bill. The strength of his arguments combined with the background education of legislators by PPA and other groups, led to a 169 – 29 victory for this bill. The Senate failed to act on the bill in 2010, however.

Because all bills die at the end of each legislative session (on November 30 of even-numbered years), Representative Briggs and Senator Browne had to re-introduce these bills in 2011. Senator Browne secured the passage of Senate Bill 200 in the Pennsylvania Senate. However, disagreements over the wording of professionals capable of making return-to-play decisions caused the bill to be amended by the House of Representatives and then sent back to the Senate for concurrence. Eventually, on November 1, 2011, the Senate concurred with the House amendments and the bill was passed. Governor Corbett signed the bill into law on November 14, 2011. The bill goes into effect on July 1, 2012.

To secure passage of this bill, Senator Browne and Representative Briggs had many face-to-face meetings, conferences, or phone calls with interested parties, including representatives of physician groups, athletic trainers, physical therapists, the NFL, the Brain Injury Association, the Pennsylvania Interscholastic Athletic Association, and others. PPA was involved in the very beginning with this legislation. PPA members responded to legislative alerts on this issue, provided background information to legislators, and spoke directly with key legislators. PPA's then-president, Dr. Mark Hogue, twice traveled to Harrisburg to meet personally with interested parties. Dr. Ruben Echemendia, a neuropsychologist from State College and past president of the National Association of Neuropsychology, also traveled to Harrisburg and was frequently consulted by proponents of this bill. I attended one of those meetings

PPA members responded to legislative alerts on this issue, provided background information to legislators, and spoke directly with key legislators.

in January 2011 with Drs. Hogue and Echemendia, and they spoke with such authority and passion on the topic of head concussions, that it became obvious to all those in the room that neuropsychologists were leaders in this field and had to be included in return-to-play decisions. That meeting ended all serious efforts to exclude neuropsychologists in this legislation.

In addition, PPA conducted a survey on the extent of neuropsychological testing of sports-related head injuries, which was cited by the supporters of this legislation to ensure that the bill included psychologists with training in neuropsychology. PPA sent letters to representatives and senators supporting those amendments that strengthened the bill and opposing others that would have weakened the bill. After the bill was passed Rep. Briggs specifically thanked PPA for our assistance.

When this issue was first raised in Pennsylvania only four states had similar legislation; now more than 30 do. Despite the delay in securing passage of this bill in Pennsylvania, many other states adopted much of the wording developed by Pennsylvania legislators. The National Football League provided technical support and assistance in securing the passage of this bill.[1] They set the standard in the field that all athletes with suspected head concussions need to get appropriate health care. Probably of greater importance, however, is that the NFL and other professional sports organizations are working to change the culture of athletics which often puts covert or overt pressure on athletes to minimize or fail to report injuries.

Reference

Briggs, T. (2010, September 28). Remarks submitted for the record. *Legislative Journal — House,* 1349–1350.

[1] At a press conference in March 2011, the NFL sent former Philadelphia Eagles stars Mike Quick and Harold Carmichael to speak in support of this bill. Later that day, I saw them on the commuter train going from Harrisburg to Philadelphia, but I wanted to respect their privacy and said nothing to them as we boarded the train. When the train came to my stop at the Mount Joy station, the doors were temporarily jammed and while the conductors were working to open the doors I was standing in the aisle next to Quick and Carmichael. Harold Carmichael looked at us commuters in the aisle and said, "Mount Joy? I never heard of Mount Joy." Mike Quick said, "They never heard of you either." Then I said, "I've heard of you and know why you are here and I thank you for coming."

Facebook for Psychologists: "Friend" ship Ethics

Angela M. Dean, MA
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Editor's note: Angela Dean was the recipient of the 2011 Patricia M. Bricklin Student Ethics Award. This article is an abridged version of the paper for which she was recognized.

Connections forged on social media networks often blur the lines between professional and personal, resulting in ethical conflicts that are not only relatively new to the field of psychology, but are also constantly evolving at the rate that technology transforms. In order to maintain boundaries that ensure the well being of all involved, psychologists must educate themselves on social media network usage from both professional and personal perspectives, considering topics of privacy, confidentiality, self-disclosure, multiple relationships, and identity. While this article will focus heavily on the social media network, Facebook, the applicability of the discussion should be considered in relation to other social media networks, electronic communications, and emerging technologies.

Ethical Considerations

Ethical concerns in regard to Facebook and the field of psychology are emerging as rapidly as the technology. Recent literature debates whether the American Psychological Association's (APA's) Ethical Principles of Psychologists and Code of Conduct govern Facebook and other social media network usage. The debate centers around determining whether or not the information contained in Facebook pages is public or private. The 2010 amendments to the APA's ethics code clearly state that the code is applicable only to professional behavior, and not that which is entirely private. While the ethics code states the psychologist's duty is to protect the privacy of the client, privacy is not clearly defined (Lehavot, 2009). If one considers the information public, then application of the ethics code would not exist. However, some consider the information private because privacy settings are available.

Angela Dean is pictured with her professor, Dr. Anthony Goreczny, of Chatham University.

Therefore, psychologists should consider three primary areas of concern regarding Facebook usage: boundaries and multiple relationships, confidentiality, and self-disclosure.

Boundaries and Multiple Relationships

In the consumerist society, many clients consider the discovery of any and all information regarding professionals their right. Psychologists' Facebook pages without monitored privacy may be discoverable in Internet searches. Clients may discover questionable or personal content or mutual interests and "friends" unbeknownst to the psychologist that has been posted by the psychologist or the psychologist's friends. As a result, clients may request the psychologist to be their "friend." Both accepting and rejecting "friend" requests from clients present potentially harmful consequences on the therapeutic relationship including, but not limited to, rejection issues, unintentional self-disclosure, or boundary violations that lead to unwarranted or harmful multiple relationships.

Confidentiality

When considering whether or not information on social media networks is personal or not, an essential understanding of who may have access legally or illegally is necessary. In addition to the accessibility of information because of well-documented Facebook privacy issues, information may be hacked, monitored, or viewed by system administrators, family members, hackers, or governments. For example, should a psychologist intend to discuss the details of a therapy session with a client from whom the individual has accepted a "friend" request, but inadvertently sends it to an entire network for the city, a real possibility would exist that the psychologist's other clients or clients' "friends" may know details of a very intimate, confidential conversation.

Similarly, when psychologists who search for clients without the clients' knowledge or happen upon their profile as linked from a mutual "friend," the notions of informed consent and confidentiality are challenged. Using the information without informed consent breaches the ethics code, and may very well damage the therapeutic relationship by breaking trust. Suppose a client reveals having self-injurious thoughts or behaviors on Facebook but not in session, yet has also commented that this will be the topic of the therapy session the next day. What is the psychologist to do? If the information is deemed public because it is accessible by hackers or system administrators, then taking appropriate action to ensure the safety of the client is ethical. However, if the information is deemed private because the user has applied privacy settings, a psychologist may have ruined a therapeutic relationship and potentially face cyber-stalking charges in an attempt to ensure the safety of the client.

Self-Disclosure

While many theoretical orientations promote extensive use of self-disclosure to enhance, build, and maintain an authentic therapeutic relationship, doing so should always be in the best interest of the client, and not for personal interests of the psychologist. Yet, because Facebook privacy matters continue to evolve and are difficult to manage, clients may have access

to information that would not be in their best interest, potentially harming the therapeutic relationship. For example, a client working through communication issues in regard to family or friends about their homosexuality, may happen upon their psychologist's religious affiliation through a mutual "friend" and potentially wrongly assume based on media presentations of that religion that the psychologist was not empathetic towards them. As a result, the client may terminate therapy early or continue therapy with or without confronting the psychologist. In either case, the unintentional self-disclosure would harm the therapeutic relationship. However, had the psychologist acknowledged the religious position in session at the appropriate time, the therapeutic process may have resulted in therapeutic progress by acknowledging biases of both the client and the psychologist. Therefore, because the consideration of the client's best interest is foundational for therapeutic success, the potential for unintentional disclosures on Facebook, either by the psychologist or the psychologist's "friends," may inflict harm on the relationship and the client's well-being.

Summary and Recommendations

In deciding whether or not to set up a personal Facebook profile, psychologists must consider the professional implications doing so may have. While building and fostering personal relationships may initially seem like a harmless means to relaxation, unmonitored usage may lead to unintentional or intentional self-disclosure, confidentiality, multiple relationships, or other professional issues for which few guidelines have yet been established. In lieu of those standards, graduate studies, continuing education, self-monitoring, and institutional policies should be utilized to guide those in the field of psychology with regard to Facebook and other budding technologies. It is imperative that psychologists have an understanding of emerging technologies and view usage in the best interests of clients. Whether or not to use the technology is a personal preference, but being educated on the potential impact is necessary regardless of usage.

Reference

Lehavot, K. (2009). "Myspace" or yours? The ethical dilemma of graduate students' personal lives on the Internet. *Ethics & Behavior, 19*(2), 129–141. doi:10.1080/10508420902772728

Knapp Article Misses Mark on Christian Consumers

Editor:

Dr. Sam Knapp's article under the title, "Would You Like to See a Christian Psychologist?" (October 2011) gives a good reminder to psychologists to try to work with clients to find solutions for their psychological issues in a manner consistent with the client's religious framework.

Nowhere in the article, however, was the alternative offered of actually helping the client find what they are requesting. This can have the subtle implicit message that the request is inappropriate—perhaps even narrow-minded. One could conclude from the article that the client request is irrelevant, given competent and ethical psychologists offering services.

This overlooks several factors pertaining to successful psychotherapy outcome. If a client feels the therapist shares his or her values, I think the client is more likely to continue with sessions, and is more likely to be open to alternate views of their problems if they believe their therapist shares their basic faith perspective. The Bible contains a number of warnings against false teachers and false doctrine, and because of this Christians may be more wary of solutions to their problems that could be contrary to their faiths. Research has shown that post therapy, the values of clients are more similar to the therapists than before, so there could be some legitimacy to Christians' caution about finding psychological help apart from their faith orientations. Aside from any fear of their Christian faith being eroded by interactions with a non-believing therapist is simply a comfort level and a desire to talk to someone who understands their subculture and the language of their faith.

Few non-Christian therapists, as respectful as they might be, would know the difference between a Calvinistic versus an Armenian theological position, or the varieties of Christian views of the Holy Spirit, or the devil, or the concept of a sinful nature. It should be said that even if the client finds a Christian therapist, some of the same issues could be present. The countryside is dotted with Christian churches of different denominations representing various views on points of life and doctrine. There are also differences in approaches among those who would identify themselves as Christian psychologists.

The PPA website goes to extensive lengths to help people find a psychologist they can relate to. The website identifies 27 languages and 101 specialties (one of which is religious issues), but there is nothing that would help a prospective client identify shared values—religiously or otherwise. Some insurance companies offer the opportunity for therapists to self-identify Christian counseling as a service they offer.

Dr. Knapp's article in one sense offers a nice tone of respect for clients' values, but it could also inadvertently convey a dismissive attitude toward the concerns expressed by an individual seeking a Christian psychologist. A cursory skimming of the article could communicate that if a person seeks a Christian therapist we should convince them that their concern is unfounded, rather than helping them find what they are straightforwardly asking for. I think it is a libertarian perspective to allow people to seek what they want, rather than shape them toward our view of how they should be seeking and evaluating psychological services.

Respectfully,
John T. Hower, PhD

Psychology in Norway and Sweden – Successes and Stresses

Jacqueline Sallade, EdD

Dr. Jacqueline Sallade

The roving psychologist roves again. Both in Norway, where the dollar buys little, and in Sweden, where it buys a little more, I have interviewed patients, medical doctors, social workers, psychologists, and bureaucrats from receptionists to managers, more than 40 people in all. No one – that's right, *no one* – wanted to be identified. That's because publicly everyone from waiters to doctors will say in both countries, "We pay our 36% taxes from the heart and we get it back." After all, maternity leaves are 11 months in Norway with full pay or 13 months at 80% pay, and fathers are required to take off 3 months paid. In Sweden, both parents take about a year off at full pay. It's such a pleasure to see fathers pushing strollers during the day!

However, the government really can't afford these perks in either country as the elderly population expands, and health care has taken a big hit. Treatment is not totally free, as the governments like to claim. There's a deductible based on income and copays, though they aren't high. Regular medical exams have been disbanded in Sweden, and the copay in Norway for them is about $50. If the wait is too long, as it often is, for a public doctor in either country, people will pay as much as $200 for a private visit. Mind you, though, minimum wage in Norway is $20 per hour, and while it's less in Sweden, it's still high. In Norway, the maximum emergency room wait is four hours, so if you've been waiting that long, you'll be taken to another hospital, possibly out of town, for another four-hour wait. In Sweden, I needed some thyroid pills and no pharmacist would honor the information on my prescription container, so I waited many hours at an ER to see a doctor, then gave up and went to a private clinic, where I paid $250 for a one-minute visit.

The wait for cancer treatment, of course, is less than the wait for psychotherapy, which is almost unheard of among the general population in Norway. A definite stigma exists, and talking about feelings is culturally about the way Prairie Home Companion portrays it. Psychologists or therapists have been well trained both in Norway and Sweden, often partly abroad, and have a good reputation as researchers as well as healthcare providers in Norway, when they can be found. Clinicians do exist, though, and are more popular and available in Sweden. In one clinic that serves 12,000 patients, for example, there are two therapists: a nurse trained in cognitive behavioral therapy (CBT) and a psychologist, who also does CBT, and they offer about five sessions on average in combination with SSRIs prescribed by primary care physicians. In that clinic, PCPs see about five or six patients a day for half an hour to an hour at a time, so they really get to know their patients. They are well aware of the psychosomatic and trauma-based connections involved in chronic pain and illness, and they discuss patients in all their complexity, with caring and perspective.

Physicians in both countries sometimes refer patients to psychologists and other times try to handle cases themselves. Most psychologists have master's degrees, comprising five years of university after specialized high school plus one year of internship. Education is compulsory from ages 7 to 16, but many students elect and qualify for specialized high school education from 16 to 19. In both countries, the slowest students get a lot of help, and the illiteracy rate is near zero. Even for private schools, vouchers pay most of the fee. Some psychologists have as much as six to nine years of higher education without an extra degree, though. I spoke with several. Doctoral level psychologists are more likely to work in hospitals as neuropsychologists or in private clinics alongside psychiatrists. A lot of the basic counseling provided by mental health services in the U.S. are provided by social workers in Sweden. Many recent college graduates work in neighborhoods and schools with children by "hanging out" with them, informally playing, guiding and participating in their lives, and talking with their families. It's grassroots sociological participation, with as many as 2 workers to 30 students. However, they have more of a common-sense approach and a theoretical sociological education than any grounding in psychological practices or techniques.

Indeed, there are many inequities and black holes in the system. One woman in Sweden, a social worker, told of her own child being "beaten" and suffering post-traumatic stress at a day care with poor teacher supervision. Some social workers described efforts to privatize, of patients sent away if their cases are too complicated, and of people made to wait a long time to be seen in hopes that they will go to a private clinic instead of a government one, or get better without intervention. Many students with serious problems are placed in special schools, where they get substandard education and little therapeutic help. Elderly patients are required to have home care with visiting personal care aides three times, until they become so physically ill that a placement must be found. It is believed that home care is better for the patient, but the effect on the rest of the family may be ignored. In general, money is now the bottom line in all health care, so tests are put off as much as possible with some exceptions such as Alzheimer's. Medication is pushed, rather than therapy, and therapy sessions are limited in number, not legally but by expectation. Cognitive behavioral therapy is the norm and usually required by insurances, both governmental and other, in the belief that other approaches are not as cost effective. Hypnosis is almost unheard of.

Psychodynamic therapy is used but frowned upon when the hospital, national government, district, or county is paying. One woman told me she had been in traditional psychoanalysis for 17 years back in the '60s and '70s, paid for by the government before the system started changing.

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The Stresses of "Military Children" and a Call to Action

Christine C. Ganis, PsyD

Dr. Christine C. Ganis

Many American families have been affected personally by wars over the last decade, and as the drawdown of the war appears imminent, two million military-connected children will be reunited with deployed parents. Whether we watch from a comfortable distance or welcome service personnel home will be our decision, of course, but I would urge you to open your arms and your heart to those who have sacrificed so much.

The Military Child Education Coalition (MCEC), a nonprofit organization founded by military moms in 2003, is just such a way to channel our efforts. It supports families all year who experience the enormous stresses of deployment overseas, multiple moves, school transfers, and family disruptions too numerous to list. It also informs teachers and school personnel in helping a "military child" deal with the stark realities these children can face, such as that of a parent with PTSD, traumatic brain injury, or even death.

I strongly suggest readers look at www.MilitaryChild.org to better understand the challenges children, partners, and the veterans themselves face, no matter the extent of the presence of military families in the community. Many veterans' families are quite distant from military bases, as for example when the military serviceperson serves in the National Guard, so the usual supports, support groups for the civilian parent, military housing, and the PX are also missing, but we as sensitive community members can provide some of that missing support.

Some of the needs that arise range from foster care for a pet during the serviceperson's deployment, to helping make paychecks stretch with food and clothing banks and coupons. Did you know, for instance, that military families can use many coupons for up to six months past their expiration dates? Many companies extend special discounts or no-interest short-term credit to families of veterans. Some of us own small companies, and serving vets is just good business that strengthens our communities too. The website www.milserve.org matches civilian volunteers with military families whose members need services such as job searches, or even adaptive construction such as wheelchair ramps for wounded warriors. Comfort Zone camps are available through scholarships for teens who have lost a military parent. The Bernard Curtis Brown Foundation offers scholarships for one week of Space Camp at NASA for a child survivor between 5th and 9th grade. An essay of interest is all that is required. When stress is reduced in adults, of course, it is reduced in children, and vice versa.

Since the Iraq War began a decade ago, many of these children have "aged out," but many were born during the conflict, and multiple deployments are all they know—hence the end of the war will be the "new normal" for them and all of us. MCEC trains teachers and administrators about these kids' needs in more than 800 colleges and universities. It offers scholarships, and it partners with other organizations to assist in children's emotional, academic, and financial adjustment. Dr. Ken Ginsburg, a pediatrician from Children's Hospital of Philadelphia and the University of Pennsylvania, has worked with MCEC. His book, *Building Resilience in Children and Teens: Giving Kids Roots and Wings*, is written in ordinary language anyone can use, and lists pages of websites to put these resources into use as well. Dr. Ginsburg's approach boils down to helping adults re-set their expectations of youth to positive ones. He cites a website, www.mostofus.org as helpful in accenting the positive in our youth. One of his mantras is "never stop catching your child being good." He reminds us it is our job to set clear expectations, and then get out of the way. In other words—promote independence whenever possible, striving for age-appropriate and

> *Let us all bring our best expectations and optimism to meet the challenge of military kids in our communities.*

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Classifieds

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PSYCHOLOGY IN NORWAY AND SWEDEN

Continued from page 8

She had been in a special school for delinquent children, had done poorly in her first attempt at higher education, and went for help. Her two analysts over the years helped her realize "that my mother stopped loving me after I was one and a half years old, and that explained my behavior and even now why I live alone and only have had bad relationships with men." She said that her analysts were well-known authors, professors, and therapists who "saved my life." Today, she is a teacher and functions well. Were 17 years needed? She thinks so. However, taxpayers consider this an abuse of the system. The system is still abused by people taking off work for long periods of time at full pay for minor physical or mental difficulties and "becoming disabled," which, once determined, rarely gets reviewed or reversed and results in permanent unemployment and dependence on government funds.

Psychologists in the clinical office may be wearing jeans. The therapy hour lasts about 45 minutes. The clinicians I interviewed love their work but hate the system. They talk about their patients with the same dedication, caring, and interest we do. Like us, they treat depression and other mood disorders, including anxiety and panic; ADHD, a new diagnosis, in children and adults who want to understand some of their past and present difficulties; work stress and family problems; and trauma from bullying, abuse, and physical illness. Obesity is on the rise, and the medical system there, having seen America's problem, is trying hard to contain it. Forensic and disability psychology are less common than in the U.S., as is neuropsychology.

Psychologists feel manipulated and pushed around by insurance companies, both government and private ones. Physicians, psychologists, nurses, and clerks do electronic billing, depending upon where they work. They are paid salaries in clinics or hospitals, and very few have private practices. Their yearly earnings average midway between teachers and PCPs, or approximately $50,000 – $70,000 per year, and the hourly rate for a patient ranges from nothing to $200 per hour private pay – but the price of living is high there: My ice cream cones cost $6–$10 each!

I had a great time in Norway and Sweden. There was an overall feeling of prosperity in the main cities of Oslo and Stockholm and the smaller city of Vasteras, where I visited a family of doctors. I loved seeing well-behaved and happy children with their parents, the low rate of obesity, the clean stylish appearance of most people, and a general atmosphere of civility. Yet, poverty, drug and alcohol addiction, and criminal behavior exist, too. People have problems wherever they are, and psychologists are needed and are there to stay.

THE STRESSES OF "MILITARY CHILDREN"

Continued from page 9

authentic success. He borrows the "7 C's" of resilience from the website www.resilienceinaction.com. They are competence, confidence, connection, contribution, character, control, and coping. He borrows from the work of Dr. Martin Seligman, the website www.resilienceinaction.com, the National Child Traumatic Stress Network at www.NCTSN.org, and the American Psychological Association, www.apa.org.

So this winter find some room in your heart to say "thank you" and "we're glad you're here" for the many sacrifices that military families, and especially military children, have made for us. Let us all bring our best expectations and optimism to meet the challenge of military kids in our communities.

Some additional websites that will help direct you in specific ways are: www.homesforourtroops.org; www.dav.org/volunteers; www.guardianangelsforsoldiers.org; to donate old cell phones for an hour of talk time overseas at www.cellphonesforsoldiers.com; to donate movies or television shows go to www.dvds4vets.org; participate in a local food or clothing drive at www.operationgratitude.com/volunteer. The Kitchen Table Gang connects you with hospitalized veterans and troops so your group can send a care package with a note to www.soldierpackages.org. Big Brothers Big Sisters has a special military mentoring project at www.bbbs.org. Each branch of the military has links to volunteer opportunities. Michelle Obama's favorite site is www.createthegood.org. Finally, for a range of services for military children, youth, and families, go to www.mfrc-dodqol.org/MCY/index.htm.

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Spring Continuing Education and Ethics Conference
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Marti Evans (717) 232-3817

June 20 – 23, 2012
Annual Convention
Hilton Harrisburg
Harrisburg, PA
Marti Evans (717) 232-3817

October 18, 2012
APA Insurance Trust Risk Management
Harrisburg, PA
Marti Evans (717) 232-3817

Podcast
A Conversation on Positive Ethics with Dr. Sam Knapp and Dr. John Gavazzi
Contact: ppa@PaPsy.org

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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