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# Pennsylvania's Child Protective Services Law: Where Are the Loopholes?

*Samuel Knapp, EdD, Director of Professional Affairs*

*Dr. Sam Knapp*

In the aftermath of the sexual abuse scandal at the Pennsylvania State University, legislators in Pennsylvania are planning on revising the Child Protective Services Law to ensure better compliance with reporting, expanding the reporting requirements, or taking other steps to reduce child abuse and protect children. The Pennsylvania Senate and House of Representatives have created a joint Task Force on Child Protection that will hold hearings and submit a report by November 30, 2012; it will recommend changes in the statutes, practices, and policies in Pennsylvania concerning child abuse. Bills to modify the Child Protective Services Law have already been introduced in the General Assembly, although it is unlikely that anything will pass until the Task Force on Child Protection completes its report. PPA will be monitoring the activities of this task force and offering its perspective on needed changes. Although mandated reports are a necessary component of such legislation, PPA will be on guard against requirements for breaches of confidentiality when they are not essential and in the public interest.

An analysis of the data shows that Pennsylvania does poorly in identifying child abuse. The identification of victims of child abuse occurs through two processes. First, the Department of Public Welfare's Office of Children, Youth and Families (or similar agencies in other states) receives reports of abuse and then they investigate the report, resulting in a determination of whether or not the abuse actually occurred. Pennsylvania has the lowest rate of reported child abuse in the nation (8 reports per 1,000 children compared to an average of 40 per 1,000 nationwide). Even after a report of abuse is made, only about 15% (about 1 in 7) result in a child being identified as abused, compared with a 22% average nationwide (U.S. Department of Health and Human

*Continued on page 8*

# Termination of Supervision Requires Planning

*John A. Mills, PhD, ABPP*

*Dr. John A. Mills*

It is easy to underestimate the significance of the closing phases of supervision. Even in situations in which the supervision has been dominated by technical development of the trainee (such as in the supervision of neuropsychological assessment), the ending of supervision is a time with some risks and many opportunities. This has been clear since the early days of the formal therapeutic industry, even reflected in Sigmund Freud commenting on the power of the supervision experience. The following discussion will highlight some important issues that may be prominent when supervision ends. A major theme of this discussion is the way in which supervision termination is an extension of the earlier stages of supervision.

It will not surprise the thoughtful clinician to hear the suggestion that the quality of a supervision termination is greatly influenced by the quality of the supervision framework that was established at the outset. Such issues as setting clear mutual expectations, agreeing on the appropriate ways to

*Continued on page 10*

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# Medicare Faces February 29 Deadline

At press time we learned that the U.S. Congress approved an extension to the end of February to continue Medicare reimbursement rates at the 2011 levels. This was part of the larger legislation concerning the payroll tax level, unemployment benefits, and other issues. Many PPA members have received feedback from their members of Congress that they support a long-term fix of Medicare reimbursements so that they don't have to go through the process of constantly staving off dramatic decreases in reimbursements to psychologists and other providers. However, that is a tall assignment since it will cost a great deal of money, and legislators can't agree on how to pay for it.

In the meantime, Congress will be considering legislation before the end of February to at least override the scheduled reimbursement decrease through the end of the year. Members are asked to watch for further requests to contact their U.S. senators and representatives and to act promptly to urge them to support a reasonable reimbursement rate in the Medicare program. Many private insurance companies tie their rates to the Medicare rates, so this action affects most psychologists delivering health care services and the access that patients have to those services.

# Best Practices in Billing for Couples Therapy

*Appreciation is expressed to Dr. Vince Bellwoar, Dr. Richard Small, and members of the PPA Insurance Committee for reviewing an earlier version of this article.*

Very often psychologists will receive requests from prospective patients who want marital or relationship counseling. They may be persons in good health who are interested primarily in promoting relationship harmony. However, usually they are under great emotional stress, and one or both meet the criteria for a DSM diagnosis. For example, Rose et al. (2011) found that depression or anxiety among one spouse puts a strain on the marital relationship. Also, the distress scores of couples seeking marital therapy on the Outcome Questionnaire 45 were comparable to the scores of other patients seeking outpatient therapy (Shimokawa et al., 2010; Tambling & Johnson, 2008). Zaider et al. (2010) found that husbands of women with anxiety disorder often felt significant distress themselves. Finally, the involvement of couples as adjunct or collaterals to treatment is often indicated. Although this is seldom called "marital therapy," both partners may be in the room and the intervention may indirectly benefit the non-patient. Given that relationship counseling is often clinically indicated, how then should psychologists bill for it?

**Q Can psychologists bill health insurance companies for couples therapy?**

The answer depends on what is meant by couples therapy. If it means therapy in which the focus is ONLY on the relationship between two persons, then the answer is probably not, because this fails to meet the standards of medical necessity. However, if it means therapy in which the standards of medical necessity are met and the modality for meeting medical necessity involves having a partner as a collateral participant in treatment, then the answer is probably yes.

The standards of medical necessity involve at least three questions. First, is there a patient with a DSM diagnosis? Second, is the treatment reasonably expected to treat that diagnosis? Third, do the psychotherapy notes document how the treatment is directed to alleviating the presenting diagnosis? Of course, developing a diagnosis requires that the psychologist take time to ask the questions and get the background necessary to establish the criteria for the diagnosis for the identified patient.

**Q How can systems-oriented psychologists, who view the presenting issue in terms of relationships and not individual pathology, practice within the parameters of the individualistic-oriented health care reimbursement system?**

Every systems-oriented psychologist needs to answer this question for himself or herself. Some systems-oriented psychologists refuse to participate with third-party reimbursement programs. Others will follow the rules of the health insurer, yet still conceptualize the intervention and problems in terms of weaknesses in relationships or communication patterns. Psychologists can reasonably conceptualize treatment in more than one way. For example dynamic therapists can legitimately fill out symptom-oriented treatment plans even if they don't believe these forms capture the important essence of the treatment.

**Q When billing health insurance policies for couples therapy, is it desirable to create a chart that includes the names of both spouses?**

No. The medical necessity criteria of health insurance companies require demonstration of the medical need for one patient who is covered under the policy. Therefore, the psychologist needs to create one chart in the name

*Continued on page 4*


**BEST PRACTICES...**
*Continued from page 3*

of one patient. One partner will become a patient and the other will become a collateral contact who will be present to assist the other spouse.

The implications are that the partner identified as the patient will have a mental disorder assigned to him or her and will have control over the release of information. Although the psychologist may help the collateral (non-patient) partner feel involved in the therapy session, design interventions that account for their well-being, and treat him or her with respect and courtesy, the collateral contact is not a patient for purposes of controlling the release of records.

**Q Isn't billing for couples therapy under the insurance company's standards of medical necessity similar to putting a square peg in a round hole?**

Yes. It is, because the medical necessity model ignores the deep interconnectedness between emotions, emotional well-being, and the quality of interpersonal relationships. Affective states are closely linked to interpersonal relationships and often the optimal treatment of affective disturbances requires the close involvement of other family members. Even disorders that appear to be primarily intrapsychic, such as panic disorders or OCD, often improve more when psychologists involve family members in treatment. Many psychologists have written about the poor fit between the medical model and helping people with psychological problems. Like those entering the legal arena, psychologists must decide whether they have the flexibility to do quality work and still follow the guidelines of the insurance system.

**Q Isn't it deceptive to describe the therapy session in terms of benefitting one partner while another partner is also benefitting?**

It is not deceptive as long as what psychologists document is true. The health insurance company is interested in whether the intervention helps relieve a DSM disorder. If it does so, then it is consistent with the standards of medical necessity (as long as it is documented). Whether or not the collateral contact benefits from the treatment of their partner is incidental as far as the insurance company is concerned, although it is far from incidental as far as the couple is concerned.

**Q How should the psychologist establish a chart if both partners are equally distressed?**

Many psychologists handle this issue by explaining the medical necessity criteria to both partners and then having them decide who should be the focus of treatment.

**Q How should psychologists proceed if neither of the partners has a DSM diagnosis?**

If neither partner has a DSM disorder, then the treatment will not meet standards of medical necessity and would not qualify for health insurance. However, some couples may benefit from marital therapy even if neither of them has a DSM disorder. The fact that insurance does not choose to pay for a service does not mean that the service is not psychologically indicated and helpful.

**Q How should psychologists proceed if one of the partners appears to be in psychological distress, but the psychologist is not certain if the distress meets the criteria for a DSM diagnosis?**

Psychologists need to use their best judgment to decide and document accordingly.

**Q Can psychologists alternate billing each partner? For example, can a psychologist bill under the name of one spouse for 10 sessions, and then bill under the name of the other spouse for 10 sessions?**

Psychologists who are uncertain how to bill should check with the insurer to determine how that insurer wants treatment to be coded. Insurers may have unique standards or procedures on how they would want these sessions to be billed. The general rule, however, is for the psychologist to have accurate documentation that can justify however the session was billed.

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# Poverty in America

*Samuel Knapp, EdD, ABPP, Director of Professional Affairs*

Statistically, the U.S. Census Bureau defines poverty as income below a certain standard, and according to this standard about 15% of Americans are poor (Poverty Definitions, 2011). However, this categorization has limitations because income does not accurately represent the totality of family wealth or resources. Also, other organizations use different formulae for computing poverty resulting in some variation in the estimated rates of poverty. More importantly however, statistics fail to capture the struggles, experiences, and diversity of those living in poverty.

Poverty is intermixed with gender, age, and race as poverty rates are higher among women, older adults, children, African Americans, Hispanics, and Native Americans (although the majority of impoverished Americans are of European descent). Poverty in America has a geographic feature as well. Some parts of America (such as Southern Appalachia, the Yazoo River Valley [from Memphis to New Orleans], inner cities, the Deep South, or Native American reservations) have rates of poverty far higher than the nation in general. Rates vary from a low of about 8% in New Hampshire to more than 21% in Mississippi. Pennsylvania is near the middle with a poverty rate of 12% (Persons Below Poverty Level, 2008).

In the aggregate, people living in poverty have higher rates of mental illness and physical illness, shorter life expectancies, less access to high quality health care, higher rates of vocational disability, and lower ratings of subjective well-being. They have more exposure to trauma (child abuse or intimate partner abuse), more unwanted pregnancies (more abortions and more children born out of wedlock), higher divorce rates, higher rates of incarceration, and less education. The relationship between education and income is so high that some sociologists will use education as a proxy for income when conducting research. Obviously, the above facts are statistical generalizations. Many persons living in poverty are healthy and happy and live long lives.

Moreover, the experience of poverty is diverse. The experience of poverty for an inner city African American youth may differ considerably from that of an older European American adult living in Appalachia, or a recently divorced woman living in the American Midwest. Furthermore, even the lives of impoverished inner-city African American youths may vary considerably depending on the parents, teachers, church members, or other relationships and emotional resources available. Objective indices of poverty are so limited in understanding an individual that Liu et al. suggest "that social class should be a descriptor of a psychological process such as a worldview, much like the research on racial identity or gender identity" (p. 14). Indeed, about 40% of those with family incomes below $20,000 a year describe themselves as "middle class" (Holmes, 2011). Conversely some persons with incomes above the poverty line act like poor people. During the 1970s I worked in Indiana County, Pennsylvania, during the boom in the coal industry precipitated by the energy crises of 1973 and 1978. The coal companies were hiring about anyone they could, and many people suddenly had a lot of money but retained attributes and habits commonly associated with their unemployed neighbors. (I recall commenting that "these poor people have a lot of money.")

Poverty has shown itself to be remarkably intractable. Efforts to reduce poverty through educational enrichment programs, monetary grants, back-to-work programs, subsidized child care, and other programs have had mixed results. No doubt many have benefitted from these programs and lifted themselves out of poverty, but none has been an unqualified success.

The following articles are designed to help psychologists to better serve patients in poverty by looking at the experiences of those living in poverty, describing the link between poverty and health, and looking at ways to improve the effectiveness of psychotherapy with persons living in poverty.

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# Health and Poverty

*Samuel Knapp, EdD, ABPP*

Disease and death are not randomly distributed across the population. Poor people are more likely to get sick, to become disabled, or to die early (Adler, 2009). This inverse link between health and socioeconomic status (called the "SES gradient;" Sapolsky, 2005) was documented famously in the "Whitehall Study," which found that the mortality rates gradually increased as the employment level of English civil servants decreased (Marmot et al., 1984).

Several explanations have been put forth to explain the SES gradient including lifestyles (people with higher SES are more likely to engage in healthy behaviors); access to health care (people with higher SES are more likely to have good health insurance or the resources to pay for necessary treatments); the impact of stress on overall health (people with fewer economic resources are more vulnerable to the impact of stressful life events, or are more likely to use unhealthy habits to mitigate the impact of stress); psychological factors (growing up in conditions of poverty may impact overall intelligence or the development of health-sustaining personality factors); or downward drift (people with illnesses may be less likely to achieve high occupational or educational success). None of these factors account for the entire SES gradient, but they interact in complex ways.

Unhealthy behaviors (such as smoking, overeating, underexercising) are more common among lower socioeconomic groups, accounting for much, but not all, of the disparity in the life expectancy and overall health among socioeconomic groups (Stringhini et al., 2010). However, the relationship between SES and health appears to be bi-directional, at least in part. That is, SES may influence lifestyle behaviors. For example, those who live in an unsafe neighborhood would be less likely to go outside for walks or other physical recreation. Also fruits and vegetables are more expensive than low-cost pastas, so that people with lower incomes end up paying a substantially higher percentage of their income for fruits and vegetables than those with higher incomes. Furthermore, the increased stress associated with lower SES may encourage the use of unhealthy behaviors as a way to cope with everyday life (Adler, 2009).

Lack of access to adequate health care among those lower on the SES ladder explains only a portion of the entire SES gradient. The relationship between SES and health occurs even in countries such as the United Kingdom or Canada, which have had universal health care for many years.

Some research suggests that socioeconomic status is related to certain personality traits, such as conscientiousness or intelligence, which are linked to healthy lifestyles and behaviors. For example, Gottfredson (2004) claimed that general intelligence mediates the differences between SES and health outcomes. He noted that children born into poverty perform more poorly on standardized psychometric tests, on the average, than those born in more affluent conditions. However, the culprit might not be bad genes, but the circumstances in which the children were raised, as chronic stress and limited opportunities may prevent the children from developing the verbal skills or having the word-intense environments necessary for them to increase their intelligence. Furthermore, the chronic stress associated with poverty can impair memory, weaken the immune system, and may lead to physical problems such as elevated blood pressure or cardiovascular diseases (Morozink, et al., 2010). Finally, for some people poor health causes them to fall in SES. Some with physical illnesses cannot physically hold a job, or are unable to assume more demanding jobs, thus leading to downward mobility. Or people with serious health problems may go bankrupt paying their medical bills.

In summary, the relationship between SES and health is complex. Efforts to improve the health among those living on the lower rungs of the SES ladder will likely require a multifaceted approach addressing educational opportunities, changes in health-related behaviors, access to health insurance, and other interventions.

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# The Working Poor in America

*Reviews of*
***Nickel and Dimed* by Barbara Ehrenreich**
***The Working Poor* by David Shipler**
***The World of Mexican Migrants* by Judith Adler Hellman**

*Samuel Knapp, EdD, ABPP*


The actual experience of the working poor lies behind the statistics and demographic data. In an engaging manner, reporter Barbara Ehrenreich describes her work in several different low-paying jobs (waitressing, housekeeping, sales associate) in Maine, Florida, and Minnesota. Being white, healthy, educated (she has a PhD in biology), and with financial resources to fall back upon in an emergency, she knew that she could not truly experience a life of poverty. Instead, her modest goal was "to see whether I could match income to expenses, as the truly poor attempt to do every day" (p. 6). In *Nickel and Dimed* she describes the frustrations, boredom, work-related friendships, and the difficulties in finding acceptable housing, transportation, and budgeting for food on her limited income. She was struck by the generally authoritarian attitude of managers who assumed that their workers would be slackers, and the generally dedicated attitude of the workers who took pride in their work despite often arbitrary and petty rules imposed by management.

In *The World of Mexican Migrants,* Judith Adler Hellman describes the lives of undocumented Mexican migrant workers. Many facts are generally known: about 12 million undocumented Mexicans work in the United States; crossing into the United States is dangerous and sometimes lethal; most undocumented workers take low-paying jobs and are often exploited by employers who violate labor laws; and poverty motivates most of these migrants who send money back to their families in Mexico. Also, undocumented workers deal with slum landlords, language barriers, and ethnic discrimination (especially, Hellman claims, from American citizens of Mexican descent).

However, Hellman shows the difficulty in assuming a typical experience for an undocumented worker. Despite frequent exploitation, many found jobs with employers who treated them decently. Despite being foreigners in a strange land, many lived with people from their own village, or even family members who helped them navigate the cultural and linguistic barriers. Although many emigrated to escape poverty in Mexico, others emigrated for other reasons. One man earned a degree in dentistry in Mexico, but then worked construction to earn enough money to purchase the dental equipment he needed to start a dental practice in his home town. In spite of the variation in individual experiences, almost all of these undocumented workers sacrificed much, showed great family loyalty, and worked hard.

Her stories also illustrate the immense cultural gap between Mexicans and Americans. For example, Hellman described a school presentation for parents on child abuse, which included a section on sexual abuse. This frightened the parents because in rural Mexico men in their twenties commonly marry teenage girls. As one worker stated, "we had teenage sex, but it was with our husband!" (p. 198).

Also, gender roles differ considerably in the United States. Mexico is a heavily patriarchal society. In rural Mexico newly married girls commonly move into the houses of their husbands, where they must submit to the authority of their mothers in-law; and husbands (or mothers in-law) have the authority to physically discipline them. However, many women saw working in the United States as an opportunity to avoid this tyranny. Mexican men working in the United States appeared to use more restraint in physical violence against spouses because of a fear of police intervention, which was unheard of in Mexico.

In *The Working Poor* David Shipler focuses primarily on eight working individuals who live in poverty, although other workers are presented as well. He combines personal stories with background commentary on poverty, relying on psychological and sociological data. He does not shy away from describing ways in which they contribute to their own poverty through impulsive decision-making, poor health habits (e.g., smoking, drug abuse, poor diets), or lack of anger control.

But he also discusses their nobility as well, and how they worked hard, saved, committed themselves to the welfare of their children, and otherwise strived to make a decent life for themselves and their loved ones. However, the margin for error is slim. A random event can make the difference between self-sufficiency and disaster.

> Every problem magnifies the impact of the others. . . . A run-down apartment can exacerbate a child's asthma, which leads to a call to the ambulance, which generates a medical bill that cannot be paid, which ruins a credit record, which hikes the interest rate on an auto loan, which forces the

*Continued on page 8*

## THE WORKING POOR IN AMERICA

*Continued from page 8*

> purchase of an unreliable used car, which jeopardized a mother's punctuality at work, which limits her promotions and earning capacity, which confines her to poor housing (Shipler, 2001, p. 11).

Shipler's relationship with one worker started with her insisting on a pseudonym ("call me Peaches," p. 150) presumably because of her embarrassment over her childhood of abuse and foster homes, and her adult life of homelessness, beatings, and rape. She eventually got to a job-training facility where very basic job skills were taught, including manner of speech, dress, and punctuality. "There was no false praise in the room, but there was more support than Peaches had ever had in her life" (p. 257). Eventually she achieved financial security through employment and got engaged to a "good man" with a steady job. As an adult she returned to visit the church of her childhood where she thanked the now-elderly parishioners who nurtured her as a child when her mother was unable to do so. They inspired her, "even when I was at my very lowest" (p. 308). She connected with a man who lived in a foster home with her ("her foster brother"), and his children called her "auntie" and made her part of their family. When author David Shipler contacted Peaches to send her a near-final copy of the book, he reiterated that he had honored his promise to use her fictitious name. She responded brightly, "You can use my real name now. It is Celestine Travers" (p. 309).

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## PENNSYLVANIA'S CHILD PROTECTIVE SERVICES LAW

*Continued from page 1*

Services, 2010). Finally, Pennsylvania has the lowest rate of identified child abuse in the nation (1.3 identified victims per 1,000 children compared to an average of 9.2 per 1,000 nationwide).

An analysis of the data suggests a pattern for this large discrepancy. Child abuse in Pennsylvania (and most states) is defined as neglect (failure to meet basic necessities of life), physical abuse (non-accidental injury), emotional or psychological abuse, or sexual abuse. Although the Penn State scandal involved sexual abuse, Pennsylvania has a rate of identifying sexual abuse that is only slightly lower than the national average. Nationwide, about 10 out of 10,000 children were identified as having been sexually abused. Within Pennsylvania about 8 out of 10,000 children were identified as having been sexually abused (U.S. Department of Health and Human Services, 2010).

However, Pennsylvania lags far behind other states in the identification of neglect, physical abuse, and emotional abuse. For example, Pennsylvania identified 197 cases of neglect in 2010,[1] compared to 14,831 cases of neglect in Ohio and 19,662 cases of neglect in Illinois, both of which have a comparable number of children as Pennsylvania. Similar large discrepancies occur for physical abuse and emotional abuse, where children in Pennsylvania are far less likely to be identified as abused than in other states (U.S. Department of Health and Human Services, 2010).

There is, in my opinion, ambiguity in the definition of reporting of abuse by educational personnel that needs to be addressed. However, the major weaknesses in Pennsylvania's child abuse reporting and monitoring system appears less directly related to the sexual abuse allegations against former Penn State assistant football coach Jerry Sandusky, and more with the under-identification of children who are victims of neglect, physical abuse, or emotional abuse.

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**[1]One source reported 197 cases (U.S. Department of Health and Human Services, 2010), and another listed 194 (Department of Public Welfare, 2010). The reason for the discrepancy is not known. Nonetheless, despite the slight differences in the figures cited, they both indicate the gross under-reporting of neglect as a type of child abuse.**

# Psychotherapy with People Living in Poverty

*Samuel Knapp, EdD, ABPP*

Although people living in poverty have high rates of mental illness and would appear to need psychotherapy the most, some believe that they are among those who are the least likely to benefit from it. Patients living in poverty are seldom YAVIS patients (young, attractive, verbal, intelligent, and successful; Schofield, 1964) who enter therapy with a high likelihood of success. What can psychologists do to increase the likelihood of successful psychotherapy with patients living in poverty?

As noted in a previous article, people living in poverty vary substantially in age, race, and gender. Consequently, effective psychologists consider those factors as well as the patient's unique life history, experiences, and skill sets, and alter their treatments accordingly. Despite this diversity, a salient characteristic of poor patients is their poverty itself, and successful psychotherapists account for this in their treatment. Poverty, in addition to whatever characteristics the patient has, exerts a profound influence on their lives. People living in poverty may be overwhelmed by daily demands, such as just getting food on the table or heat for the home, that working on emotional or relationship issues becomes secondary to more immediate needs. Because their income limits housing options, they are more likely to live in neighborhoods with indices of social dysfunction (e.g., poor schools, high crime rates, more pollution or noise) that decrease the quality of life.

Successful professionals guard against classicism, or prejudice against people simply because of their lower socioeconomic status, on their part (Smith, 2007). Classicism may manifest itself through having unwarranted diminished expectations for success, or subtle behaviors that reduce the likelihood of a favorable outcome. For example, psychologists who fail to consider the contextual factors associated with poverty may commit the fundamental attribution error (e.g., in ascertaining the cause of a behavior they may be giving too much weight to stable dispositional factors and not enough weight to situational factors). For example, one family had a serious argument that centered on the difficulty that the husband had in changing his work schedule to pick his wife up from the bus station. In a middle class family, the husband would be more likely to have flexibility in his job, or the wife could have paid for a taxi. Less sensitive psychologists could interpret this argument as an example of some psychological shortcoming on the part of their patients, such as poor planning, or unwillingness to help each other. However, more sensitive psychologists would know that people living in poverty often have jobs with less flexibility, and the cost of paying for a taxi might have been prohibitive for them.

Similarly, diagnostic impressions and treatment recommendations need to consider the impact of environmental stressors. Years ago I arranged for the involuntary psychiatric hospitalization of a man who was highly belligerent and apparently paranoid. At his first interview with the psychiatrist he complained that he was hungry. Even though it was late at night and the hospital kitchen was closed, the psychiatrist arranged for him to get a meal. After the meal he said he was still hungry and the psychiatrist arranged for him to receive a second meal. After the second meal he became a model patient, cooperated with treatment, and expressed deep appreciation to the psychiatrist and the staff. His extreme hostility, which I had initially interpreted inaccurately as paranoia, was based on his recent experiences at a boarding home which did not consider his basic needs. Major depression was a more accurate diagnosis.

At times it may be indicated for psychologists to seek supplemental resources for their patients. Case managers from public or private organizations can sometimes help patients with day-to-day issues, such as getting food, transportation, or access to other needed resources. Although I would be very reluctant to make a phone call to a social service agency on behalf of a verbal middle class patient, I have made such phone calls for people living in poverty if I perceived they lacked the social skills or background needed to effectuate successful access to services. Psychologists need to make decisions such as this on a case-by-case basis, to avoid the perception that therapy is simply a gateway to receive other social services.

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SAVE THE DATE

## Advocacy Day
## April 30, 2012

Please save the date of Monday, April 30, 2012, for our annual Advocacy Day in the state Capitol. The agenda will include House Bill 1405, authorizing psychologists to make recommendations on insanity in criminal cases, and a plethora of bills now being introduced dealing with child abuse reporting. The state House and Senate have established a joint legislative Task Force on Child Protection, which will consider recommendations in this area. PPA will have materials available to guide your discussions with legislators on changes that should (and should not) be made to the Child Protective Services Law. Please plan to attend!

## TERMINATION OF SUPERVISION REQUIRES PLANNING

*Continued from page 1*

prepare for and participate in supervision, the goals for the trainee in supervision, and the expected domains of evaluation are just a sample of the possible elements that form the foundation of a solid supervision agreement. (For more thoughts on the essential elements of informed consent to supervision, consider the work of Sutter, McPherson, and Geeseman, 2002.) Beyond the immediate initiation of supervision, it can be very useful to engage in substantive discussions of the role of past supervision experiences in the current development and attitudes of the trainee. Not only can these discussions be useful in considering the possible nature of the upcoming supervision, they can be helpful to both parties in considering how to maximize the benefit gained from how supervision is conducted. In addition, these discussions form the groundwork for optimal closing discussions.

Throughout the supervision experience, it is essential that the relationship be maintained within the structure of the organization/agency in which the supervision is conducted. This means that formal mechanisms of evaluation and other administrative matters be followed carefully. Ideally, the framework will be maintained with sufficient care that the focus of most supervision attention can be on the specific matters of clinical technique. Without such attention, the gains that are possible during the termination phase can become obscured by an accumulation of difficult feelings.

Even in contexts in which the supervision relationship enjoys a nurturing organizational context, there can be temptations to individualize structural and thematic elements of supervision, and this can be very important and positive. At the same time, even if there are differences of opinion about how an agency is administered, any unique practices must remain under the broad umbrella of agency structure. This issue is particularly important at the time that supervision is closing. With the range of issues that can be part of the termination experience, any collusion related to agency defiance between the supervisor and trainee can be exacerbated.

Within the framework created by the supervision context, it is important for the trainee to be encouraged to verbalize the subjective reactions to the ending of supervision. When such personal elements are brought out into the open, the supervisory dyad will maximize the growth potential that can be intrinsic to the termination process. There is debate in the literature about the significance of determining whether a reaction represents a manifestation of transference versus realistic reaction, but what seems more important is that these areas of experience be resolved well. There might be some importance to developing an intellectual understanding of the type of reaction that is present, but careful expression of the reactions is of greater immediate and concrete significance. For example, it is important to discuss the satisfactions and dissatisfactions with the supervision experience. There is a natural temptation to omit or avoid such an anxiety-provoking topic, but such work can help to solidify training gains as well as help to build goals for future professional development.

*Throughout the supervision experience, it is essential that the relationship be maintained within the structure of the organization/agency in which the supervision is conducted.*

The closing phase of supervision is an important time to bolster the professional autonomy of the supervisee. One key to this component of termination is the fate of the dual roles in supervision. Ethical codes and practice guidelines are clear that professionals should avoid multiple relationships and/or should mitigate risks associated with multiple relations. At the same time, supervision is an enterprise that is born of dual roles. Most authors in the field agree that supervision usually contains elements of multiple relationships that cannot be avoided (e.g., Gottlieb, Robinson, & Younggren, 2007). For example, the emotional safety in a supervisory relationship exists in some contrast to the need for the supervisor to function as a gatekeeper for the profession. At the same time, the fate of the extra-supervisory roles can take many shapes that are important to clarify.

Since ethical standards are clear that multiple relationships should be avoided or the risk of any possible deleterious effects of such relationships mitigated, it is reasonable to consider that the supervisory relationship has already managed these risky waters before the termination phase. It is suggested here that issues related to multiple relationships continue through and beyond the termination phase, and that the termination phase offers another opportunity to enhance the experience of the supervisee. In particular, the new possibilities for multiple relationships need to be brought into the current relationship and discussed. For example, what, if any, new roles will exist between the supervisor and professional? This question can include considerations as superficially mundane as how the two individuals address each other to the far more significant question of whether there will be any real life relationship at all. Within this range of possibilities include questions such as, what kind of contact will we have? What procedures should be followed to secure letters of recommendation for further professional opportunities?

At a more subjective level, there may be subtle efforts to prolong the supervision relationship as it was previously functioning. In many cases, supervision is a safe and enriching place for both parties, and it is natural to wish to make the most of such experiences. Care and discipline with the timing of termination can help transform what is an emotional loss into the most constructive possible experience, with fond memories and clarity for the future.

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Editor — Andrea L. Nelken, PsyD
PPA President — Judith S. Blau, PhD
PPF President — Richard F. Small, PhD
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