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Stephen N. Berk, PhD
A Man of Great Spirit Departs

DR. STEPHEN N. BERK died at the age of 65 on February 2, 2012, after a brief illness. Dr. Berk had served in some capacity within PPA's governance almost continuously since 1986 and served as president of PPA in 2004-05. During his presidency, PPA secured the passage of legislation allowing minors aged 14 or older to seek treatment on their own. In that year PPA also helped secure the passage of regulations that prohibited corporal punishment in public schools, and our association initiated the e-newsletter for the public. Most recently he served as the representative from Pennsylvania to the APA Council of Representatives. As president of PPA's Clinical Division in the 1990s, Dr. Berk had helped found the initiative that eventually became PPA's Practice-Research Network; prior to that he was president of the Academic Division. From 2000 to 2002, he chaired the first Student Membership Initiative Project Group, which was the forerunner of PPAGS, PPA's graduate student organization. He had actually joined PPA in 1972 as a student member. During his long tenure of service to PPA he also served on both the PennPsyPAC and Pennsylvania Psychological Foundation Boards of Directors and chaired the Awards Committee for many years.

Dr. Stephen N. Berk

Dr. Berk had been a positive force in psychology in Pennsylvania for many years. He had a specialty in neuropsychology and had supervised and trained many of the neuropsychologists in Southeastern Pennsylvania. He advocated strongly for covering neuropsychological services under health insurance programs, and for including psychological services under Medicare. In addition to his independent practice in neuropsychology, Dr. Berk taught physiological psychology and other courses in the doctoral program in psychology at Chestnut Hill College. As a teacher he combined excitement for learning, exacting standards, and great relationships with students.

He was known for his positive attitude, good sense of humor, modesty, hard work, kind disposition, dedication to his family, and love of learning. According to executive director Thomas DeWall, "Dr. Berk represented the best in psychology, with his dedication to the public welfare and commitment to high professional standards." He was much loved by his professional colleagues, as evidenced by a tremendous outpouring of love and respect at his funeral, attended by an overflow crowd of hundreds of people.

Dr. Berk is survived by his wife of more than 30 years, Karen Berk, and their two sons, Matthew and Jason.

The Under-Identification of Child Abuse in Pennsylvania: Where Does the Problem Lie?

Samuel Knapp, EdD, Director of Professional Affairs

Pennsylvania has the lowest rate of substantiated child abuse of any state in the United States (one-seventh the national average). The scandals at Penn State involved allegations of sexual abuse and the non-reporting by individuals who should have reported it. Whether they had a legal obligation is a matter of debate, but they certainly had a moral obligation to do so (Tepper, Knapp, & Baturin, 2012). Consequently, it is only natural to question whether the identification of sexual abuse is especially problematic in Pennsylvania and whether the mandated reporting laws in Pennsylvania need to be strengthened.

However, a closer look at the data shows that Pennsylvania identifies childhood sexual abuse at about the same rate as other states. About 8 out of 1,000 children nationwide

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Exploring Latino Cultures: An Amazing Sabbatical Experience

Sybil L. Holloway, PsyD, Bloomsburg University

Dime con quién andas y te diré quién eres.
(Tell me with whom you travel, and I will tell you who you are.)

Trabaja para más valer, estudia para más saber.
(Work to be worth more, study to know more.)

– popular Spanish sayings (Nava, 2000)

Dr. Sybil L. Holloway

My interest in Hispanic/Latino cultures goes way back to my childhood. I learned my first Spanish words from "Sesame Street" and established my first intercultural friendship with a girl from El Salvador who lived in my neighborhood. In high school, an excellent Spanish teacher provided me with a three-year introduction to Spanish languages and cultures. Later, I traveled to Spanish-speaking countries (Spain, Mexico, Costa Rica, and Puerto Rico) for further study and immersion. I continue to be fascinated by the rich cultural traditions of these friendly and diverse groups of people. *¡Qué magnífica!*

As an African American female, I can relate to many of the struggles of Latinos and other minority groups in the United States. Although our stories are different, several common points of understanding exist. Many of the Latino values – honesty, loyalty, hard work, faith, and others – reflect my own. This is one of the reasons I feel drawn to this particular population.

During my fall 2010 sabbatical, I had the opportunity to pursue this cultural interest more deeply. I moved to San Antonio, TX, for the semester in order to enroll in graduate-level courses in the Psychological Services for Spanish Speaking Populations certificate program at Our Lady of the Lake University (OLLU). This first sabbatical experience was excellent in many respects.

To begin with, I had selected a project of deep personal and professional interest, and for which I spent many years preparing for the right opportunity. Eight years of studying Spanish had provided me with a solid foundation upon which to build a more complete knowledge base that carried me from the basic conversational realm into the professional/technical uses of Spanish in clinical settings. This is not easy, and my sabbatical courses serve only as a beginning. I still have a lot to learn.

At OLLU, I audited two courses in the APA-accredited doctoral psychology program. These courses were Language and Psychosocial Variables in Interviews and Assessments with Latinos, and a Spanish clinic team practicum at Community Counseling Service. Spanish was the primary language of instruction for both courses. I was excited to be taking these courses, but also nervous because I lacked confidence in my verbal Spanish abilities. So, for additional instruction and practice, I signed up for private Spanish lessons at Spanish, English and Foreign Languages for America, Inc. (SEFLA), a local language school. A wonderful instructor at SEFLA taught advanced conversational Spanish for two hours per week for ten weeks. Furthermore, I read books by Latino authors (e.g., Cisneros, 1991; and Esquivel, 1995), including an excellent one by Nava (2000) about *"dichos"* (sayings and proverbs) as well as Spanish children's books to increase my cultural knowledge and language skills.

In particular, the courses at OLLU were taught by excellent professors and contained many Latino students of varying heritage. As for non-Latinos, there was one white student in my class, who spoke excellent Spanish, and I, the only black student. My classmates were very friendly and helpful. They even invited me to hang out with

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Advocating for You

Bruce E. Mapes, PhD
Chair, PennPsyPAC Board

Dr. Bruce E. Mapes

A primary function of PPA is advocating for the interests of psychology, psychologists, and the people we serve in Pennsylvania. Through advocacy, PPA has helped to do such things as establishing school psychology as a profession in Pennsylvania, enacting the licensing of psychologists for independent practice, instituting basic patient protections under managed care, establishing minimal mental health coverage limits for serious mental illness, and the recent passage of the student concussion bill, which protects student athletes and also includes psychologists as "qualified health care professionals."

Currently, PPA is advocating for the passage of legislation to allow psychologists to offer opinions on the insanity defense and competency to stand trial. We are advocating for legislation that will assure that managers in the Department of Corrections receive salary increases that are at least as high as civil service employees. At this point a psychologist who leaves civil service to assume a management / supervisor position must take a substantial cut in pay. This situation has resulted in the loss of post-doc internship opportunities because of the lack of qualified supervisors. A myriad of child abuse reporting bills have been introduced. PPA is currently working to develop principles for legislators to follow when evaluating these bills. As they are introduced, PPA will be actively advocating for the passage, modification, or rejection of proposed bills. We also anticipate that intensive advocacy will be necessary as new health care legislation is implemented.

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ADVOCACY FOR YOU

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Advocating for you starts with the PPA staff. Sam Knapp, Rachael Baturin, and Tom DeWall maintain ongoing communications with select legislators and executive branch officials to recommend new legislation, to provide information, and to advocate for the passage, modification, or rejection of proposed legislation. Through legislative action alerts and advocacy day, PPA members are able to communicate directly with their legislators as constituent voters.

Advocacy also involves supporting the election or re-election of legislators who are friendly to psychology, psychologists, and the people we serve. PPA is a nonprofit corporation and is prohibited by law from making campaign contributions. PennPsyPAC exists independent of PPA to raise funds for such contributions. Approximately 11% of PPA members currently contribute to PennPsyPAC. If every member contributed $25 a year, PennPsyPAC would raise the money it needs for campaign contributions.

In order to meet the challenges facing psychology today and in the future, PPA needs all members to be involved actively in the advocacy process. PennPsyPAC needs greater support of its fundraising events. Together, we can promote the interests of psychologists, the field of psychology generally, and the people who rely on psychological services in Pennsylvania.

EXPLORING LATINO CULTURES

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them; I had a delicious Thanksgiving dinner with a classmate and her family. I felt honored to be included.

Thankfully, the textbooks (Tienda & Mitchell, 2006; Santiago-Rivera et al., 2002) were written in English. The courses included readings, discussions, journal entries, role-plays, an annotated bibliography, and a final exam. As a psychologist and writer, I really enjoyed crafting and editing my journal entries, written in Spanish. I also enjoyed the group atmosphere of my class and Spanish clinic team. I wasn't proficient enough in Spanish to conduct counseling sessions in the language, so I observed the clinic team. Working in pairs to counsel Latino clients who presented with a variety of issues, my classmates demonstrated an impressive level of clinical skill and Spanish language proficiency. I saw generational differences in clients' comfort with Spanish and English and "code switching" in which a couple of clients frequently alternated between Spanish and English. I also saw clients dealing with immigration issues – legal, familial, social, physical, and psychological issues of transition to a new country (the United States) and culture. This was fascinating to witness firsthand, hearing their perspectives as well as those of my clinic team members and supervisor. I learned about culturally sensitive counseling methods, from initial client contact and intake for services to developing a strong therapeutic relationship through which clients could meet their goals.

Multilingualism and cultural competence are themes addressed by many writers (e.g., Clay, 2010; El-Ghoroury, 2010; Flora, 2010; and Knapp, 2011). While I don't know if I'll ever be proficient enough to competently and ethically conduct counseling entirely in Spanish, knowledge of these cultural variables will serve me well professionally because I will be able to better understand my clients' backgrounds, respond effectively, and offer useful resources. To combine my interests in psychology, writing, and Spanish, I hope to publish mental health articles in Spanish. Having published newspaper and magazine articles on mental health topics for English-speaking audiences, I'd like to expand this service to the growing number of Spanish speakers in the United States.

One of the highlights of my sabbatical was attending for the first time the National Latina/o Psychological Association conference where I heard from Latina pioneers in the profession as well as current researchers about topics being explored. I was pleased to hear keynote speaker Sandra Cisneros (author of *The House on Mango Street*) and to meet Dr. Melba J.T. Vasquez, the immediate past president of the American Psychological Association (Azar, 2011) and the first Latina to hold this prominent position. I felt very welcomed and am proud of my Latino colleagues for their successes in the face of discrimination based on race/ethnicity, gender, and class. They are working hard to educate others about these relevant cultural issues and to advocate for social justice.

Looking back, I can truly say I've had a fantastic sabbatical experience.

References

Azar, B. (2011, January). Meet your 2011 president. *Monitor on Psychology*, 64-66.

Cisneros, S. (1991). *The house on Mango Street*. New York: Random House.

Clay, R. A. (2010, September). How do I become culturally competent? *gradPSYCH*, 24-26.

El-Ghoroury, N. H. (2010, September). Preparing to work with a diverse population. *gradPSYCH, 27*.

Esquivel, L. (1995). *Like water for chocolate: A novel in monthly installments with recipes, romances and home remedies*. New York: Doubleday.

Flora, C. (2010, September/October). Double talk. *Psychology Today*, 70-79.

Knapp, S. (2011, October). Ethics, diversity, and multiculturalism. *Pennsylvania Psychologist*, 5-6.

Nava, Y. (Ed.). (2000). *It's all in the frijoles: 100 famous latinos share real-life stories, time-tested dichos, favorite folktales, and inspiring words of wisdom*. New York: Simon & Schuster.

Santiago-Rivera, A. L., Arredondo, P., & Gallardo-Cooper, M. (2002). *Counseling latinos and la familia: A practical guide*. Thousand Oaks, CA: Sage.

Tienda, M., & Mitchell, F. (Eds.). (2006). *Hispanics and the future of America*. Washington, DC: The National Academies Press.

Turning Good Intentions into Good Behavior:
Self-perception, Self-care, and Social Influences in Ethical Practice

Samuel Knapp, EdD, ABPP; Director of Professional Affairs
John D. Gavazzi, PsyD, ABPP; Chair, PPA Ethics Committee

Dr. Sam Knapp

Dr. John D. Gavazzi

Most of us want to fulfill our ethical mandate to help our clients as best as we can. However, non-rational factors, such as faulty thinking habits, situational pressures, or fatigue can overpower our good intentions and lead to less-than-optimal ethical behaviors. We are not just referring to flagrant misconduct that would leave us vulnerable to a licensing board complaint or lawsuit. Instead, this less-than-optimal behavior is more subtle, such as delivering acceptable (but not top quality) professional services.

Traditional approaches to improve ethical conduct and clinical skills involve attending didactic lectures. As helpful as these lectures may be, behavioral change is more likely to occur when we take a more active role in exploring how important variables such as self-perception, self-care, and social factors influence clinical performance (Tjeltveit & Gottlieb, 2010). Reducing our blind spots, increasing our self-knowledge, and enhancing our awareness of work pressures and organizational cultures are worthwhile processes to explore in order to investigate our basic ethical obligations (Bazerman & Tenbrunsel, 2011).

"Professional narcissism," or an "overestimation of one's abilities" (Younggren, 2007, p. 515) represents one such blind spot. For example, Davis et al. (2006) asked physicians to perform a standardized patient procedure, and then estimate their competence at that procedure. Most physicians rated themselves higher than justified, including a few who performed incompetently but nonetheless rated themselves very high. While a modest amount of overconfidence may be harmless (or perhaps even healthy), we need to guard against the tendency to see ourselves as much better than we really are. We can avoid professional narcissism through activities that promote self-reflection, such as keeping a journal geared toward clinical experiences and contemplating ethical nuances of practice. We can also establish routines to ensure regular feedback about our behavior, such as asking patients questions at the end of sessions. We can ask how the session went or how we could have been more helpful. Some psychologists have adopted a productive philosophy of admitting mistakes, apologizing for them (when appropriate), learning from them, and then moving on (show self-compassion). "People can learn to see mistakes not as terrible personal failings to be denied or justified, but as inevitable aspects of life that help us grow" (Tavris & Aronson, 2007, p. 235).

Medical residents who are fatigued make more errors as their fatigue increases (Harvard Work Group, 2004). Similarly, we are less able to focus on our professional obligations and we can become more prone to errors when we are fatigued. Highly competent psychologists engage in positive self-care activities, such as regular exercise, good sleep hygiene, healthy eating, and other activities that promote health and wellness. Part of self-care means accepting our limitations in terms of time, energy, and resources. Healthy psychologists acknowledge that they cannot help everyone and cannot master every facet in the psychology domain.

Some practices, agencies, or organizations may not value ethical behavior, even though they may have an ethics policy, an ethics code, mandatory ethics education, or other formal structures designed to promote ethics. However, the "hidden culture" of the organization often has more influence then formal guidelines when framing ethical dilemmas and determining ethical behavior. "Formal systems are the weakest link in an organization's ethical infrastructure" (Bazerman & Tenbrunsel, 2011, p. 118). That is, the interactions and comments that occur among members of the organization create the day-to-day ethical tone of an organization. The informal ethical culture of an organization courses through the stories that employees tell, the euphemisms that they use to describe issues, or the socialization rituals that employees undergo. In many cases, the cultural influences on practitioners remain unseen, especially to those who remain frame-dependent.

Here are some strategies, activities, or routines that some psychologists have used to reduce the gap between good intentions and good behavior.

Self-Directed Activities to Enhance Ethical Practice

Encourage self-reflection (to reduce or to avoid professional narcissism)

- Keep a journal or a diary to focus on therapy and possible ethical issues in daily practice, engage in therapy, try to be more open-minded, listen to feelings.
- Routinely ask patients for feedback at the end of each session (what did I do that was helpful today? Not helpful?). Routinely gather outcome data. Reread therapy notes to become aware of any unproductive emotions or countertransference.
- Think in terms of ethical issues when facing clinical problems. Have a productive philosophy concerning mistakes: Admit them, apologize (if helpful), learn from them, and move on (show self-compassion).

Attend to environmental influences

- Encourage friends or colleagues to tell me when they think I am doing something wrong.

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GOOD INTENTIONS...

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- Develop schedules—although not too rigidly—and think about time management.
- Attend to environmental circumstances that might influence me to engage in less than optimal ethical behavior.
- Be aware of temptations to minimize the worth or individuality of clients or other people (e.g., interpret troublesome behaviors as barriers, not manifestations of evil).

Establish healthy routines

- Make checklists or schedule healthy activities.
- Make learning a habit. Attend CE programs (especially programs on ethics), read journals, get advanced training or certification in an area of psychology.
- Keep the APA Ethics Code or the Pennsylvania licensing law and regulations close by.
- Get in the habit of using an ethical decision-making model.
- Belong to and participate in a professional association (or present at a CE program, join a listserv, start a blog, or participate in student groups, committees).
- Uphold ideals without being sanctimonious.

Prevent problems ahead of time

- Practice self-care: e.g., pay attention to exercise, sleep hygiene, and diet.
- Maintain a good work-life balance.
- Reduce dysfunctional emotions through meditation, mindfulness exercises, therapy, or recreational activities unrelated to school or work.
- Manage time and tasks carefully (breaking big tasks into smaller ones).
- Accept my limitations in terms of time, energy, and resources. (I can't help everyone; I can't do everything). Balance compassion and altruism with my own needs.[1]
- Show concern for others, including your fellow psychologists (help them out if I can); commit random acts of kindness; express appreciation (say "thank you").

[1] W.D. Ross (1998) says that supererogatory obligations should not distract us from our primary obligations to family, close friends, and ourselves.

References

Bazerman, M., & Tenbrunsel, A. (2011). *Blind spots*. Princeton, NJ: Princeton University Press.

Davis, D., Mazmanian, P. E., Fordis, M., Van Harrison, R., Thorpe, K. E., & Perrier, L. (2006). Accuracy of physician self-assessment compared with observed measures of competence: A systematic review. *Journal of the American Medical Association, 296*, 1137-1139.

Harvard Work Hours Health and Safety Group. (2004). *New England Journal of Medicine, 351*, 1838-1848.

Ross, W. D. (1998). What makes right acts right? In J. Rachaels (Ed.). *Ethical theory* (pp. 265-285). New York: Oxford University Press. (Original work published 1930).

Tavris, C., & Aronson, E. (2007). *Mistakes were made*. Orlando, FL: Harcourt.

Tjeltveit, A., & Gottlieb, M. (2010). Avoiding the road to ethical disaster: Overcoming vulnerabilities and developing resilience. *Psychotherapy: Theory, Research, Practice, Training, 47*, 98-110.

Younggren, J. (2007). Competence as a process of self-appraisal. *Professional Psychology: Research and Practice, 38*, 515-516.

Four Candidates Running for APA Council of Representatives

Dr. Andrea M. Delligatti

Dr. Paul W. Kettlewell

Dr. Linda K. Knauss

Dr. Dianne S. Salter

In mid-April the American Psychological Association will mail ballots to all APA members in Pennsylvania for the election of representatives from our state to the APA Council of Representatives. Pennsylvania has two positions on the APA Council, resulting from the apportionment voting in the fall. The two winners will serve three-year terms on the PPA Board of Directors as well as the APA Council.

The candidates are Drs. Andrea M. Delligatti, Paul W. Kettlewell, Linda K. Knauss, and Dianne S. Salter. All four are past presidents of PPA. The statements in support of their candidacies will appear on the APA website, at www.apa.org. Please be sure to read these statements and to vote in this election.

In Memoriam

HENRI DEUTSCH, PHD, a longtime PPA member, died in February 2012. Dr. Deutsch had maintained a practice in clinical psychology with his wife, Dr. Marilyn Deutsch, in Clarks Summit (outside of Scranton). Among other professional interests, he was very active in promoting the welfare of persons with developmental disabilities. Dr. Deutsch also taught psychology at various local colleges and volunteered with the American Red Cross Disaster Response Team. He was also involved in other local charities. Dr. Deutsch received a doctorate from the Ohio State University in 1975.

CHILD ABUSE...

Continued from page 1

will be identified as victims of sexual abuse, compared to about 6 out of 1,000 children in Pennsylvania. But Pennsylvania identifies other forms of child abuse (neglect, emotional abuse, or non-accidental injury) at a rate that is far lower than other states. For example, as Table 1 shows, a child in Illinois or Ohio is about 15 times more likely to be identified as a victim of neglect than a child in Pennsylvania (United States Department of Health and Human Services, 2011).

A reasonable question therefore arises as to why the number of children identified as abused is so low in Pennsylvania. A review of child protective services laws shows that Pennsylvania defines the word "child" in approximately the same manner as other states, has definitions of mandated reporters that correspond to the definitions in most other states (including states with high rates of substantiated abuse), and has a threshold of certainty for making a report equal to or even lower than the level of certainty required in other states.

Table 1:

Total Cases in Pennsylvania Compared to States with Populations Close to That of Pennsylvania[1]

State	Child Population	Medical Neglect	Neglect	Physical Abuse	Emotional Abuse[2]	Sexual Abuse	Total[3]
Pennsylvania	2,775,132	98	99	1,178	42	2,328	3,555
Georgia	2,583,792	1,062	12,794	2,768	4,949	1,014	19,976
Illinois	3,177,377	592	19,662	5,667	27	4,375	26,442
Michigan	2,349,892	1,018	29,759	7,486	11,156	1,177	32,412
Ohio	2,714,341	565	14,831	12,270	2,050	5,790	31,295

[1] A few states have unique categories of abuse listed by the Department of Health and Human Services as "other."

[2] Some states classify some forms of emotional abuse as neglect.

[3] The figures across columns do not necessarily equal the totals because some children may be the victims of more than one type of abuse. The frequency with which children are identified as having been victimized by more than one type of abuse varies considerably across states. Nationwide it is about 1 in 5. In Pennsylvania it is 1 in 20, and in Michigan the average child is a victim of at least two types of abuse.

A review of the child abuse reporting data shows that fewer reports of suspected abuse are made in Pennsylvania and, when reports are made, fewer of them are substantiated. As Table 2 shows, Pennsylvania's rate of reporting child abuse is one-fifth the national average (United States Department of Health and Human Services, 2011). Whereas nationwide there will be reports of suspected abuse on 40 out of 1,000 children, in Pennsylvania there will be reports of suspected abuse on only 8 out of 1,000 children.

In addition, the frequency with which a report of child abuse will become substantiated in Pennsylvania is below the national average. About 15% of reports of abuse in Pennsylvania will be substantiated, compared to a national average of 23%. In several counties in Pennsylvania fewer than 10% of reports were substantiated in 2010 (Pennsylvania Department of Public Welfare, 2011).

Across states the overall rates of reporting vary with the rate of substantiating reports. Of the 10 states with the lowest rates of substantiated child abuse, 9 of them were below the national average in terms of overall reporting rates. Of the 10 states with the highest rates of substantiated child abuse, 8 of them were above the national average in terms of overall reporting rates. In addition, studies have shown that the reporting behavior of mandated reporters is driven, in part, by the response that has been made by previous reports. For example, Jones et al. (2008) surveyed pediatricians and found that they were less likely to make a report if they believed that the investigative agency would dismiss the report without an investigation.

These findings make intuitive sense. If a psychologist has made several reports to Children and Youth concerning behavior that appears abusive, but Children and Youth continually considers the reports unfounded (or does not even accept the report), a sort of informal learning occurs whereby the legal definition of child abuse in the mind of the psychologist becomes gradually

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Table 2:

Rate of Identification of Child Abuse Among Neighboring States or States with Population Close to that of Pennsylvania

	Reporting Rates per 1,000 children	Rate of Identification per 1,000 children
Pennsylvania	8.0	1.3
Delaware	64.9	10.3
Georgia	22.8	7.7
Illinois	38.4	8.3
Maryland	24.6	9.7
Michigan	62.2	13.8
New Jersey	37.0	4.4
New York	50.7	17.4
Ohio	33.8	11.5
West Virginia	88.2	10.2
National	40	9.2

CHILD ABUSE...

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constricted, resulting in a general decline in the number of reports made. These findings raise the question as to whether the benchmarks for establishing child abuse in Pennsylvania are too high.

This data suggests that efforts to increase the identification of child abuse by increasing fines for mandated reporting or by expanding the number of adults that are considered mandated reporters are unlikely to improve the protection of vulnerable children in Pennsylvania. In summary, the events that allegedly took place at Penn State, as bad as they appear to be, are unrepresentative of the greatest weaknesses in the Child Protective Services Law in Pennsylvania, which is that the benchmark for the substantiation of non-sexual abuse is too high. Instead it appears that the best way to increase the identification of abused children is to reconsider the legal definition of what constitutes non-sexual abuse.

References

Jones, R., et al. (2008). Clinicians' description of factors influencing their reporting of suspected child abuse: Report of the Child Abuse Reporting Experience Study Research Group. *Pediatrics, 122*, 259-266.

United States Department of Health and Human Services. (2011). *Child Maltreatment 2010*. Retrieved from http://www.childwelfare.gov/systemwide/statistics/can.cfm

Pennsylvania Department of Public Welfare. (2011). *2010 Annual Child Abuse Report*. Retrieved from http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/report/p_011342.pdf

Tepper, A., Knapp, S., & Baturin, R. (2012, March). The Pennsylvania Child Protective Services Law and the recent Penn State University scandal. *Pennsylvania Psychologist, 5*.

Can Checklists Help Reduce Treatment Failures?

Samuel Knapp, EdD, ABPP, Director of Professional Affairs
John Gavazzi, PhD, ABPP, Chair, PPA Ethics Committee

Checklists have become a stable feature of safety science. Airline pilots, for example, will meet with other members of the airline crew and go through a checklist before they fly a plane. Checklists have been proposed for surgeons (Gawande, 2009) and other physicians (Ely et al., 2010). Could checklists be useful for psychologists? If so, when could they be useful?

Using checklists for complex procedures such as general medicine, surgery, or psychological services may seem overly simplistic. However, proponents argue that checklists have value because of the complexity of these processes. Although the items in the checklist may seem basic, the risk that decision makers will make "dumb" mistakes increases when they are confronted with large amounts of complex information, much of which may be contradictory or ambiguous. Checklists can help health care professionals in difficult situations by reducing reliance on memory alone and, more importantly, by allowing them to step back, reflect on, and rethink their initial decisions (Ely et al., 2010).

For most patients, checklists would be unnecessary. Most patients do well in therapy, and 50% of patients terminate therapy in 10 sessions or fewer. Nonetheless, a few patients have more complicated problems, take more time to report therapeutic benefits, drop out of treatment unexpectedly, or otherwise fail in therapy. Checklists may be especially helpful with these difficult patients.

Knapp and Gavazzi (2012) proposed that treatment outcomes can be improved by using the "four-session rule." According to this rule, if a patient is not making gains at the end of four sessions or does not have a good working relationship with the psychologist (in the absence of an obvious reason), the psychologist should reassess the treatment with this patient. The four-session rule does not require transferring the patient. Instead, the rule requires psychologists to reconsider the case, perhaps using the checklist provided at the end of this article.

Often, the reasons for a lack of improvement in psychotherapy may be obvious. For example, a patient enters therapy with a minor depression, but then gets worse because of a sudden and unanticipated layoff from work. The reason for the deterioration is clear and the psychologist has almost automatically talked to the patient about new modifications to treatment in light of the new life circumstances. However, the mere deterioration in the patient's condition in this situation does not appear predictive of a treatment failure.

Member News

Dr. Tad Gorske

DR. TAD GORSKE, of Pittsburgh, is an invited speaker at the University of Stockholm and Uppsala University in Sweden on May 11 and 12, and at the 18th Annual College of Clinical Neuropsychology Conference on November 22–25 in Launceston, Tasmania, Australia. He is the primary author, with co-author Dr. Steven Smith, of *Collaborative Therapeutic Neuropsychological Assessment* (CTNA) and will be discussing his new book.

Dr. Charles Zeiders

DR. CHARLES ZEIDERS, a Philadelphia area clinical psychologist, has been invited by the European Movement for Christian Anthropology Psychology and Psychotherapy to be the only American to speak at a plenary session during the group's 11th Symposium to be held in Warsaw, Poland, in September. The European Movement brings together international leaders and pioneers in the field of Christian psychology and psychotherapy. Intervarsity Press will publish Zeiders's work on Christian holism in an upcoming anthology on clinical best practices with wellness strategies based in Christian spirituality and mysticism.

We consider the "four-session rule" as a useful heuristic because it helps control for over-optimism on the part of the psychologists. Evidence suggests that many psychologists are overly optimistic about their ability to help patients. For example, Stewart and Chambliss (2008) found that psychologists worked with patients for a median of 12 sessions before concluding that treatment was not working and considering alternative steps. Nonetheless, Lambert (2007) claims that his algorithm can predict risk for treatment failure by the fourth session with a high degree of accuracy. These two sources suggest that psychologists should adopt a lower threshold for considering a case at risk of failure.

We suggest using a checklist when treating a patient who falls into the "four-session rule." After identifying an area of concern from the checklist, the psychologist can follow up in more detail, such as by answering some of the questions footnoted.

We know of no empirical studies to validate the use of the checklist for those patients at risk of treatment failure. Nonetheless, it does represent an effort of self-reflection that is needed in difficult cases. Readers may send any feedback or comments on this checklist to Drs. Sam Knapp (sam@PaPsy.org) or John Gavazzi (johngavazzi@aol.com).

Four-Session Checklist

Patient Collaboration (What does the patient say?)

YES ☐ NO ☐ 1 Does the patient think you have a good working relationship?

YES ☐ NO ☐ 2. Do you and your patient share the same treatment goals?[1]

YES ☐ NO ☐ 3. Does the patient report any progress in therapy?[2]

YES ☐ NO ☐ 4. Does the patient want to continue in treatment? [3] If so, does the patient see a need to modify treatment?

Additional Reflections (What do you think about the patient?)

YES ☐ NO ☐ 5. Do you believe you have a positive working relationship with your patient? (Does he or she trust you enough to share sensitive information and collaborate?)[4]

YES ☐ NO ☐ 6. Is your assessment of the patient sufficiently comprehensive?[5] Do you need to obtain additional information?

YES ☐ NO ☐ 7. Do unresolved clinical issues of significant concern impede the course of treatment (such as Axis II issues, possible or minimization of substance abuse, or ethical concerns)?

YES ☐ NO ☐ 8. Does the patient need a medical examination?

Documentation

YES ☐ NO ☐ 9. Have you documented appropriately?

[1]Do you understand your patient's goals and how he or she expects to achieve them? How do they correspond to your goals and preferred methods of treatment? If they differ, can you reach a compromise? Does the patient buy into treatment? Did you document the goals in your treatment notes? What did the patient say was particularly helpful or hindering about therapy? Have you incorporated your patient's perceptions into your treatment plan?

[2]Do you agree on how to measure progress (self-report, reports of others, psychometric testing, non-reactive objective measures, etc.)? Does the patient need a medical examination?

[3]If yes, why?

[4]Can you identify what is happening in the relationship to prevent a therapeutic alliance? Does the patient identify an impasse? Do your feelings toward your patient compromise your ability to be helpful? If so, how can you change those feelings? Have you sought consultation on your relationship or feelings about the patient? If so, what did you learn?

[5]Have you reassessed the diagnosis or treatment methods using the BASIC ID, MOST CARE, or another system designed to review the presenting problem? Are you sensitive to cultural, gender-related status, sexual orientation, SES, or other factors? What input did you get from the patient, significant others of the patient, or consultants (this is especially important if there are life-endangering features)?

References

Ely, J., Graber, M. L., & Croskerry, P. (2011). Checklists to reduce diagnostic errors. *Academic Medicine, 86*, 307-313.

Gawande, A. (2009). *The checklist manifesto*. NewYork: Holt.

Knapp, S., & Gavazzi, J. (2012). Ethical issues with difficult patients. In S. Knapp, M. C. Gottlieb, M. Handelsman, & L. VandeCreek, (Eds.), *APA handbook of ethics in psychology*. Washington, DC: American Psychological Association.

Lambert, M. (2007). Presidential address: What have we learned from a decade of research aimed at improving psychotherapy outcome in routine care? *Psychotherapy Research, 17,* 1-14.

Stewart, R., & Chambliss, D. (2008). Treatment failures in private practice: How do psychologists proceed? *Professional Psychology: Research and Practice, 39,* 176-181.

Record-Copying Charges Changed for 2012

Under Pennsylvania's Act 26, known as 42 Pa.C.S.§6152 and 6155 (relating to subpoena of records and rights of patients), the Secretary of Health is directed to adjust annually the amounts that may be charged by a health care facility or health care provider upon receipt of a request or subpoena for production of medical charges or records. Because the law specifically references "health care providers," as opposed to just physicians, PPA believes that the law applies to psychologists. The amounts for 2012 vary only slightly from last year's amounts.

Effective January 1, 2012, the following payments may be charged in response to a subpoena:

	Not to Exceed
Search and Retrieval of Records	$20.62
Amount charged per page for pages 1-20	$1.39
Amount charged per page for pages 21-60	$1.03
Amount charged per page for pages 61-end	$ .34
Amount charged per page for microfilm copies	$2.04

In addition to the amounts listed, charges may also be assessed for the actual cost of postage, shipping and delivery of the requested records.

In addition, a flat fee that can be charged by a psychologist for a claim or appeal under the Social Security Act or any federal or state financial needs-based benefit program is $26.12 plus charges for the actual cost of postage, shipping and delivery of the requested records. The flat fee that can be charged for a request made by a district attorney is $20.62 plus charges for the actual cost of postage, shipping and delivery of the requested records. Requests from independent or executive branch agencies of the government are exempt from the record-copying fee requirements. This law does not apply to copying required by insurance companies to monitor services under an insurance contract. The rate is increased annually according to the Consumer Price Index.

The law does not alter the requirement that psychologists must have a signed release from the patient or a court order before releasing the information to a third party.

Please Register for Advocacy Day

Our Advocacy Day in Harrisburg this year is Monday, April 30. It will again be in room 60 East Wing of the Capitol Building. The schedule will consist of registration at 9:30 a.m., an issue orientation session from 10:00 to 11:30 a.m., and meetings with legislators after that. Please make your own appointment with your state representative and senator. The main issues we will cover will be House Bill 1405, authorizing psychologists to make determinations of insanity in criminal cases, and child abuse reporting laws.

We will be providing more information about it by e-mail and on our website. We hope to have a good turnout of PPA members. No room for social loafers here!

Please register today at www.PaPsy.org. Registration fees are $20 for PPA members, $30 for non-members, and free for student members. Fees include continental breakfast and 1.5 CE credits.

Advocacy Day is sponsored by the Pennsylvania Psychological Association and PennPsyPAC. PPA is approved by the American Psychological Association to sponsor continuing education for psychologists. PPA maintains responsibility for the program and its content. Credits offered: 1.5 CE credits. Certificates of completion will be mailed to participants who attend the entire workshop and complete the evaluation form. Partial credits will not be given. The Pennsylvania Psychological Association is an approved provider for Act 48 continuing professional education requirements as mandated by the Pennsylvania Department of Education.

Classifieds

POSITION AVAILABLE

OPPORTUNITY TO EXPAND YOUR PRACTICE Increase your service capability using two way visual internet connections set up at your office and at the client's site. Behavioral Health PC has opportunities for part-time PA licensed psychologists. If you are planning to retire or have done so, this is one way to keep active. To learn more about this opportunity email a one-page resume to GPS24@aol.com or phone 717-766-5494.

LICENSED THERAPIST (PSYCHOLOGIST, SOCIAL WORKER, COUNSELOR) Cornerstone Counseling Center is an established group practice in the Harrisburg area seeking a licensed therapist (psychologist, social worker, counselor) interested in joining a growing private practice. Managed care network participation or network-eligible required. Excellent professional opportunity in a supportive and stimulating environment with the potential to establish a full-time practice. To apply, please email resume and cover letter to: cornerstonecounseling@verizon.net.

OTHER

PRACTICE OPPORTUNITY/PROFESSIONAL OFFICE SPACE, NORTH WILMINGTON, DE. Opportunity for Licensed Psychologist or Licensed Clinical Social Worker to either join or share space with an independent network of collaborative, experienced mental health professionals. Large office (16.5 X 13 feet) with windows available; ideal for seeing families, couples, groups, as well as individual clients, in attractive, accessible office suite. Furnished waiting room, locked file room/kitchen, fax, copier, ample parking. Reasonably priced. Contact Kris Bronson, PhD (302) 477-0708 ext. 4 or Leslie Connor, PhD at Connorysh@comcast.net, members of Alliance-Counseling.com.

BHRS EVALUATION PRACTICE (WRAP AROUND) FOR SALE. Evaluations of children and teens one day a week with current appointments scheduled into the future. This is a turn key operation in a commercial area on the first floor facing a major shopping area in Hermitage, PA, Mercer County. Premises have been remodeled to suit and are leased to include two clinical offices, reception , rest room, and waiting area. Included are furnishings, four years of electronic records and a competent associate who may chose to continue if desired. Associate needs only your presence for supervision and review of completed evaluations one day a week. Current practice involves between 8 and 16 evaluations weekly, with excellent growth potential the remainder of the week. Please call Shannon at 724 630 3978 for information.

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2012 CE Calendar

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

June 20–23, 2012
Annual Convention
Hilton Harrisburg
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

November 1 and 2, 2012
Fall Continuing Education and Ethics Conference
Exton, PA
Marti Evans (717) 232-3817

April 4 and 5, 2013
Spring Continuing Education and Ethics Conference
Monroeville, PA
Marti Evans (717) 232-3817

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

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

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

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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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