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The Pennsylvania Psychologist

September 2012
QUARTERLY

DIAGNOSIS

ALSO INSIDE:

- Presidential perspective: Mission and meaning
- Mandatory reporting of impaired professionals
- Electronic medical records legislation
- Identifying giftedness in Pennsylvania

PENNSYLVANIA PSYCHOLOGICAL ASSOCIATION

2012 ANNUAL CONVENTION

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ALSO INSIDE

Mission and Meaning: Using PPA to Enhance Your Professional Mission

David J. Palmiter, Jr., PhD, ABPP

Dr. David J. Palmiter

What follows is a truncated version of the presidential address I delivered at our convention this past June. The slides for the presentation can be found at http://d.pr/f/6Qey.

As I begin this year as PPA's president I wish to heed the counsel of author Stephen Covey, "begin with the end in mind." In service of that I would invite you to engage an imagery exercise. To get the most out of this, please take at least two minutes with each prompt, closing your eyes and imagining what each of your senses would experience. Try not to read ahead in order to get the full experience.

Prompt #1: You are getting up on a sad morning to go to the funeral of someone you love. Imagine getting ready for the day.

Prompt #2: You commute to the funeral home on a warm and sunny day.

Prompt #3: You meet friends and family at the funeral home.

Prompt #4: You pay your respects to the deceased only to learn that you are the deceased. This is your funeral. However, you are lying in the casket conscious. What do you most celebrate about your life now that it is over?

Prompt #5: What are your regrets?

Prompt #6: What will people say about you?

As a clinician I've learned that my clients have deep wells of wisdom inside them. They don't need my wisdom as much as they need my help in finding theirs. One such well is to examine decisions from the context of one's deathbed, when wisdom is often acute and focused. This kind of information can be highly useful when crafting professional and personal mission as it keeps one from being distracted by here-and-now fluffernuffle that can seem so compelling from a narrow lens.

Another key aspect of establishing an effective mission is to engage one's top strengths. I've not the space here to elaborate on this argument, but I subscribe to a model that suggests that all humans, barring serious brain-based afflictions, have top strengths. Just as stronger muscles can move more weight than weaker muscles, top strengths can be more impactful than average strengths. Finally, our agitations can be most helpful in crafting a professional mission, as they can point us in the direction of action. So, the short script for a self-actualized vocational plan is to begin with the end in mind and use one's top strengths to try to resolve top agitations.

I've learned that my clients have deep wells of wisdom inside them.

However, I find that there is a common neurosis in our profession that interferes with realizing important missions. I've named this neurosis WAIT, or "Who am I to?" "Who am I to try to fix that big problem?" "Who am I to contribute to an important project or to take on an important leadership role?" "It is other people who are better equipped and able to do the most important things." Indeed, a few years ago I became conscious of WAIT in myself and began the work of expunging it. Doing that work on myself has made me more sensitive to the fact that so many of us suffer from WAIT. For this reason I was struck by something past president Emily Stevick shared with me when I sent out an email to past presidents asking for advice on how to be an effective president of PPA. Emily wrote: "What I did learn was how many psychologists underestimated themselves ... when I spoke to board chairs about running for treasurer or president, etc. ... there was always a question about the ability to do so."

So, here I sit wanting to engage the top strengths of our volunteer leaders to try to resolve important agitations. However, I also need to pay close attention to the most common piece of advice I received from former PPA presidents: don't try to do too much. So, heeding this counsel, I'm limiting myself to three initiatives. I'd like to briefly review these and then extend two invitations to you.

First initiative

In the May 2102 edition of this publication I reviewed research indicating that mental health problems in children, by adulthood, are nearly as universal as physical problems by adulthood. However, unlike medical maladies, only about 20% of the kids who need mental health care get it. And, those who do get it have often been suffering for years and/or the care they receive is either not evidence-based or is tragically truncated. This is the case even though the effect sizes of meta-analytic studies of evidence-based child psychotherapies are in the range mid .70s to low .80s (i.e., a "whopping" range). This is as wrong a thing as a thing can be wrong. And I, like so many others, have grown sick to death of it. So, together with the Pennsylvania Chapter of the American Academy of Pediatrics, we have formed a task force with two primary goals (we have 15 total goals): to get kids in Pennsylvania routinely screened for mental health problems in pediatric practices and to craft baseline evaluation standards for mental health professionals to use when doing evaluations on children. To learn more about this work, please see the aforementioned article.

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Annual Report: PPA Promotes Members' Interests

Thomas H. DeWall, CAE


Thomas H. DeWall

Our association worked hard on behalf of our members in the 2011-12 program year. Under the direction of our Board of Directors we pursued the three main initiatives of our strategic plan. The first of these is advocating for public access to psychological services. As members know by now we were successful in gaining passage by the state General Assembly of the Safety in Youth Sports Act. This new law, which took effect July 1, will help prevent repeat concussions for student athletes. We fought to make sure, among other things, that our members with neuropsychological training are authorized to make the return-to-play decisions.

Another bill that we supported would authorize psychologists to make determinations of insanity in criminal cases. It passed the state House of Representatives in March 2012 and is still pending in the Senate Judiciary Committee. We helped to stall a bill that would authorize only physicians, dentists, and podiatrists to be on the medical staff of general hospitals. The bill, backed by the medical society, appeared to be on a fast track for House passage in June when PPA, along with other health care professional associations and sympathetic legislators, convinced the leadership to keep it in committee. We are remaining vigilant since it could still come up in the fall.

We held our annual Advocacy Day in April to advance the insanity-determination bill and to explain to legislators several critical issues related to child abuse reporting. It was attended by 50 members, half of whom were students. PPA staff and volunteer leaders also conducted outreach efforts to regional psychological associations in Philadelphia, Pittsburgh, Bethlehem, Erie, and Lancaster. To fill vacancies on the State Board of Psychology, we made recommendations to the governor, who subsequently appointed Drs. Steven Cohen and Richard Small, both former presidents of PPA.

Our current president, Dr. David Palmiter, initiated a Pediatric Mental Health Task Force in collaboration with the Pennsylvania Chapter of the American Academy of Pediatrics. The task force's goal is to increase the identification of, and treatment for, children with mental health problems.

On national issues, we were very active in generating support for reforms to the Medicare program, such as rescinding reimbursement cuts and including psychologists in the definition of "physician." PPA members' response rate to our legislative alerts was far higher than that of any other state.

Our political action committee, PennPsyPAC, received income of $42,000, which was down slightly from prior years. We made campaign contributions to 85 candidates from both parties for the state House and Senate as well as to Judge David Wecht, a friend of psychology and successful candidate for Superior Court.

Our second major strategic initiative calls for promoting and advancing psychology in Pennsylvania, including via professional development of our members and public education about psychological issues. One of the principal ways we did this was through members' consultation with staff members Dr. Sam Knapp and Rachael Baturin. They responded to literally thousands of phone calls and e-mails on a wide range of issues relating to the practice of psychology.

A significant medium of professional development is this publication, the *Pennsylvania Psychologist*. We were the only state that printed a newsletter/journal on a monthly basis. It included quarterly themes on geropsychology,

PPA members' response rate to our legislative alerts was far higher than that of any other state.

psychologists' resilience, the annual convention (with a "mini-theme" of gender differences in psychology), and sexual minorities. Legal columns in the quarterlies included employers' restrictive covenants, response to a licensing board complaint, the Child Protective Services Law, and pitfalls in verifying postdoctoral experience. We have published 74 legal columns since the first one in 1991. A school psychology section was included in each quarterly. We produced "Psych Tech" and other columns on technology to educate our members. Other articles focused on ethics, mental health parity, effective billing practices, and termination of supervision.

Another aspect of professional development is our continuing education program. We presented a Fall Conference, a Spring Conference (each two days), an Ethics Educators Conference, and a "Day of Ethics Education With Dr. Sam Knapp." More than 500 people attended these CE presentations. Our Annual Convention in June was attended by more than 300 people. We also made CE available through home studies, online courses, and a podcast on positive ethics. Of course, members received substantial discounts for all of these programs compared to the nonmember rate.

Other means of professional development are our website, with a wealth of information helpful to our members,

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Mandatory Reporting of an Impaired Professional

Allan M. Tepper, JD, PsyD, Legal Consultation Plan
Samuel Knapp, EdD, Director of Professional Affairs
Rachael L. Baturin, MPH, JD, Professional Affairs Associate


Dr. Allan M. Tepper


Dr. Samuel Knapp


Rachael L. Baturin

The Pennsylvania State Board of Psychology is charged with protecting the public from the unprofessional, unauthorized, and unqualified practice of psychology (63 P.S. §1201). As part of this public protection mandate, the Board can discipline a psychologist who is unable to practice psychology with reasonable skill and safety by reason of illness, drunkenness, excessive use of drugs, narcotics, chemicals or any other type of material, or as a result of any mental or physical condition (63 P.S. §1208 (a)(8)).

The policy of the Bureau of Professional and Occupational Affairs (the oversight body for the psychology and other health care licensing boards) is to place the impaired professional into a program that includes both rehabilitation and monitoring. Most licensees who go through this program will never receive a public disciplinarily action against them and will be able to resume their professional careers productively.

The Board can become aware of a potentially impaired psychologist in a number of ways. For example, a psychologist can self-report impairment and seek voluntary treatment and supervision. A patient or a member of the public can report an impaired psychologist. A fellow psychologist can make a report of a suspicion of impairment. With respect to this latter example, the question arises as to whether, and under what circumstances, a fellow psychologist is mandated to report a suspicion of impairment.

Mandated reporting of an impaired psychologist

The Professional Psychologists Practice Act contains a section that addresses the impaired professional (63 P.S. §1218). This section outlines the process by which an impaired professional can obtain treatment and supervision in lieu of a formal finding of discipline being lodged against the psychologist's license. This section also contains a subsection governing the mandatory reporting of suspected impairment.

Pursuant to 63 P.S. §1218 (f), a peer or colleague who has substantial evidence that a professional has an active addictive disease for which the professional is not receiving treatment, is diverting a controlled substance, or is mentally or physically incompetent to carry out the duties of his or her license shall make or cause to be made a report to the Board. The one exception to this provision is that any person who acts in a treatment capacity to an impaired professional in an approved treatment program is exempt from the mandatory reporting requirements of this subsection.

A cursory reading of this subsection suggests that this reporting requirement is clear-cut in nature. A more nuanced reading of the subsection, however, raises a number of procedural and substantive questions.

First, it is the responsibility of a *peer* or *colleague* to effectuate a report. The licensing board statute contains no definition of what constitutes a peer or a colleague. At a minimum, however, it would appear that a peer or colleague can be defined as another Pennsylvania licensed psychologist.

Second, the peer or colleague must report certain behavior exhibited by a *professional*. Once again, the licensing board statute contains no definition of what constitutes a professional under this subsection. It would be reasonable to assume, however, that a professional under this subsection constitutes a Pennsylvania licensed psychologist.

Third, the mandated reporter must have *substantial evidence* of impairment. Given the wording of this subsection, it would appear that this substantial evidence could be gathered through first-hand observations; through secondary sources, such as the report of a patient who previously had been treated by the psychologist in question; or through reports of colleagues, friends, or acquaintances of the psychologist in question. In this regard, it could be argued that the potentially mandated reporting psychologist may be "on duty" on a continuous basis, rather than being a potentially mandated reporter merely when functioning within his or her professional capacity.

Fourth, the licensing board statute does not define what constitutes *substantial evidence*. Prior Pennsylvania cases, however, have described substantial evidence as "such relevant evidence that a reasonable mind might accept as adequate to support a conclusion (*Yonkin v. State Real Estate Commission,* 774 A.2d 128 (Pa. Cmwlth 2001)), and evidence that so "preponderates in favor of a conclusion that it outweighs in the mind of the fact-finder, any inconsistent evidence and reasonable inferences drawn there from" (*R.P. v. Dept. of Public Welfare*, 820 A.2d 882 (Pa. Cmwlth 2003)). In addition, the United States Supreme Court has held that substantial evidence is evidence "which would be sufficient to allow a reasonable fact finder to reach the same conclusion; while it must exceed a scintilla, it need not reach a preponderance of the evidence (*Richardson v. Perales,* 402 U.S. 389 (1972)). Despite these legal definitions, however, it would appear that

even the more experienced practicing psychologist might experience difficulty determining what constitutes substantial evidence of impairment.

Fifth, there is a question as to when a potentially mandated reporter is exempt from the mandatory reporting requirements. That is, the general reporting requirement of the subsection states that there must be substantial evidence of an active addictive disease for which the professional is **not** receiving treatment. This language would imply that a private psychologist who is treating a psychologist for an addictive disease is not required to report the impairment. A later portion of the subsection, however, states that a person treating the impaired professional in an *approved treatment program* is exempt from the mandatory reporting requirement. Although there is no definition of what constitutes an approved treatment program, earlier provisions of the section refer to an approved treatment program as being part of the Voluntary Recovery Program (VRP) sponsored by the Bureau of Professional and Occupational Affairs. In this regard, it is unclear whether a private psychologist treating an impaired psychologist for an addictive disease outside of an approved VRP treatment program is exempt from the mandatory reporting requirement, or whether the treating psychologist is required to breach confidentiality and effectuate the report.

Under 63 P.S. §1218 (f), a psychologist who fails to provide a mandated report within a reasonable time from receipt of knowledge of impairment shall be subject to a fine not to exceed $1,000. This penalty shall be levied only after the psychologist is afforded the opportunity of a formal administrative hearing. What is unclear, however, is whether following a formal administrative hearing, the Board not only can levy a civil penalty against the non-reporting psychologist, but also can lodge a formal finding of discipline against the non-reporting psychologist's license, administer additional sanctions, and report the violation to a federal data bank.

Discussion

The Pennsylvania State Board of Psychology is charged with protecting the public from the unqualified practice of psychology. One method by which the Board carries out this mandate is to ensure that psychologists are not suffering from any type of impairment that prohibits the psychologist from practicing with reasonable skill and safety.

The Pennsylvania Psychologists Practice Act contains a subsection that requires a peer or colleague to report a suspicion of an impaired professional. Although the intent of this subsection is clear, a number of the definitions, procedures, and possible penalties associated with this subsection are less clear-cut. However, we do know for certain that a psychologist who has substantial information derived from a non-confidential source (such as the direct observation of another psychologist in a public setting) must report that psychologist. The report does not go through the regular disciplinary channels, but to the Division of Professional Health Monitoring (1-800-554-3428).

In the future, the Board may address these outstanding issues. For the present, however, psychologists who obtain information of possible impairment of another psychologist must proceed in a measured manner. That is, potentially reporting psychologists must review the statutory provisions in question, should consider obtaining peer consultation or legal advice, and should document their findings and course of action in a clear manner. In this way, the potentially reporting psychologist can seek to balance the responsibilities owed to the public, the profession, and their individual practice.

Electronic Medical Records Initiative Moves Forward

The movement toward electronic medical records is moving forward on both the state and federal levels. This movement was started during the presidential administration of George W. Bush and has continued under President Obama. The hope is that medical records will reduce medical errors, lead to better coordination of treatment, and reduce redundant services. The federal Health Information Technology for Economic and Clinical Health (HITECH) Act provides substantial subsidies and incentives for physicians and hospitals that utilize electronic medical records. In addition, Medicare and Medicaid offer financial incentives for physicians who adopt meaningful use of medical records. Unfortunately, the HITECH Act excluded most non-physician health care providers such as psychologists. However, Representative Tim Murphy (R-PA), a psychologist, and Senator Sheldon Whitehouse (D-RI) have introduced legislation in Congress (the Behavioral Health Information Act; H.R. 6043 and S. 539, respectively) that would provide support for psychologists and mental health agencies who move toward electronic medical records.

In the meantime Governor Corbett signed Act 121 on July 5. This law will create the Pennsylvania eHealth Partnership Authority, an independent agency of the Commonwealth, which would establish an electronic health information exchange consistent with federal law. One important provision of the federal HITECH law is that it allows states to create agencies to coordinate the implementation of HITECH provisions. Act 121 does this for Pennsylvania. As a result of the advocacy efforts of PPA Act 121 specifically protects existing confidentiality laws for psychological and other health care services. Act 121 states that "nothing in this act shall supersede or limit any other law which requires additional consent to the release of health care information or otherwise establishes greater restrictions or limitations on the release of health information" (Section 701 (a) (2)). In addition, it is expected that the federal government may issue regulations requiring more detailed privacy protections for mental health or certain other sensitive health care records.

The Bill Box

Selected Bills in the Pennsylvania General Assembly of Interest to Psychologists

As of August 1, 2012

Bill No.	Description and Prime Sponsor	PPA Position	Senate Action	House Action
SB 8	Establishes the eHealth Partnership Authority and regulates a system of electronic health records - Sen. Mike Folmer (R-Lebanon)	For stronger version	Passed 6/12/12, 47-0	Passed 6/26/12, 199-0 Signed by Governor 7/5/12 – Act 121
SB 10	Constitutional amendment prohibiting implementation of federal health care mandate - Sen. Joseph B. Scarnati III (R-Jefferson)	Against	Passed, 3/28/12, 29-19	Passed by State Government Committee; on tabled calendar
SB 115 HB 58	Provides for involuntary commitment to outpatient treatment - Sen. Stewart J. Greenleaf (R-Montgomery) - Rep. Mario M. Scavello (R-Monroe)	Against unless amended	In Public Health & Welfare Committee	In Human Services Committee
HB 42	Prohibits Pennsylvania from implementing the federal health care mandate - Rep. Matthew E. Baker (R-Tioga)	Against	None	Passed by two committees. On tabled calendar
HB 300	Prohibits discrimination based on sexual orientation in housing, employment, and public accommodations - Rep. Dan Frankel (D-Allegheny)	For	None	In State Government Committee
HB 646	Authorizes licensing boards to expunge certain disciplinary records after four years - Rep. Kate Harper (R-Montgomery)	For	In Professional Licensure Committee	Passed 6/18/12, 197-0
HB 663	Restricts insurance companies' retroactive denial of reimbursement - Rep. Stephen E. Barrar (R-Delaware Co.)	For	None	In Insurance Committee
HB 1405	Authorizes psychologists to testify in court on the determination of insanity and competency to stand trial - Rep. Glen R. Grell (R-Cumberland)	For	In Judiciary Committee	Passed 3/12/12, 193-0
HB 1570	Restricts hospital medical staff to physicians, dentists, and podiatrists - former Rep. Reichley; now Rep. Bryan Cutler (R-Lancaster)	Against	None	Passed by Health Committee 6/6/12; in Rules Committee

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

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EXECUTIVE DIRECTOR'S REPORT *Continued from page 3*

and our listserv, whose 700 subscribers received peer consultation on a wide range of issues. Our Ethics Committee produced an ethics blog, which was updated frequently. We continued our Psychologically Healthy Workplace Awards program. Of the four state-level winners in June 2011, one of them, ReMed Recovery Care Centers, received the national award in Washington, DC, in March 2012. We recognized another three winners in June 2012. PPA also gave numerous other awards in June, some of which are featured in this issue.

PPA was very active in public education with about 40 members giving talks to community groups and making appearances on television, radio, and other media. We presented 12 workshops for the public during the Annual Convention in Harrisburg, and we published an e-newsletter for the public that went to all PPA members and many members of the public who have signed up to receive it. PPA is the only state psychological association to publish such an e-newsletter.

The final strategic initiative is building and maintaining organizational strength. We ended the fiscal year with total membership of 2,950, which was 3.1% less than the prior year. We continued to work hard at recruiting and retaining members, but it has been more of a challenge in recent years than in the 20 years ending in 2008, when our membership increased every year. We remained the second largest state psychological association behind only California. Our nondues revenue remained strong with significant income from continuing education, bulletin and website advertising, sustaining memberships, the career center, and book sales. We continued to offer direct membership benefits such as a free listing in the psychologist locator on our website, a merchant credit card program at competitive rates, health insurance, discounts on CE, and the staff and listserv consultation noted above. Until this year we had not raised the dues in 13 years. After running deficits and having to dip into our reserves in recent years, the Board of Directors raised the top two dues categories by about 10% (which is contrasted with the 38% increase in the CPI since the last increase).

Our sister organization, the Pennsylvania Psychological Foundation, raised about $30,000, most of which was earmarked for scholarships for graduate students as well as for the public education campaign, the disaster response network, and other educational and charitable endeavors.

The Pennsylvania Psychological Association of Graduate Students had a successful year, with internship fairs in both Philadelphia and Pittsburgh, articles in the *Pennsylvania Psychologist* by and for students, significant participation in advocacy, and an awards program.

A measure of our organizational strength is our members' participation in the annual apportionment of the APA Council of Representatives. Again this year Pennsylvania received far more votes than any other state or province, retaining our two Council representatives.

We regretted the passing during the fiscal year of three former PPA presidents: Dr. Bernard Yadoff (1970-71), Dr. William Wilson (1978-79), and Dr. Stephen Berk (2004-05).

On the whole PPA remains a strong organization committed to advancing psychology in Pennsylvania as a means of promoting human welfare.

PRESIDENTIAL PERSPECTIVE
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Second initiative

The second initiative regards a personal agitation that impacts all of our professional missions. In my next column I will elaborate on this more. But, here let me offer that I'm troubled by how we often discuss, or don't discuss, multicultural issues. Too often I believe we ask the wrong questions and engage in a dialogue that promotes shame and a fear of saying the wrong thing. Referencing an interaction between two people of different races, this is an example of a wrong question: "Is race impacting our relationship?" I would propose that race is too powerful a factor to not be having an impact when people of different races are interacting. So, I would argue that the correct question is "What impact is race having?" We so often seem to confuse being impacted by a cultural variable as an "ism" (e.g., if I, as a Caucasian, am impacted by my colleague being African American that this makes me a racist). Such conscious and unconscious ways of thinking cripples the discussion (e.g., I can't let myself acknowledge that your race impacts me as I'm certainly not racist). Moreover, we too quickly use words like "racist," "insensitive," "prejudicial," and "microaggression." Yes, these words represent real and painful phenomena that need attention. (Few things get me more worked up than when one of my children, who are biracial, suffers from racism.) But, I'd like to transform our discussions about multiculturalism in the way that people like Drs. Sam Knapp, Leon VandeCreek and John Gavazzi have endeavored to move the discussion about ethics. They propose that we do better to avoid casting discussions about ethics as "do this bad thing and this bad thing can happen to you" and instead suggest considering "do this good thing so that you can more fully realize your professional mission." They also try to wait until late in the discussion to use words like "unethical," and then only when necessary. This allows for a positive focus and a more vibrant discussion. So, under the leadership of Dr. Beatrice Salter, and in partnership with Drs. Tim Barksdale and Jeanne Slattery, and building upon the inspired work done by many leaders in our community (e.g., Drs. Eleonora Bartoli, Richard Small), a Subcommittee on Positive Multiculturalism has been formed within the Committee on Multiculturalism. These are the members: Drs. Hue-Sun Ahn, Tim Barksdale (ex officio), Eleonora Bartoli, William Davis, Audrey Ervin, Cheryll Rothery, Jeff Pincus, Beatrice Salter (chair), Jeanne Slattery (ex officio) and Jeffrey Sternlieb.

This is the draft definition of positive multiculturalism that I have asked this subcommittee to refine: "To explore and understand our cultural differences and to learn how an understanding of such can enrich our professional missions. This process endorses the concept that all humans are impacted by cultural

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differences in a manner that traverses a wide continuum of reaction, some of which are conscious and some of which are unconscious, some of which are adaptive and some of which are not. In considering these issues positive multiculturalism eschews the promotion of shame and embraces the promotion of enrichment." I have also proposed the following draft goals for the subcommittee to edit as they please:

- To examine all PPA bodies, including the Committee on Multiculturalism at-large, in order to answer the question: "What is this body doing well to realize the agenda of positive multiculturalism?"
- To examine all PPA bodies, including the Committee on Multiculturalism at-large, in order to suggest answers to the question: "Is there anything this body might do to more fully realize the agenda of positive multiculturalism (e.g., in how it defines itself, goes about its mission)?"
- To suggest answers to the question: "Are there any interactive and practical training opportunities in which PPA's leadership and/or bodies might engage to more fully realize a positive multicultural agenda?"
- To coordinate with the Committee on Multiculturalism at-large regarding how educational materials might be cast, or recast, from the lens of positive multiculturalism.

Third initiative

My third initiative embeds within it a proposal to shift how we think about the role of PPA's president-elect. One year is not enough time for most to make a substantive impact (despite what great past presidents like Dr. Andrea Delligatti were able to do). Hence, I think it is very useful for the president and the president-elect to partner on a project that is important to both people and which is primarily the baby of the president-elect. Dr. Vince Bellwoar is your president-elect. Vince and I, and many of you, share the same agitation: Tom DeWall and Sam Knapp are going to be retiring in the near future. Tom will be retiring sometime during the summer of 2013, while Sam will follow him about 15 months or so later. So, we have assembled a Succession Planning Task Force comprised of the following people: Drs. Judith Blau, Vince Bellwoar (Chair), Rex Gatto, Mark Hogue, Linda Knauss, Bruce Mapes, Don McAleer, Jeff Pincus, Dianne Salter, Emily Stevick, and me, with Tom DeWall as staff support. Our work is well underway under Vince's effective leadership.

Two invitations

But enough about what my partners and I plan for this year. What about you? What is your professional mission? Do you have enough electricity flowing through the veins of your vocational life? If yes, I salute you! And I salute you double if part of that includes service to PPA. However, if you don't feel that way about your professional life, why not consider partnering more with us? I cannot think of an important agitation within the field that we are not taking on. This is just a sample of what our 29 committees endeavor to do:

- √ Educate the public about the power of psychology to understand, heal, and advance the human condition.
- √ Advocate for fair and just insurance reimbursement
- √ Promote self-care and wellness within our community
- √ Provide information on how to use technology effectively
- √ Advocate for fair and just laws and public policies
- √ Promote psychologically healthy business practices
- √ Provide excellent continuing education
- √ Advance practical applications of evidence-based clinical services
- √ Promote wellness in the elderly
- √ Provide graduate students and early career psychologists with the information and support they need to be successful
- √ Promote excellent service to schools and the courts

So, if you'd like more meaning in your life, and our community does not already experience the benefit of your top strengths, I'd ask you to consider partnering with us on one or more of these important causes. I think you will find that doing so can promote tremendous meaning and satisfaction.

In closing let me say that this past year has witnessed us losing some of our most precious blood. The death of these colleagues has reminded us that the time between now and our departure from this earthly plane is unpredictable. However, whether our moment of departure is this year, or 80 years from now, may we each have the chance to reflect on the meaning of our life. Hopefully that reflection can cause us to display a deeply meaningful smile that says "I'm leaving this place much better than I found it." If between now and that moment in your life we here at PPA can do something to facilitate the formation of that smile on your face, I hope you will let us know. You would truly honor us to ask.

Rebooting Diagnosis: The Case History of a Movement

Frank Farley, PhD, Temple University

Dr. Frank Farley

The current state of psychiatric and psychological diagnosis is in flux. The so-called "bible" of diagnosis, the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association (ApA) is in the process of revision, with the current fourth edition (DSM-IV) being revised as DSM-5, due to appear in 2013.

The DSM has always had a context of controversy about it, particularly as each of the previous versions were in the throes of revision. One of the most famous controversies concerned the proposed inclusion of homosexuality as a disorder. A battle ensued over that in the 1970s and it finally was removed. Various proposed disorders related to women have come and gone. Other controversies have swirled around the transparency of the process by which the DSM gets revised , and who is invited to the table. The science involved in the DSM has always been under a checkered flag, with such issues as the quality of the empirical bases for decisions, reliability and validity of evidence, replicability, reductionism, the issue of categorical versus dimensional approaches, the medical versus psychosocial and cultural models, the role of Big Pharma and whether it may have any influence on the DSM, the role of ethnic and cultural variations in the expressions and understandings of distress and illness and how these get factored into the DSM, to mention a few contentious issues.

Last year something momentous in the life course of the DSM happened. The Society for Humanistic Psychology (Division 32 of the American Psychological Association) entered the fray. Its leadership became concerned about some of the revisions being proposed by the DSM-5 Task Force. For example, there were proposals to expand categories and disorders (a process I call "the sickening of society") and the creation of new diagnostic categories with weak scientific support. The society leaders were especially concerned about certain new diagnostic categories where the lowering of diagnostic thresholds could result in hundreds of thousands of individuals, including young children and the elderly, being inappropriately diagnosed with a disorder and treated with powerful psychiatric drugs. The society was also concerned about the primacy of the biological model in the proposed DSM-5 and the seeming lack of emphasis on psychosocial factors.

Because of the foregoing concerns, in October 2011, the society, on a petition website, published "An Open Letter to the DSM-5 Task Force and the American Psychiatric Association," where mental health professionals could sign and express their concerns to the ApA and its DSM-5 Task Force over the proposed DSM-5. This act of an APA division creating such a petition on an easily accessed website to encourage our profession to think about and take a stand on a major and timely issue of practice and science, is largely without precedence in APA's or psychology's history. The petition started out modestly with a few hundred signatories, but exploded into a current count of almost 14,000 individual signatures, as well as 15 APA divisions, and more than 53 other professional organizations from around the world signing as organizations! Some major non-APA organizations that have signed on include the British Psychological Society (approximately 50,000 members), several divisions of the American Counseling Association, the Association for Black Psychologists, the Association for Women in Psychology, the National Latina/o Psychological Association, and many others.

Clearly our petition struck a chord. But not at the American Psychiatric Association! There it fell on essentially deaf ears. They accorded it little to nothing, declining a major request of the petition to submit the proposed DSM-5 to an independent scientific review. This review could have highlighted the strengths and weaknesses scientifically, and could have provided recommendations for strengthening and improving the revision of this important health document.

The society (Division 32) had created a committee (the "Open Letter Committee"), chaired by society President Dr. David Elkins, of which I am a member, with other members Drs. Jon Raskin, Dean Brent Robbins, and Donna Rockwell, with consultant Dr. Sarah Kamens, to create the petition and open letter. It considered a range of possibilities to influence the DSM revision, or reconsider the very nature of diagnosis itself.

Interestingly, one of the most vocal critics of the proposed DSM-5 is psychiatrist Dr. Allen Frances, who chaired the DSM-IV! He has an ongoing blog on Psychology Today directed against the revision, and frequently blogs on the topic for the *Huffington Post*. In a recent *Psychology Today* blogpost, he notes that two members of the DSM-5 Personality and Personality Disorders Work Group resigned in April 2012 because they "...considered the current proposal to be fundamentally flawed..." with a "...truly stunning disregard for evidence." Further, the two members stated "...the proposed classification is unnecessarily complex, incoherent, and inconsistent. The obvious complexity and incoherence seriously interfere with clinical utility" (Frances, 2012).

Given the apparent intransigence on the part of ApA, our strategy concerning diagnosis has evolved. The petition with the individual and organizational signatories, and the extensive media coverage including national TV and radio coverage, *New York Times, USA Today, Washington Post, Chicago Tribune, Huffington Post*, and many more worldwide, which our efforts have produced, has created a nascent mental health movement directed at a better, more valid approach to diagnosis. Add to the list of concerns above the fact that the DSM is owned and controlled by one professional association, American Psychiatric Association, despite

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Can the *PDM* Bring Thinking Back to Diagnosis?

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Dr. Janet Etzi

DSM-5 will be arriving on the scene as ICD-10-CM (*International Classification of Diseases and Related Health Problems,* World Health Organization) becomes the official system for diagnosis in 2013. Yet it is widely acknowledged that major problems exist in the reliability, validity, and clinical utility of these systems (Reed, 2010). The developers of the *Psychodynamic Diagnostic Manual (PDM;* PDM Task Force, 2006), and more recently users and reviewers of it (Huprich & Meyer, 2011), are providing a theoretical conceptualization to diagnose and assess personality/mental functioning with the potential to bring back inference and in-depth thoughtfulness to a field that has been dominated by surface-oriented descriptions of disease-like symptoms.

The task of assessing an individual's problems within a few initial sessions without bypassing the complexity of unique personality characteristics and mental functioning is very difficult. Since teaching a graduate psychopathology course for two decades to students typically engaged in diagnosis using the DSM (*Diagnostic and Statistical Manual of Mental Disorders*, 4th ed., Text Revision (*DSM-IV-TR*), American Psychiatric Association, 2000), it seemed important to me to teach them to use it well. The categorical reasoning process involves transforming the list of symptoms into questions and then deciding whether or not the person answers yes or no; in other words, surmising whether a symptom is present or absent. If enough are present to meet criteria, the diagnosis is made.

In 2006 the PDM was published. It sat on my bookshelf for a long time as I considered its length, heft, and volume. When I finally decided to learn it, I immersed myself in it. Once I felt familiar enough with it, I incorporated it into my course. Students quickly realized how much more depth of understanding of psychopathology and personality functioning it provided (Bornstein, 2011; Huprich, 2011; Porcerelli, Cogan, & Bambery, 2011), especially in comparison to DSM (McWilliams, 2011). They appreciated the individualized approach in the form of a profile instead of a diagnosis, and the attention to the full range of functioning, including strengths, weaknesses, and subjective experiences. They expressed great interest in being able to utilize the data obtained in the therapeutic work with clients. They got it. But there was a problem.

Given how easy it is to come up with a DSM diagnosis, needing little if any formal training, or background theoretical knowledge of psychopathology or personality functioning, and how relatively difficult it is to get through the PDM, let alone carry out an assessment with it, students feared that the demands of clinical settings would leave them no choice.

Still wanting very much to provide beginning clinicians with an alternative to DSM, I set about devising a user's guide to the PDM, a kind of manual for the manual. I explored a significant amount of the literature on which it is based. The problem, as I saw it, was twofold: (1) how to teach the PDM to students and beginning clinicians, especially those with little or no background in psychodynamic theory; (2) how to use the PDM itself in a systematic way.

The PDM was developed to assess personality in its full complexity, range, and depth. The person being assessed, not diagnosed (Bornstein, 2011), would have his/her unique individuality highlighted, and adaptive as well as maladaptive traits would be addressed. Mentally healthy functioning is covered in addition to psychopathology because clinical utility demands that both be taken into account in order to come up with the most effective and well-rounded therapeutic interventions. The individual profile is developed by observing functioning within three broad dimensions:

Dimension I–Personality Patterns and Disorders (P Axis)

The first dimension addresses personality because symptoms cannot be understood, assessed, or effectively treated in the absence of knowledge of personality functioning. For example, depression manifests in radically different ways depending on the personality type, including preferred defenses, temperament, and aspects of interpersonal dynamics (McWilliams, 1994).

Dimension II–Mental Functioning (M Axis)

The second axis provides a very innovative way to operationalize a significant degree of the complexity and range of personality functioning (Porcerelli, Cogan, & Bambery, 2011). The capacities include information processing; self-regulation; forming and maintaining relationships; emotional experience, expression, and organization; integrating experience; coping strategies and defenses; observing self and others; forming internal standards.

Dimension III–Manifest Symptoms & Concerns (S Axis)

The third dimension begins with a DSM diagnosis but goes beyond it "to describe the affect states, cognitive processes, somatic experiences, and relational patterns most often associated clinically with each one" (PDM Task Force, 2006, p.8). Symptoms are understood in terms of the person's subjective experience.

I continued to work on transforming the concepts in the PDM into steps to be taken by clinicians for a methodical way to obtain in early sessions data about their clients' personality dynamics, mental functions, symptoms, and unconscious/implicit mental processes. I reviewed several tools developed for this purpose (DeWitt, Hartley, Rosenberg, Zillberg, & Wallerstein, 1991; *OPD* Task Force [Eds.], 2008; Shedler & Westen, 2006). I concluded that one measurement

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tool is as complex and unwieldy as the next for the average psychologist who may give herself only one or two sessions to diagnose. There exists a very real and powerful tension between understanding an individual's personality functioning and coming up with concise descriptive terminology to refer to that functioning.

Knowledge and understanding of personality dynamics have evolved over the decades, and the PDM is the culmination of an enormous amount of theory, research, and clinical experience in a coherent and organized handbook. Perhaps it was a mistake to call it a diagnostic manual. In its present form it cannot be used, and perhaps was not meant to be, in a standardized fashion, retaining the ability to individualize the profile maximally. The task of operationalizing personality and mental functioning is essential to the goal of assessing individuals while retaining the complexity, depth, and range inherent to this process. Psychologists are still lacking in a practical manual for coming up with a sufficiently complex yet succinct enough assessment to match the understanding provided in the PDM concepts. We have our work cut out for us.

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REBOOTING DIAGNOSIS: THE CASE HISTORY OF A MOVEMENT

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its widespread use by other professions, many of whom, I note, signed the petition. The role of the DSM in insurance coverage alone involves the practices of many non-psychiatrists. The access to psychological and mental health services across the American landscape is provided more by non-psychiatrists than psychiatrists – for example, psychologists, social workers, counselors, marriage and family therapists, etc. It was our view that those most likely to provide services should have an important role in the development of any diagnostic system, perhaps a potential example of practice-based evidence!

Our committee's strategy at this point is to reboot the whole program of diagnosis, to re-examine the very fundaments of the concept of diagnosis, and to assess what might be involved in creating an alternative approach to those presently available, primarily the DSM and the ICD system of the World Health Organization. Any new or evolved system would have to meet more rigorous scientific criteria responding, in my view, to what I call "The Seven Sins of Psychiatric/ Psychological Science," (Farley, 2012), incorporate the cultural/social/relationship/humanistic side of our lives, and involve all the principal disciplinary and professional stakeholders. Given the relentless criticisms of the DSM over several decades and the failure to take many of these serious criticisms into account, our committee has decided to convene an International Summit on Diagnostic Alternatives planned for 2013, co-chaired by Dr. Raskin and myself. Among other things we anticipate bringing together the best and the brightest scholars and practitioners from across the fields involved in issues of diagnosis to address the Olympian task of an alternative improved approach or approaches to what we have now, taking into account cultural variations. We feel the psychological health and well-being of every distressed individual requires a valid approach to diagnosis, and the Zeitgeist is ready!

Stay tuned.

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The author thanks the other members of the Society for Humanistic Psychology "Open Letter Committee" and especially Chair David Elkins, PhD, for their outstanding contributions to the efforts I have tried to summarize above, and to Dr. Elkins for his comments on this article.

The DSM-5 Approach to Diagnosing Personality Disorders: All It Needs Is Love

Christine Molnar, PhD

Dr. Christine Molnar

Optimally, the DSM-5 would integrate an approach to diagnosing personality disorders (PDs) that has clinical utility, addresses comorbidity, identifies dimensions for understanding and treating PDs, and inspires research into the nature and treatment of PDs (www.dsm5.org). Instead the proposed approach presents several clinical and research concerns. These include unexplained and unjustified complexity of the system, which has little clinical utility; failure to offer concepts related to etiology or mechanisms of change during treatment; and a conceptual legerdemain of "accounting" for comorbidity by embracing it within a factor analytic strategy that allows the same dimensions to appear in multiple personality domains. Two PD work group members resigned from the committee recently, citing some of these concerns along with incoherence, inconsistency, disregard for research findings, and a lack of receptivity to widespread criticism and feedback.

In what follows I describe the proposed PD classification system and illustrate some problems with it. I reference some of the ignored research findings about PDs including findings from taxometrics, a procedure designed to reveal the latent structure (i.e., taxonic or dimensional) of constructs such as PDs. I describe an alternative to diagnosing and treating PDs with clinical and research utility. The alternatives for diagnosis and treatment are called Structural Analysis of Social Behavior (SASB: Benjamin, 1979; 1996/2003; Benjamin et al., 2006) and Interpersonal Reconstructive Therapy (IRT: 2003/2006; and draft), respectively. Both have utility for understanding PDs and treating our clients, especially those who are non-responsive to empirically supported therapies (ESTs; Chambless & Hollon, 1998) because of PD symptoms.

The proposed DSM-5 classification system has clinicians rate all clients on dimensional scales to capture personality functioning. Clients are rated on "self" functioning, which includes identity and self-direction, and "interpersonal" functioning, which includes empathy and intimacy. Six PD diagnoses, now called "types," are retained including borderline, obsessive-compulsive, avoidant, schizotypal, antisocial, and narcissistic. A diagnosis called personality disorder trait specified (PDTS) is added to encompass all other PD symptoms. One or more pathological trait domains or facets is required to diagnose PDTS. Trait domains include negative affectivity, detachment, antagonism, disinhibition vs. compulsivity, and psychoticism. Each domain is composed of dimensional facets (25 total) on which clients can be rated. Some facets, such as anxiety, depressivity, and hostility are included on more than one domain and are criteria for more than one PD diagnosis. Clinicians will find the proposed PD classification system frustrating, subjective, and lacking in clinical utility. Scales include complex anchors that require much inference from the rater. Language used to describe domains and facets is abstract, judgmental, and lacks empathy. What might a clinician say to a client about working on facets such as "manipulative," "deceitful," "irresponsible," "attention seeking," and "grandiose?" It is likely that DSM-5 PD language will not be in the service of a collaborative therapy relationship. This is concerning because alliance and relationship are related to treatment outcome.

Clients appreciate SASB because it relates their current interpersonal patterns to what they have learned in relation to loved ones without difficulty.

Many conditions converged to produce the proposed system, including findings from taxometrics research about the latent structure of DSM constructs. Many of the categorical diagnostic types we have been using to "carve nature at its joints" (Waller, 2006) are in fact multivariate dimensional constructs and not true types/taxons. Thus, DSM-5 has attempted to integrate dimensions into its classification system, which is useful and will further research. Unfortunately, some of the processes used to identify and select dimensions have neglected clinical concerns, research findings, and the need for cohesive theory in classifying PDs.

In contrast to the DSM-5 model, Benjamin's SASB approach to assessment and diagnosis integrates dimensions into diagnosis with skillful language. Interpersonal phenomena of relevance to understanding problems in intra- and interpersonal relationships are captured by SASB. Validated dimensions include affiliation, with poles of love/friendliness and hate/hostility; interdependence, with poles from control to independence/differentiation; and what is called focus. Focus includes relational behaviors that are transitive (e.g., a parent directing protection behaviors toward an "object," a child), intransitive (e.g., a child focusing on self and trusting and relying on a parent who is protecting), and introjection (e.g., the same child learning to treat the self transitively with protection). The SASB has behavioral specificity, clinical utility, and elegantly captures personality and Axis I dimensions. Clients appreciate SASB because it relates their current interpersonal patterns to what they have learned in relation to loved ones without difficulty. This fosters development of both an alliance and a useful IRT treatment plan that incorporates ESTs.

SASB inspires research into the causes and treatment of PDs. It is grounded in a cohesive and refutable theory that is based on the evolutionary premise that we are "wired" to learn to relate with and

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Impact of Culture, Ethnicity, and Bias on Diagnosis: Can We Make Peace With Bias, Prejudice, and Racism?

Jeffrey L. Sternlieb, PhD

Dr. Jeffrey L. Sternlieb

Increasing our cultural awareness and sensitivity and reducing our blind spots have been identified for decades as goals crucial to produce a culturally sensitive psychological diagnosis on an individual level. When we use diagnostic categories to help us understand psychopathology and communicate these conclusions to patients, it is presumed that we have an appreciation of the validity of our categories, the reliability with which these labels are used, and the appropriateness of the normative data to compare our client/patient.

It has long been said that we judge others on their behavior and ourselves on our intent. What is new is a personal challenge to examine, identify, and own our biases. Without such an effort, we will continue to fool ourselves by claiming we are unbiased, we do not collude, and we practice culturally relevant psychology.

Below is a series of observations of resources that could have been used to do our own personal work. This is an invitation to revisit the sources and ask ourselves questions stirred up by the issues represented.

Observation 1: In 1950 Erik Erikson published *Childhood and Society*. In it he described the eight lifespan stages of psychosocial development for which he is so well known. However, he also described significant child rearing differences between two Native American tribes – the Sioux and the Yurok – and he related these differences to their unique cultures, beliefs, and personal traits and characteristics. How much more aware and sensitive to these differences are we today? Are the Sioux and Yurok so far removed from us that we treat these reports only as interesting footnotes in history? Or could we learn something else about non-Western ways of life?

Observation 2: In 1955, Luft and Ingram published a paper coining the term Johari Window. It describes their graphic portrayal of a two-by-two grid used to identify and contrast what we do and do not know about ourselves with what others do and do not know about us. The result is four quadrants containing differing sets of personal descriptors. They can be described as open (known to self and to others), hidden (known to self, but not to others), blind spot (known to others but not to self) and unknown (to both self and to others). The obvious relevant quadrant is the presence of blind spots and the essential need for feedback. What might be in your blind spot?

Observation 3: In 1958, the Burdick and Lederer book, *The Ugly American*, was published. The title became synonymous with American arrogance, especially with regard to culturally different people. It received acclaim for its identification of an attitude of superiority, lack of respect, and ignorance of others' ways of life and traditions. It was reported that President Kennedy purchased copies of this book for all 100 U.S. senators because the message was so important. Are non-Western (and other) cultures still practices we read about in a book or an article, or have we learned to have conversations with people from different cultures about these differences?

Observation 4: In 1973, David Rosenhan published "On Being Sane in Insane Places" in Science. Dr. Rosenhan and seven emotionally healthy associates became pseudo-patients in psychiatric hospitals by feigning one symptom – auditory hallucinations. Upon admission, they all dropped their symptom and acted normally. Although other patients recognized the impostors, staff members did not.

A reverse experiment was conducted at a hospital that claimed it could never happen there. The hospital staff was alerted to the possibility of a pseudo-patient being sent. Despite not sending anyone, hospital admission officers identified about 40% of those attempting admission as either impostors or suspect of being an impostor.

Although many (most?) of us might want to claim that 'things have changed since then,' I wonder if we are no more advanced in the area of self-awareness, our own biases, cultural awareness and sensitivities, and in general owning our subjectivity. How well do we guard against our own self-fulfilling expectations and prophesies?

Observation 5: In the DSM-IV (1994), Appendix I is an explanation of a cultural formulation for the responsible assessment of individuals from cultures different from the examiner. As regular users of this manual, how familiar are any of us at using this approach to culturally responsible assessment?

Observation 6: In 1997 Anne Fadiman's book, *The Spirit Catches You and You Fall Down,* describes the tragic misunderstanding between well meaning physicians and the refugee Hmong family of a two-year-old patient diagnosed with epilepsy. The book was hailed as a testimony to the need for more culturally sensitive health care.

Observation 7: In 2011 Daniel Kahneman's work, *Thinking Fast and Slow,* delineates the automatic fast thinking inherent in intuition contrasted with the slower rational thought process we would like to think we engage in more often. I believe we can usually identify our slow thinking. How aware are we of our fast thinking and the conclusions that style leads us to?

Observation 8: If diagnosis were paint, it would color every way we see, think, and act toward a person. We would likely not see behaviors that do not fit with the diagnosis. And what does it say that some diagnoses have this effect – coloring everything about a person – and others do not? This is a metaphor that is as true today as it was at the time of the Rosenhan study. Do we see what colors are on our palette?

Observation 9: How would you explain your own cultural identity to a total stranger? If we have not had this conversation about our own cultural history and influences, how can we expect to intelligently explore with others their

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Where to Find Diagnoses Online

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Dr. Edward Zuckerman

If you rarely need to look up the code number for a diagnosis or the diagnosis for a number use one of the sites below in sections A or C. Entering a code number to find the exact diagnosis is easy but finding the code number from a diagnosis requires more effort because you will have to drill down one digit/space at a time.

A. Where to get single ICD-9-CM diagnoses

Chris Endres in Denver offers us a great resource at http://icd9cm.chrisendres.com/. Simply enter the number or name in the box at top center: "Search Diseases and Injuries in the Tabular List." You can also search for procedures (CPT), drugs, hospital codes, and definitions. Codes were last updated in 2009 (although mental health has had minimal changes since then).

Very similar sites worth a look are:

- Find-A-Code – http://www.findacode.com/icd-9/icd-9-cm-diagnosis-codes.html
- ICD9Coding – www.ICD9coding.com
- ICD9Data – http://www.icd9data.com offers the latest version (2012) of ICD-9 and it allows conversion between ICD-9 and ICD-10.

Wikipedia offers essentially a free textbook at https://en.wikipedia.org/wiki/List_of_ICD-9_codes. See much more information for each diagnosis by clicking on its name.

B. Where to get all of the ICD diagnoses at once

You can get a listing of all of the codes and diagnoses but with some effort or cost.

- The Centers for Disease Control is in charge of tailoring the ICD for the U.S. To download, free, all of the ICD-9-CM codes. Go to ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Publications/ICD9-CM/2011/ and download the zipped folder "Dtab12.zip" by clicking on it. Unzip it, manually if necessary, and open it in any word processor. You want pages 165 to 196 – Chapter 5. Note that what you will get is 31 pages, with lots of white space, and for some codes more than a dozen diagnoses are listed. Many are obscure or antiquated and most are almost repetitive.
- The version at CMS (The Centers for Medicare & Medicaid Services) is online at http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/codes.html but is more complicated to access and less well laid out.

Versions without these unnecessary codes are available from two sources.

- Rapid Coder *Reference Chart for Psychiatry* at http://www.rapidcoder.com/index.php?route=product/product&path=59&product_id=53 is cramped, alphabetical (useless when all you have is the code number and want the diagnosis), and $25.
- My own version has none of these handicaps and is cheaper. See https://www.theclinicianstoolbox.info/ICD-9.html.

C. Where to get DSM-IV diagnoses

Although the American Psychiatric Association tries to control and prevent copying there are many versions online. However, few list both numbers and diagnoses.

1. A list of diagnoses without all the code numbers is available at http://allpsych.com/disorders/disorders_alpha.html. A similar list is available at http://behavenet.com/apa-diagnostic-classification-dsm-iv-tr. Clicking on the name brings up the diagnostic criteria and some interesting resources – books, films, chemistry, directories of services, etc.
2. Although somewhat tricky to download, a free 50MB .pdf file of the entire DSM-IV is at www.depositfiles.com. The entire 955-page DSM-IV-TR book is at http://www.scribd.com/doc/39470480/DSM-IV-TR and can be downloaded as .pdf or .txt file for a $5 one-day pass. Many neat books are there as well so plan well.
3. Usenet.nl may have it available. Start at https://en.usenet.nl/registration/
4. If you need to discriminate a diagnosis, the diagnostic criteria are online. "DSM-IV Complete Criteria for Mental Disorders" from James Morrison's superb book are at http://www.neurosurvival.ca/ClinicalAssistant/scales/dsm_IV/dsm_index.html. A PowerPoint of them is at http://www.spiritualmentoring.com/page2/page46/page46.html.

D. Crosswalks

There is no universally accepted crosswalk between DSM and ICD.

1. There is a crosswalk between DSM-IV and ICD-10 in the back of the DSM-IV manual. Note that this is not for ICD-9 and that changes have been made to ICD since publication. These changes are noted at http://www.psych.org/practice/dsm/dsm-icd-coding-crosswalk.
2. A crosswalk that included ICD-9-CM, DSM-IV-TR *and* the infant diagnoses for ages 0-3 is downloadable from http://www.mi-aimh.org/crosswalk courtesy of the Michigan Association for Infant Mental Health. It offers only the higher level diagnoses in a seven-page table.
3. The crosswalk from DSM-IV to ICD-9 at the APAPO site is very incomplete and inaccurate. Not recommended.
4. My own (obsessively complete) crosswalk is not available online but is in the Appointment Calendar from PPA and from http://nationalpsychologist.com/2011/06/2012-appointment-calendar-for-mental-health-professionals/101520.htm and in my book, *The Clinician's Thesaurus*.

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E. Where to see provisional DSM-5 diagnoses

The official site for the DSM-5 (the odd Roman numeral and spacing has been abandoned for this edition) is http://www.dsm5.org/Pages/Default.aspx. While much on its development and procedures is there, the current numbers, names, and actual criteria are available for each chapter by clicking on the list toward the bottom of the page.

F. Where to see ICD-10-CM Diagnoses for mental health

Although you can't actually submit or use these before October 1, 2014, they are available for training and planning.

1. The Centers for Disease Control has the whole and current ICD-10 (170,000 diagnoses) available for download at the index of ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Publications/ICD10CM/2013/ in .txt and .pdf versions. Download it, open the file with the word "Tabular," and then select Chapter 5 by clicking. This runs from pages 193 to 234 and is nicely laid out but unwieldy.
2. For looking up individual codes the site www.ICD10Data.com has very complete and functional resources. Mental conditions in ICD-10 are the F01-F99 codes.

G. Where to see ICD-11

If you want to be impressed with big improvements in diagnosing, working together, integrating electronic records, etc., and want to contribute go to its page at http://www.who.int/classifications/icd/revision/en/index.html.

Full disclosure: I have no relationships of any kind which might affect my judgment with any of the organizations listed above except my own company, The Clinicians' ToolBox, and Guilford Press, publisher of my books including *The Clinician's Thesaurus*.

DSM-5 APPROACH TO DIAGNOSING PERSONALITY DISORDERS

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perceive ourselves and others as we perceive important others have related with us. We seek to maintain attachment and proximity to our caregivers, and we wish for love from them even in adulthood in the form of internalized representations of them. Psychopathology makes sense in terms of the "gift-of-love" (GOL; Benjamin, 1993) which accounts for the mental and behavioral habits that children internalize from attachment figures' rules, values, and behaviors in order to be safe and maintain the very attachment needed for survival.

SASB has predictive principles that account for both relationship phenomena and have treatment implications outlined in IRT. For example, client behavior can be explained in terms of the principle of complementarity: If a parent blames, belittles, and exerts hostile power toward a child, that child will sulk, scurry, and comply. That, according to IRT theory, is one path to depression. The principle of introjection further predicts that children will learn to treat themselves as they have been treated. The principle of similarity accounts for the phenomenon whereby these children may grow to treat not just themselves, but also others, as their early caregivers treated them.

In summary, SASB diagnoses with friendliness and is designed to teach people where their patterns are from and what they are for (e.g., the GOL). IRT treatment goals are linked to SASB dimensions: to develop friendly differentiation from early attachment figures while maintaining a healthy level of connection to safe others. Many DSM diagnoses can be parsimoniously captured using SASB dimensions. The GOL and Benjamin's approach to diagnosis and treatment of PDs keeps on giving, if we could receive it!

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IMPACT OF CULTURE...

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own cultural experience? Inclusive Cultural Empathy, an approach described by Pederson and Carlson in their APA-published DVD, asks questions in a societal and cultural context rather than the Western focus exclusively based on an individualistic perspective. Reflective listening works best when we are working with people who are products of the dominant Western subculture.

Each one of these observations could lead to conversations that could be helpful in guiding us to more culturally responsible diagnosis and treatment. Maybe one of the reasons seeing a psychologist is still so stigmatizing has to do with the degree to which people do not feel understood. Maybe we can make an even bigger difference when we enroll in our own culture school.

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Shifting Paradigms: The Impact of DSM-5

Bradley R. Beckwith, MS, and Rutvi S. Kapadia, MA

Bradley R. Beckwith, MS

Rutvi S. Kapadia, MA

"New but not Necessarily Improved;" "A Warning Sign on the Road to DSM-V: Beware of Its Unintended Consequences;" "DSM-V Badly off Track." These are just a few of the titles that came up when doing an Internet search of the upcoming edition of the *Diagnostic and Statistical Manual of Mental Disorders, 5th Ed* (DSM-5). This proposed revision is scheduled to be released in 2013 and has already received significant attention, both positive and negative, within the field of psychology.

The proposed changes to the DSM have come under great scrutiny among mental health professionals – specifically, psychologists, who have begun a petition (see page 9) against the publication of this edition ("Open Letter," 2011). It may be beneficial to understand how this edition will impact the nature of our field, particularly for those of us currently in training.

In DSM-5 many previously established diagnoses will be altered and/or removed. In DSM-5 greater emphasis will be placed on dimensional representation of various mental disorders. The shift from a categorical system to a dimensional system in DSM-5 is said to provide a way in which symptoms can be described in a manner that better accounts for their nature, degree, and extent. Supporters of DSM-5 will argue that focus on categorical representation indicates that symptoms are identified as being present or absent without much consideration for the patient's "lived experience" (Flanagan, Davidson & Strauss, 2007). Their belief is that a dimensional approach provides a more comprehensive description of patient functioning, a more accurate representation of pathology, and allows clinicians to better understand how their patients experience symptoms (Huprich & Bornstein, 2007; Flanagan et al., 2007).

On the other hand, those who are in opposition of the DSM-5 have voiced significant concerns regarding the newest revision of this manual. Major points of dispute include: lowering the diagnostic thresholds for multiple disorder categories, introducing disorders that may lead to inappropriate medical treatment of vulnerable populations, and questions regarding the proposed changes to mental illness as there is less emphasis on sociocultural factors and greater emphasis on biological criteria ("Open Letter," 2011). Those who have reservations regarding the publication of DSM-5 believe that psychologists and psychiatrists should work together to develop an alternative concept of mental health concerns by taking into account aspects of both disciplines. If the proposed changes from a categorical to a dimensional system are adopted in the final version, the DSM-5 would indicate a shifting paradigm in this field.

The DSM has not experienced a paradigm shift since the criteria established by the DSM was revamped by the DSM-III (First, 2010). Although many welcome the potential paradigm shift, others note that the DSM-5 will actually continue to utilize a descriptive categorical approach, with an expanded dimensional component (First, 2010). Many issues persist regarding the dimensional/categorical system, and some may be related to recent questions about diagnostic reliability.

Additional questions have been raised pertaining to the reliability thresholds the APA uses in the development of the DSM-5 (Frances, 2012). The American Psychiatric Association established a reliability goal for diagnoses to have a kappa value between 0.4 and 0.6, but is also willing to accept scores between 0.2 and 0.4 (Kraemer et al., 2012). Acceptable kappa cut-offs for previous DSM versions was 0.6. Lower reliability thresholds diminish the credibility of the DSM-5 and may affect its utility in treatment planning, research, and even in the courtroom (Frances, 2012).

With so many questions being raised about the DSM-5, graduate students are in a unique position to contribute to the solution. However, as graduate students, how do we begin to determine which side of this debate we agree with, and why? More importantly, how do we find balance between these two distinct perspectives as we enter the field as novice clinicians during this contentious time?

While still establishing our roots in this field, graduate students may be more accepting of these revisions and welcome the opportunity to play a role in a potentially shifting paradigm. Questions about diagnostic criteria create research opportunities. An expanded dimensional component could be enriched by case studies and qualitative research. Learning a new diagnostic system from its inception allows students to become the new experts in this emerging paradigm. Even though we have questions about the clinical utility of certain aspects of the DSM-5, as graduate students it is difficult not to be excited about these changes and the inherent opportunities they create.

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State Representative Timothy P. Briggs (left) received the Public Service Award, presented by Dr. Mark A. Hogue.

Dr. James Huggins was presented the Public Service Award by Dr. Nancy Chubb.

Dr. Andrea Delligatti received the Distinguished Service Award from Dr. David A. Rogers.

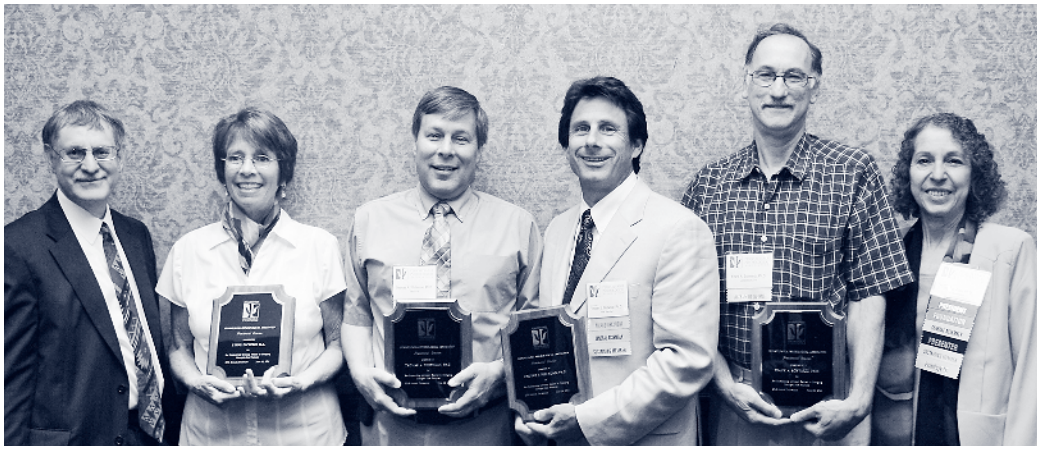
(Right) Dr. Jana Martin, CEO of the APA Insurance Trust, was the keynote speaker. She addressed the theme of "Public education: A mission, a message, and a map for psychologists."

Incoming President Dr. David Palmiter accepted the gavel from outgoing President Dr. Judith Blau.

Annual Convention in Pictures

PPA's photographers captured many of the events at the Annual Convention in June 2012.

Dr. Gail R. Karafin (r) was presented the Award for Distinguished Contributions to School Psychology by Dr. Marie McGrath.



Four psychologists were honored with a special presidential award for outstanding advocacy. Pictured (l-r) are Dr. Sam Knapp (PPA staff), the four awardees, Lynne DiCaprio, Dr. Thomas Whiteman, Dr. Vince Bellwoar, and Dr. Frank Schwartz, flanked by then-President Dr. Judith Blau.

The late Dr. Stephen N. Berk, a past president of PPA, was honored posthumously with the Distinguished Service Award. It was presented by Dr. Judith Blau to Dr. Berk's son, Jason.

Dr. David J. Palmiter Jr. (l) presented the Distinguished Contributions Award to Dr. Edward J. O'Brien.

Dr. Bradley C. Norford (l) presented the Psychology in the Media Award to Michael W. Gillum.

Maiken Scott of WHYY, Philadelphia, received the Psychology in the Media Award from Dr. Bradley C. Norford.

Thanks for Supporting the Student and ECP Networking Reception!

More than 50 students and early career psychologists (ECPs) attended the annual Student and ECP Networking Reception on June 22, during PPA's Annual Convention. A new feature, "speed mentoring," was added to the event this year. Mentors included Drs. Andrea Delligatti, Linda Knauss, Don McAleer, David Palmiter, Jeff Pincus, David Rogers, Cheryll Rothery, and Dianne Salter. They offered counsel to help ECPs and students to define, execute and advance a variety of professional missions and goals.

The Associates of Springfield Psychological, Chestnut Hill College, and Taylor Study Method of Post Falls, Idaho, were the financial sponsors this year.

Each student and ECP also received a door prize. Dr. Pauline Wallin donated a one-year membership to the Practice Institute: Resources for your Success, and Simone Gorko donated three test kits (TSCC, TSI and DAPS). Books on a variety of psychology topics were donated by Drs. Francine Barbetta, Scott Browning, Janet Sasson Edgette, Eric Griffin-Shelley, Samuel Knapp, George McCloskey, David Palmiter Jr., Ari Tuckman, Ed Zuckerman, and Impact Publishers in Atascadero, California.

Entertainment was provided by "Rhythm on Main" from Mechanicsburg. The group of five talented young musicians, including Greg Gavazzi (son of Dr. John Gavazzi), delighted everyone in attendance. We hope you will consider supporting the event during next year's Annual Convention.

Pennsylvania Psychological Association
2013 Award Nominations Sought

For each nomination you would like to make for the categories below, please prepare a one-page narrative describing the person's contributions and his/her vitae with contact information, and send the information to Marti Evans, mevans@PaPsy.org, or to the following address by the deadline listed.

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

Award for Distinguished Contributions to the Science and/or Profession of Psychology to be given to a Pennsylvania psychologist for outstanding scientific and/or professional achievement in areas of expertise related to psychology, including teaching, research, clinical work, and publications. Deadline for entries is **October 20, 2012**.

Distinguished Service Award to be given to a member of the association for outstanding service to the Pennsylvania Psychological Association. Deadline for entries is **October 20, 2012**.

Public Service Award to be given to a member (individual or organization) of the Pennsylvania community in recognition of a significant contribution to the public welfare consistent with the aims of the association. Deadline for entries is **October 20, 2012**.

Award for Distinguished Contributions to School Psychology: The School Psychology Board of the Pennsylvania Psychological Association nominates a candidate annually for this award. Criteria for nominations include persons who have contributed significant research in the field of child, adolescent, school, or educational psychology; have contributed significant public service to children, families or schools; have made major contributions to the field of assessment; have made significant contributions in the media; have advocated politically for children, families or schools; have been a voice advocating for school psychologists in Pennsylvania; and/or have made significant contributions to the Pennsylvania Psychological Association. Deadline for entries is **December 31, 2012**.

Psychology in the Media Award: Deadline for entries is **December 31, 2012**. Members of the Pennsylvania Psychological Association and members of the media in Pennsylvania who have presented psychology and psychological issues to the public are encouraged to apply for the 2013 Psychology in the Media Award. Members who have written newspaper or magazine articles or books, have hosted, reported or produced radio or television shows or commercials about psychology or psychological issues, or have designed psychologically oriented websites are eligible for the award. We are seeking candidates who have had a depth and breadth of involvement in these areas with the media over a period of time. Some of the work must have been published or broadcast during 2012. An application form, which is available at www.PaPsy.org, must accompany all entries for this award. Applicants who have received this award in the past are not eligible.

Early Career Psychologist of the Year Award to be given to a Pennsylvania early career psychologist (ECP) who, in his or her practice as an early career psychologist, is making a significant contribution to the practice of psychology in Pennsylvania. Criteria for the award are available at www.PaPsy.org. Deadline for entries is **January 31, 2013**.

Student Multiculturalism Award to be given to a psychology student who is attending school in Pennsylvania and who produced a distinguished psychology-related work on issues surrounding multiculturalism, diversity, advocacy, and/or social justice. Criteria for the award are available at www.PaPsy.org. Deadline for entries is **January 31, 2013**.

Bridging the Gaps Between Leaderships, Other Organizations, and the Community

Tim Barksdale, PsyD, Chair, Committee on Multiculturalism


Dr. Tim Barksdale

The Committee on Multiculturalism (CoM) has had the good fortune of being chaired, for the past four and a half years, by Arcadia University's director of the Counseling Psychology graduate program, Dr. Eleonora Bartoli. Under her inspired leadership, the CoM membership has grown by 30%, has added four subcommittees, and has become one of the largest and most prolific committees within the Pennsylvania Psychological Association in regard to published articles, community services and presented workshops. During the 2012 PPA convention, the baton was passed to CoM member and new chair, Tim Barksdale, a 15-year veteran in the field of psychology and recent graduate of the Philadelphia College of Osteopathic Medicine (PCOM) with a clinical psychology doctoral degree.

Dating from 2001, the CoM has had an on-going goal of forming alliances with other psychologists from multicultural associations. After three years of conversations the CoM addressed this goal with the facilitation of a community conference organized by the Delaware Valley Association of Black Psychologists (DVABPsi), on June 28, 2012, marking the first collaboration between the two groups. The all-day conference, held at the Monumental Baptist Church in West Philadelphia, was titled, "Creative Teamwork: Bridging Critical Gaps in Community Mental Health." The conference included a series of comprehensive workshops seeking to address issues relevant to the community in various aspects of behavioral health. Specific subjects included bridging the gap between traditions of faith and mental health resources; home, school and mental health support; mental health providers and consumers; caregiving issues for the chronically mentally ill; and community policing and community mental health. The event was highlighted by an informative and humorous keynote presentation by Dr. Arthur Evans, the Commissioner of Philadelphia's Department of Behavioral Health and Intellectual disAbility Services (DBHIDS).

The CoM's new chair was active in the planning and facilitation of the event, and developed the conference brochure and flyer. Dr. Bartoli and the clinical coordinator of the graduate program in Counseling Psychology at Arcadia University, Carol Lyman, facilitated the CE credits and the training of volunteers to administer the credits through the university. CoM member Crystal Taylor and Arcadia University student Alex Mamolou were active in registration and program facilitation. PPA's past board secretary and new CoM member, Dr. Cheryll Rothery, was a standout in her presentation on "Bridging the Gap Between Male and Female Relationships".

With the assistance of CoM members, this well-attended, first time event was primarily organized by outgoing DVABPsi President Dr. R. Dandridge Collins (affectionately known as Dr. Dan) who, this year, passes the presidency on to President-elect Dr. Yuma Tumes, PCOM associate professor, and director of Masters of Science in School Psychology Program. The Delaware Valley Association of Black Psychologists has been an established entity of the American Association of Black Psychologists since 1973. DVABPsi, based in Philadelphia, serves the tri-state area as a source of education, networking, advocacy, and psychologically based resources for the membership of behavioral health professionals and for the community at large. The CoM looks forward to nurturing this relationship as well as the development of other alliances with groups that celebrate diversity.

ASPPB Receives Licensure Portability Grant

The Association of State and Provincial Psychology Boards (ASPPB) has been selected to receive one of two licensure portability grants offered by the Health Resources and Services Administration (HRSA), a division of the U.S. Department of Health and Human Services. The primary purpose of the grant is to provide support for state professional licensing boards to carry out programs that will reduce statutory and regulatory barriers to telemedicine. The funds will be used to continue the development and implementation of the ASPPB Psychology Licensure Universal System (PLUS).

As an integral means of addressing the barriers associated with telepsychology, ASPPB has developed an online application system, the PLUS, that can be used by any applicant who is seeking licensure, certification, or registration in any state, province, or territory in the United States or Canada that participates in the PLUS program. With the assistance of this grant, ASPPB will be able to expand the number of jurisdictions using the PLUS online application, including storage of licensure-related credentials for electronic transmission, and later to develop a specific program or mechanism to address the current cross-jurisdictional barriers to telepsychology.

Identifying Giftedness in Pennsylvania

Timothy J. Runge, PhD, and Mark R. McGowan, PhD
Indiana University of Pennsylvania, Center for Gifted Education

Dr. Timothy J. Runge

Dr. Mark R. McGowan

Identifying gifted and talented students in Pennsylvania requires knowing the state's definition (22 Pa. Code § 16.21) and incorporating its multiple criteria to guide decision-making. After reviewing the regulatory and theoretic bases of determination, a small sample of eligibility matrices ($N = 4$) will be used to highlight how some school districts are adapting their evaluation and decision-making practices in response to these changes.

The Chapter 16 code delineates criteria used by schools to identify students as mentally gifted and eligible for gifted support services. To receive such services, two prerequisites must exist: first, a student must be identified as mentally gifted; second, the student must demonstrate a need for specially designed instruction to adequately meet his or her superior skills and capacities.

The regulations still specify an IQ score of 130 or higher to establish giftedness in the United States (Council of State Directors of Programs for the Gifted and the National Association for Gifted Children, 2007; Newman, 2008; Worrell & Irwin, 2011). The Pennsylvania regulations specify that significant intra-individual performance deficits in memory or processing speed should be removed from the calculation of overall IQ. An alternate composite IQ is frequently a more valid indicator of cognitive abilities in gifted students (Raiford, Weiss, Rolfhus, & Coalson, 2005) because these students typically become bored with meaningless, low-level cognitive tasks on working memory subtests, and their perfectionistic tendencies often result in a comparatively low performance on timed activities.

Chapter 16 regulations further allow a student to be considered as gifted without an IQ of 130 provided the student meets multiple criteria, including academic achievement a year or higher than peers; observed or measured rates of acquisition and retention of information or skills; achievement, performance, or expertise in one or more academic areas; and high-level thinking skills, creativity, leadership, intense academic interests, communication skills, foreign language aptitude, or technology expertise. Beyond these specific criteria, no further guidance regarding their use is provided in the regulations. Some Pennsylvania school districts have developed matrices that include many of the above criteria. These matrices assign a range of point values within each criterion, and a determination of mental giftedness is based on how many total points were awarded (see Table 1).

Chapter 16 regulations further allow a student to be considered as gifted without an IQ of 130 provided the student meets multiple criteria ....

Typically a range of points is given for the IQ, with the number of points decreasing as the measured IQ falls below 130. Some schools require calculation of the alternate IQ. The student's cumulative grade point average (GPA) is often included in the matrix. If parent and teacher reports are included, they are typically a subjective rating of the student's capacity to master and retain new content and skills. Finally, most district matrices assign points based on performance on standardized tests and/or the *Pennsylvania System of School Assessment*.

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Table 1. Multiple Criteria Used in Eligibility Matrices ($N = 4$)

Domain	Criterion on Which Points are Awarded	Weight*
Cognitive Ability	Standard score(s) from an individually administered measure	50 – 96%
Academic Achievement	Standard scores exceeding two standard deviations or 90th percentile in one or more academic areas	< 1% - 50%
Parent or Teacher Report	Standard scores generated from rating scales, e.g., Scales for Identifying Gifted Students (SIGS; Ryser & McConnell, 2004)	< 1% - 33%
Classroom Performance	Performance	< 1% - 17%
Acquisition/Retention	Accelerated rates of learning	0 - <1%
Twice Exceptionalities/Special Factors	Students who have been identified with comorbid educational disabilities or diagnostically relevant factors, e.g., autism or English language learners	0 - <1%

**Note. Weight values were calculated for the categories based on the points awarded in each domain toward the total points required for eligibility.*

ADHD: Some Thoughts About Diagnostic and Assessment Issues for School Psychologists

Helena Tuleya-Payne, DEd, Millersville University

Dr. Helena Tuleya-Payne

Diagnosis is one of many core skills of school psychologists, usually within the context of identification for services and intervention determination. Diagnosing educationally related conditions such as specific learning disabilities is recognized by practitioners and the public as an appropriate function of school psychologists. In Pennsylvania, school psychologists are mandated as part of the multidisciplinary team that works to determine, for most categories, whether a child has a disability and is in need of specially designed instruction (i.e., special education).

Since 1999 when the psychiatric disorder, attention deficit hyperactivity disorder (ADHD), was included within the Individuals with Disabilities Education Act (IDEA) category "other health impairment " (OHI), the role of school psychologists in its diagnosis has become more important. The presence of ADHD may qualify the child for special education services. Does a medical professional need to be part of the evaluation team to determine whether a student has ADHD?

The Office of Special Education Programs (OSEP) addressed this issue in a 1992 letter to Parker, as described in an article by Stacy D. Martin and Perry Zirkel (2011). They reported that, according to OSEP, IDEA does not require a physician's diagnosis of ADHD for a student to meet criteria of OHI unless state law requires medical diagnosis. Pennsylvania does not require a diagnosis from a physician but follows the federal mandate that the evaluation team include an individual who is knowledgeable about the disability and its impact on educational performance. As pointed out by Martin and Zirkel (2011), many school psychologists have the necessary skills to perform this role.

Given that it is in the purview of school psychologists to diagnose ADHD, what is best practice for such a determination? A starting point to developing an assessment battery should begin with a definition such as presented in the DSM-IV (American Psychiatric Association, 2000).

Review of the definition suggests measures such as developmental and teacher interviews, rating scales, and classroom observations would inform diagnosis. Tobin, Schneider, Reck, and Landau (2008) endorsed the following tools: (a) narrow-band or ADHD-symptom parent and teacher rating scales to provide information about severity of symptoms and specific ADHD subtypes across settings, and (b) interviews to provide a context to the information obtained in the rating scale. They do not, however, recommend direct observations for diagnostic purposes due to high variability of student behavior. They do endorse the role of direct observations as a key part of a functional assessment that supports intervention development.

A diagnosis of ADHD is not sufficient to qualify for specially designed instruction. Eligibility for special education has two criteria: (a) classification and (b) need for specially designed instruction. To meet the classification criteria for OHI, the student's ADHD must be a chronic or acute health problem that results in limited strength, vitality, or alertness, with respect to the educational environment, and adversely affects educational performance (IDEA, 34 C.F. R. 300.7 (c) (9)). It is possible to have ADHD and given appropriate supports in general education, not meet the criterion for need if satisfactory educational progress is made. Martin and Zirkel (2011) suggested that school psychologists can be helpful in clarifying for physicians the differences between medical diagnosis of ADHD (DSM-IV) and the legal definition (e.g., "disability" under IDEA and Act 504).

Once eligibility has been determined, the next step is providing intervention. Indeed the most recent NASP position statement (2011) on ADHD devotes more attention to intervention than diagnostic considerations. Models of assessment that support intervention for children with ADHD call for a problem-solving model that operationalizes the problem behaviors , analyzes the conditions under which the student is most successful and challenged, assesses the implementation of the intervention(s) and evaluates the intervention plan's effectiveness (Hoff, Doepke, & Landau, 2005). Determining conditions that precede or follow behaviors of concern through functional assessment can lead to significantly improved performance of students with ADHD (DuPaul, Stoner, & O'Reilly, 2008).

IDEA does not require a physician's diagnosis of ADHD for a student to meet criteria of OHI unless state law requires medical diagnosis.

How do practicing school psychologists tackle the assessment of ADHD? Danel Koonce (2007) conducted a national survey completed by 246 practicing school psychologists. She reported that interviews represented the most frequently cited source of obtaining information followed by direct observations. Koonce reported that ratings scales were only moderately endorsed, despite their utility establishing the presence of diagnostically relevant symptoms and communication value with medical professionals. She reported a high use of traditional psychological instruments such as standardized IQ and achievement

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IDENTIFYING GIFTEDNESS IN PENNSYLVANIA

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Uncommon factors in district matrices include student reports, portfolio reviews by local experts, and points awarded for foreign language or technological aptitude.

The points are typically summed and compared to a pre-established benchmark. Students with cumulative points above the cutoff are identified as mentally gifted. Although districts' efforts in this regard are commendable (Frasier, 1997), caution is warranted until such matrices are empirically validated. Some of the matrices continue to weigh the IQ so heavily that students who earn full points for other criteria are still not found eligible because their IQ was in the low 120s. Such matrices, de facto, revert to the traditional 130 IQ single-criterion identification method.

Psychologists consulting with school districts must be familiar with the regulatory criteria for identifying giftedness, understanding its changing definition, and determining eligibility for gifted support services. Psychologists must also understand the ways in which school districts operationalize multiple criteria. Although the empirical evidence of these matrices is yet to be determined, these developments are encouraging because they prospectively identify gifted students who don't otherwise meet the IQ cutoff.

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ADHD...

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tests, despite their lack of utility in diagnosis or intervention planning for students with ADHD. Koonce suggested that the high co-morbidity with learning problems may account for inclusion of these instruments in their batteries. My thoughts are that since part of the classification process of the OHI disability is *"adversely affects educational performance,"* some valid measure of academic assessment should be used in the decision-making process.

In conclusion, diagnosis of ADHD in Pennsylvania can be made by a school-based evaluation team that contains an individual knowledgeable about ADHD and its effect on educational outcomes, i.e., a school psychologist. Diagnosis alone does not determine placement or inform intervention planning, however. School psychologists ideally engage in an assessment process that not only informs classification (i.e., rating scales, interviews) but determines need and interventions (e.g., direct observations, functional assessment). The high comorbidity with learning problems may indicate cognitive and academic assessments as well.

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In Memoriam

Dr. Betty Finney, a long-time professor of psychology at Millersville University, died on July 7 at the age of 86. She had taught at Millersville for 33 years, including several years as chair of the Psychology Department, where she was greatly admired and loved by her students. Dr. Finney invested enormous energy in providing services to her local community. There was hardly a social service initiative in Lancaster County where Dr. Finney did not have a role. Among many other activities, she served as a disaster mental health worker for the American Red Cross, and a critical incident debriefer for Lancaster Emergency Management. In addition, she was an early activist for people suffering from HIV and was one of the founders of the Betty Finney AIDS House in Lancaster.

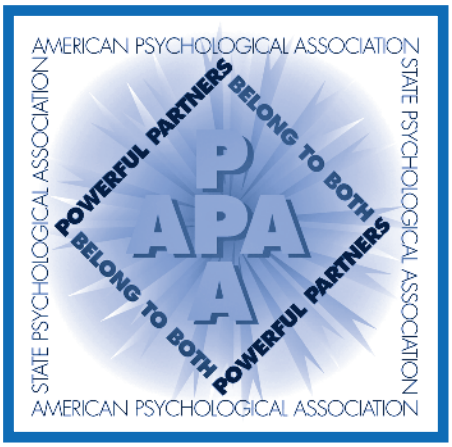
Member News

Dr. Stephen A. Ragusea

Dr. Stephen A. Ragusea, Ethics chair of the Florida Psychological Association (FPA) and a former president of PPA, received the Michael Spellman Award for Ethical Contributions to Psychology, conferred by FPA in June. He was cited for "maintaining high standards of ethics and service within the profession of psychology."

Welcome, New Members

We offer a wild, wonderful, whopping welcome to the following new members who joined the association between May 1 and July 30, 2012



NEW FELLOWS

Carl E. Bradford, PhD
Bryn Mawr, PA

Doris Eason, PhD
Philadelphia, PA

Eric S. Franzone, PsyD
Mount Bethel, PA

John R. George, PhD
Blawenburg, NJ

Brent N. Henderson, PhD
Pittsburgh, PA

Julie E. Keaveney, PsyD
Exton, PA

Jodi S. Rosenfeld, PsyD
Phoenixville, PA

Jacque Lynne Washkwich, PhD
Philadelphia, PA

MEMBER TO FELLOW

Valerie A. Lemmon, PsyD
Harrisburg, PA

NEW MEMBERS

Kari Baber, PhD
Philadelphia, PA

Michelle Berman Gagliano, PsyD
Aston, PA

Christina S. Buss, MA
Allentown, PA

Joy A. Duckett, PsyD
Westampton, NJ

Dara S. Fisher, PsyD
Media, PA

John E. Markey, PsyD
Chadds Ford, PA

Tawnya J. Meadows, PhD
Danville, PA

Duangporn O'Toole, MS
Chalfont, PA

Nermine F. Tawadrous, PsyD
Bryn Mawr, PA

Dixie L. Turner, PhD
Carlisle, PA

Lois A. Whittall, PsyD
New Hope, PA

Sarajane Williams, MA
Macungie, PA

Valerie R. Wilson, PhD
Bryn Mawr, PA

STUDENT TO MEMBER

Tim Barksdale, PsyD
Drexel Hill, PA

Jamie M. Bolton, PsyD
Hershey, PA

Louis T. Teller, PhD
Holland, PA

Lisa B. Thomas, PhD
Harleysville, PA

NEW STUDENTS

Lauren C. Bartholomew, MA
Bristow, VA

Ashley E. Collins, BS
Hershey, PA

Natalie C. Fala, MS
Havertown, PA

Carol A. Fritzsche, BS
Philadelphia, PA

Evie J. Gerber, MA
Philadelphia, PA

Kevin A. Hoffman, MA
Halifax, PA

Alison L. Masey, BS
Lititz, PA

Odelia N. McFadden, MA
Philadelphia, PA

Mohammed Mekuns, MS
Philadelphia, PA

Bethany L. Perkins, MEd
Center Valley, PA

Carinna M. Scotti-Degnan, MA
Pittsburgh, PA

Valeriya G. Spektor, BA
Bethlehem, PA

Jessica E. White, BA
Philadelphia, PA

NEW AFFILIATE

Kathleen M. France, MA
Cranberry Township, PA

CE Questions for This Issue

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

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

Complete the response form at the end of this exam, making certain to match your answers to the assigned question numbers. For each question there is only one right answer. Be sure to fill in your name and address, and sign your form. Allow 3 to 6 weeks for notification of your results. If you successfully complete the test, we will mail a confirmation letter to you. The response form must be submitted to the PPA office on or before September 30, 2014.

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

Continuing Education Programs
Pennsylvania Psychological Association
416 Forster Street
Harrisburg, PA 17102 -748

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

DeWall

1. PPA helped stall a bill in the legislature in June that would:
   a. limit hospital medical staffs to physicians, dentists, and podiatrists
   b. impose a sales tax on health care services
   c. prevent Pennsylvania from participating in the Affordable Care Act
   d. expand the scope of practice of social workers

Tepper, Knapp, & Barurin

2. Which of the following is true about mandated reporting of impaired professionals? The Professional Psychologist Practice Act:
   a. clearly defines the term "professional"
   b. is unambiguous concerning what constitutes an "approved treatment program"
   c. requires psychologists to report impaired psychologists if they learn of the impairment through non-confidential sources
   d. none of the above

Farley

3. What is not one of the scientific concerns that has been raised in this article about the DSM-5?
   a. replicability of relevant studies
   b. validity of the evidence base
   c. reductionism
   d. cognitive therapy

Etzi

4. An alternative to the DSM for diagnosis is needed because
   a. insurance companies will no longer reimburse DSM categories
   b. it is widely acknowledged that problems exist with DSM validity, reliability, and clinical utility
   c. symptoms are better assessed and treated when they are understood within a context of a range of personality and mental function dynamics
   d. all of the above
   e. both b and c

Molnar

5. Which of the below are dimensions used to diagnose personality disorders using the Structural Analysis of Social Behavior (SASB)
   a neuroticism
   b. affiliation
   c. interdependence
   d. both b and c

Sternlieb

6. An unexplored and unexamined source of bias in diagnosis is:
   a. validity of newer diagnostic categories
   b. the blind spots out of the psychologist's awareness
   c. the cultural background of patients from non-Western cultures
   d. psychologists trained in non-Western countries

Zuckerman

7. A universally accepted crosswalk between the diagnoses of DSM-IV and ICD-9 can be found:
   a. on Ed Zuckerman's website
   b. in the current DSM-IV-TR
   c. at the Centers for Disease Control in Atlanta
   d. at the World Health Organization in Geneva
   e. nowhere

Beckwith & Kapadia

8. Those who feel the DSM-5 still requires additional revisions argue that:
   a. the current reliability thresholds are too low
   b. psychologists and psychiatrists should work in a collaborative manner in the development of the DSM-5
   c. the proposed diagnostic thresholds may lead to inappropriate medical treatment
   d. all of the above

Runge & McGowan

9. Eligibility matrices used to identify mental giftedness are well defined and empirically established instruments.
   True
   False

Tuleya-Payne

10. The following tools are recommended as core tools in diagnosing ADHD:
    a. rating scales, interviews
    b. interviews, direct observation
    c. direct observation, rating scales
    d. rating scales, interviews, and direct observation

Schuster

11. What was the original, main intention of HIPAA?
    a. to provide health information on patients to hospitals during emergency transport
    b. to limit the information medical and mental health providers can share without consent
    c. to make records more available if treatment is needed during travel
    d. to make it easier for patients to maintain health care coverage when they change jobs

Continuing Education Answer Sheet
The *Pennsylvania Psychologist*, September 2012

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

1.	a	b	c	d		**7.**	a	b	c	d	e
2.	a	b	c	d		**8.**	a	b	c	d	
3.	a	b	c	d		**9.**	T	F			
4.	a	b	c	d	e	**10.**	a	b	c	d	
5.	a	b	c	d		**11.**	a	b	c	d	
6.	a	b	c	d							

Satisfaction Rating

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

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

Comments or suggestions for future issues _____

_____

Please print clearly.

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A check or money order for $20 for members of PPA ($35 for non-members of PPA) must accompany this form. Mail to Continuing Education Programs, PPA, 416 Forster Street, Harrisburg, PA 17102-1748.

Computers Introduce New HIPAA Hurdles

Arnie Schuster, PhD

Dr. Arnie Schuster

Computer technology has evolved over the past 20 years to provide useful and powerful tools for managing our practices. Early in my career, I recall being unsure how computers could be of value other than for psychological test interpretation. In time, I discovered a breadth of advantages: legibility, accessibility, efficient storage of records, and more. While my colleagues were submitting handwritten outpatient treatment plans, which were sometimes illegible and had to be resubmitted, I was sending computer-generated treatment plans and getting complimented by managed care companies. They could actually read the content and had a well-organized treatment plan, in return for which they were happy to authorize more visits. As for case notes, I recall one of my colleagues telling me about a humiliating experience when, in a courtroom, he was unable to read his own illegible notes.

Yes, computers have given us a larger armamentarium of tools to make our practices more efficient and our lives easier (though I must admit that when they don't work, I want to open the windows – excuse the pun – and pitch mine out). With the use of this technology in our practices, however, comes the critical responsibility to protect and secure the data we store and transmit. Now, to be sure, this was true for those who used and still use paper charts. Paper charts need to be secured in a locked filing cabinet. Many agencies keep filing cabinets in a locked room and use fire and waterproof filing cabinets. But for those now using computers, how do these privacy and security requirements apply?

HIPAA, or the Health Insurance Portability and Accountability Act of 1996, was originally intended to make it easier for people to maintain healthcare coverage when they changed jobs. An important aspect of this was also making it easier to transfer patient records or make relevant data more portable. HIPAA has significantly expanded over the years, adding regulations to cover the privacy and protection of individually identifiable patient information known as Protected Health Information (PHI), as well as medical records.

Identifiable PHI comprises the following (Jones, 2009), but is not limited to:

1. Names
2. Geographical parts smaller than a state: street address, city, county, zip code
3. Identifying dates, i.e., birth date, admission and discharge dates, date of death
4. Phone and fax numbers
5. E-mail addresses
6. Social Security numbers
7. Medical record and account numbers
8. Health plan beneficiary numbers
9. Certificate/license numbers
10. Identifiers, including fingerprints, signatures, photographs
11. Any other unique identifying number, characteristic, or code

The American Recovery and Reinvestment Act of 2009 (the Stimulus Act) out of which came the Health Information Technology for Economic and Clinical Health (HITECH) Act not only provided incentives for the adoption of electronic medical records, but also greatly expanded HIPAA's regulations and teeth. HIPAA and HITECH are crucial to understand for healthcare providers as they maintain and transfer patient information. Penalties for violations may be as low as $100 per incident and as high as $250,000 per violation, plus 10 years of imprisonment for more serious breaches. And, while in the past, enforcement of HIPAA was not a priority, the HITECH Act has placed more of an emphasis on auditing and enforcement.

A few potential security risks of patient information exist that some clinicians may believe are safe. Patients and providers are increasingly taking advantage of e-mail and texting to communicate. However, along with convenience comes the risk of breach. While you may feel safe in corresponding by e-mail, knowing you have the correct e-mail address for the client or even in e-mailing case notes to your home to work, it is important to know e-mail is stored in multiple locations as it makes its way from one point to another: your computer, your e-mail provider, the client's computer and their e-mail provider. While it is not required to encrypt e-mail, you are required to implement measures to protect against unauthorized access to the information you send. Using an e-mail service that encrypts e-mail and provides access controls and authentication methods to ensure the intended recipient and no one else did in fact receive it protects you from liability. These services are relatively inexpensive and well worth the peace of mind. A couple of years ago, a patient in Pennsylvania contacted an attorney after learning that her physician had e-mailed unencrypted patient records to his home e-mail address (Allabaugh, 2010).

Another common practice among behavioral health providers is to use a word processor such as Microsoft Word to maintain case notes. MS Word is an easy way to create, maintain, and access your patient's progress notes and treatment plans. But, is using MS Word safe and HIPAA compliant? To start with, unless you are printing, signing them, removing them from your PC after doing so, and keeping them in a paper chart, they are at risk of being accessed. While you can password protect Word documents, it is fairly easy to break the password. Also, if maintaining them on your PC, even if they are password protected, they are still not HIPAA compliant to the extent that they can be altered. Without providing a digital or electronic signature that not only finalizes the note but secures it from being altered, your notes are non-compliant. A number of electronic medical record systems are available specifically for behavioral health that provide tools and methods to help comply with HIPAA requirements, ensure data safety and integrity, and secure transmission of records.

Another topic, for another article, is the safe storage, backup, and disaster recovery of these records in the event of a computer hard drive failure, theft, or natural catastrophe such as fire or flood.

Classifieds

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DOCTORAL-LEVEL PSYCHOLOGIST – Children's Service Center of Wyoming Valley, Inc. is seeking a full-time or part-time Psychologist with a minimum of one year of post-doctoral experience in the field of psychology. Licensure by the State of PA is desirable. Celebrating 150 years of service to the community, Children's Service Center of Wyoming Valley, Inc. is a diagnostic and treatment center for children and adolescents with emotional disturbance, severe and persistent mental illness, and pervasive developmental disorders, including autism. It also serves children with developmental disabilities. A full job description can be accessed on our website at www.cscwv.org. CSC is dedicated to creating a therapeutic living and learning environment for all clients and team members. Through implementation of the innovative Sanctuary Model of trauma informed care, Children's Service Center strives to provide safe, democratic environments that are emotionally intelligent and socially responsible for all members of our community. More information on the Sanctuary Model can be accessed at www.sanctuaryweb.com. Please send curriculum vitae and letter of interest to Children's Service Center of Wyoming Valley, Inc., Attn: HR Generalist, 335 S. Franklin Street, Wilkes-Barre, PA 18702, Phone (570) 825-6425, Fax (570) 301-0929, e-mail hr@e-csc.org. – Drug Free Work Place – EEO – www.cscwv.org

OTHER

GREAT CONFERENCE IN PHILLY THIS FALL. The International Society for Ethical Psychology and Psychiatry is holding its annual conference in Philadelphia this November 2 and 3. The theme is Alternatives to Biological Psychiatry: Treatments That Work. See the full-page ad in this issue for presenters and topics. Go to www.psychintegrity for more info and to register. Call 215-579-1706 for information.

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PSYCH TECH *Continued from previous page*

What you would do if you lost your laptop or experienced a flood or fire? And whom would you notify in case of a breach such as loss or theft? A breach of unsecured PHI involving 500 or more individuals must also be provided to major media outlets serving the relevant state or jurisdiction. How quickly could you restore or recover your client data? Could you recover it at all? According to HIPAA, you must have adequate backup and disaster recovery procedures in place. Additional compliance is the cost of computers' convenience.

Arnie Schuster, PhD, a formerly practicing clinical psychologist, is president and CEO of DocuTrac, Inc., makers of QuicDoc®, a leading behavioral health EMR, and Office Therapy® practice management and billing software. www.quicdoc.com

References

Allabaugh, D. (2010). Patient contacts lawyer after protected health information compromised. *The Daily Review*. Retrieved from http://thedailyreview.com/news/patient-contacts-lawyer-after-protected-health-information-compromised-1.1083367

Jones, E. (2009). HIPAA "protected health information:" What does PHI include? Retrieved from http://www.hipaa.com/2009/09/hipaa-protected-health-information-what-does-phi-include/

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- Withdrawing from psychotropic drugs: Clinical indications, safety, and supervision concerns.
- Treating children and adults with integrative care.
- Non-drug approaches to helping children diagnosed with ADHD.

For more information or to register, go to www.psychintegrity.org

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September 2012 • QUARTERLY

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2012 CE Calendar

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

October 5, 2012
APA Insurance Trust Risk Management Workshop
Harrisburg, PA
Marti Evans (717) 232-3817

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

June 19-22, 2013
Annual Convention
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/index.php/collaboration-communication/.

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.

also available at www.PaPsy.org – HOME STUDY CE COURSES

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*Pennsylvania's Psychology Licensing Law, Regulations and Ethics**
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For all Home Study CE Courses above contact: Katie Boyer (717) 232-3817, secretary@PaPsy.org.