Vol. 73, No. 1

The Pennsylvania Psychologist

JANUARY 2013 • UPDATE

A PUBLICATION OF THE PENNSYLVANIA PSYCHOLOGICAL ASSOCIATION • www.PaPsy.org

Pennsylvania Task Force on Child Protection Releases Its Report

In December 2011 the General Assembly of Pennsylvania created a Task Force on Child Protection with the charge of providing recommendations for reform of the child abuse reporting laws and procedures in Pennsylvania. On November 27, 2012, the task force concluded its work and issued its final report, which included more than 45 recommendations to improve a system that, according to task force chair David Heckler, "is woefully failing." Mr. Heckler is the district attorney in Bucks County and a former state senator and county judge. The full report, which runs 445 pages, is available at www.childprotection.state.pa.us. PPA had submitted testimony to the task force.

Although the task force was created in response to the unreported cases of child abuse at the Pennsylvania State University, Mr. Heckler claimed that the task force wanted to do more than react to the immediate failures, but was instead "seizing the opportunity to look at what we are doing." In a prepared statement, Governor Corbett said, "It's my hope that we can take the work of the task force to help create a culture that promotes greater awareness, more accountability, and better coordination."

Some of the recommendations included expanding the definition of non-accidental injury in Pennsylvania. According to pediatrician Dr. Cynthia Christian, a member of the task force, the current definition of non-accidental injury is "incredibly problematic." Other recommendations include eliminating the special reporting section for child abuse that occurs within the schools; expanding the definition of perpetrators beyond parents or persons responsible for the welfare of a child; expanding the classes of persons who would fall under the mandated reporting law (including college administrators, coaches, and attorneys); improving the responsiveness of ChildLine; improving the training of child protective service workers; and requiring multidisciplinary investigative teams for all counties. The Pennsylvania Department of State, which oversees all professional licensing boards, will be required to establish training programs on child abuse for all licensees who are mandated reporters of child abuse. This was consistent with PPA's recommendation, as opposed to mandating training through other organizations. PPA had urged the task force also to consider a recommendation to expand the definition of child neglect, and fortunately they did so. That category of abuse is greatly underreported in Pennsylvania compared to other states.

The task force held 17 meetings and conducted several hearings over the last year. It is up to the state legislature to craft legislation to turn these recommendations into law. It is likely that the recommendations will be presented in several different bills, which will require additional public hearings. PPA will be providing more detailed information on these issues to the membership after more careful analysis by the staff. Any reform to the Child Protective Services Law will be a major focus for PPA in 2013.

Last Chance to Make Nominations

PPA's Nominations and Elections Committee is hard at work seeking nominations for the Board of Directors for the 2013 elections. The following positions will be on the ballot: president (a 3-year commitment – as president-elect, president, and past president), treasurer, and the chairs of the Communications Board, Internal Affairs Board, and School Psychology Board. These are 2-year commitments (except the president) and people can serve for two consecutive terms. The Communications Board consists of the Committees on the Bulletin, Electronic Media Coordination, the E-Newsletter, Public Education, and Technology Implementation. The Internal Affairs Board is made up of the Committees on Awards, Budget and Finance, Early Career Psychologists, Leadership Development, Membership, and Nominations and Elections. The School Psychology Board includes the Committees on Communications, Outreach/Liaison, and Public Policy. The critical job for board chairs is to oversee the activities of all of the committees within their board.

To learn more about each position, visit the PPA website at http://www.papsy.org/index.php/governance/. Click on "General Assembly job descriptions." This is in the members-only section, so you will need your member number (found on this issue's mailing label) for the username and your last name for the password. Click the tab "Nominations & Elections." Then please nominate yourself or a colleague using the form on that page. Nominations are due to the PPA office by January 14, 2013.

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Lessons Learned as a Clinical Supervisor, *Part One*

Claudia J. Haferkamp, PhD

Dr. Claudia J. Haferkamp

Clinical supervision is one of the most rewarding yet challenging professional activities. I am lucky to have attended a graduate school that taught supervision theories and offered a supervision practicum. Many practitioners have not received that level of preparation for an activity that carries with it serious ethical, legal, and practical responsibilities. But life's critical lessons don't often come from textbooks or valued mentors. Here are some lessons I've learned after 25 years in the academic trenches as a professor and clinical supervisor:

Lesson #1: Supervisors are professional gatekeepers. This was not clear to me immediately after graduate school. I now appreciate the priorities of clinical supervision: to protect client welfare and enhance the supervisee's competence. But monitoring supervisees and managing those who (perhaps) should not be counselors or psychologists is a daunting responsibility. The challenges of defining core competencies and managing supervisee problems is beyond the scope of this article, but Falender and Shafranske's (2004) book, *Clinical supervision: A competency-based approach*, provides an excellent discussion. Most clinical supervisors know that experience, credentials and academic performance alone do not equal clinical competence. And deciding which supervisee behaviors are acceptable and which ones are not is difficult when one considers that: (1) the same behavior in supervisees at different levels of development may have different meanings and functions; (2) the behavior may be client- or setting-specific; (3) the behaviors could reflect dynamics within the supervisee-client relationship, the supervisor-supervisee relationship or other relationships, making addressing the issues more difficult; and (4) addressing a supervisee's sub-optimal performance may blur the boundaries between supervision and psychotherapy.

Our training culture emphasizes humanistic values that sometimes conflict with our ethical/legal duty to "police the profession" and protect client welfare. I experienced this conflict 25 years ago when doing a live supervision of a beginning counselor's first session with a female client with a history of physical abuse by men. Looking back, this client was a bad choice for a novice. I recall the client's "traumatized" body language: her hunched over posture, hands between her legs, looking down, rarely making eye contact and looking frightened. The counselor was seated too closely, slightly slouching with his legs spread wide. It looked as if the client was being "engulfed" by her counselor's unwittingly dominant posture. I watched for 20 painful minutes, hoping that the counselor would close his legs, sit up and shift his chair back, and show some empathy, but he fired off questions instead. I decided that the client's welfare trumped the supervisee's need to handle the session as he saw fit, so I interrupted him. I quickly explained what I saw and told him to use the listening skills we practiced in class, and pull his chair back and close his legs, being careful not to invade the client's space. The rest we'd discuss later. He did as directed and the last half of the session was much better for the client.

This decision was a conflict between the ethical principles of non-maleficence (i.e., ensure that clients are not harmed) and beneficence (i.e., ensure that treatment is good/helpful) on the one hand and supervisee autonomy on the other. In this case, I trampled supervisee autonomy in the service of beneficence and non-maleficence. Knapp and VandeCreek (2012) have discussed the conditions under which a moral principle may be overridden. First, there should be compelling reasons for doing so. (My reasons were the client's deteriorating behavior in session.) Second, there should be a reasonable likelihood that one can achieve one's objective. (I was confident that the supervisee would change his behavior if asked.) Third, there were no morally preferred options. (I believed the session would not improve without intervention; it was already half over.) Fourth, one should minimize negative consequences of the principle override. (Supervisee and I discussed what happened later and it went well.) Finally, determine whether all parties were treated impartially. (I can't recall irrelevant factors that influenced my decision. Doing nothing was clinically unacceptable.) I did not have this ethical framework 25 years ago, but I find it useful in advance of tough decisions or for reviewing after-the-fact those decisions that every clinical supervisor faces sooner or later.

Lesson #2: If you didn't see or hear your supervisee in action, then perhaps things didn't happen the way they should have. I am amazed how much supervision consists of chatting about clients with little or no direct observation of supervisees' behavior. There are no excuses for clinical supervisors NOT to periodically see and hear what supervisees are doing. The value of watching sessions was driven home by a supervisee working with a seemingly depressed client. After seeing two sessions in which the client appeared very somber, I asked the supervisee if she thought the client was depressed. She said she hadn't considered it. I was surprised by her answer but I took a practical approach and reviewed the DSM criteria for Major Depression with her. We agreed that she would ask her client about symptoms of depression in their next session. One week later in group supervision, she announced that her client was not depressed. I had my doubts but on her videotape I saw this interaction:

> *Supervisee to client:* Are you depressed?
> *Client (long pause, looked sad and tearful):* .....No...I don't think so..."
> *Supervisee:* I didn't think so either, but my supervisor told me to ask you."

To paraphrase Ronald Reagan: trust your supervisees but verify what they do anyway. And, yes, we discussed the supervisee's snarky remark about me later.

Lesson #3: Have a theoretical model for supervision. Since 1994 I have interviewed several candidates for faculty positions and I have yet to meet any graduate from a clinical psychology doctoral program who had coursework and/or a practicum in supervision. They give me blank stares when asked about supervision training. Falender and Shafranske (2004) note wide variability in supervision preparation at the graduate level. Between 79% and 84% of graduate counseling programs offer coursework and practicum in supervision but only one third of graduate clinical programs

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Reason and Emotion in Ethical Decision Making

Samuel Knapp, EdD, ABPP, Director of Professional Affairs

Dr. Sam Knapp

One view of ethical decision making sees emotions as the enemy of good decisions. When emotion gets involved, it is argued, good ethical decision making goes out the window. According to this older perspective, a rational individual will be more likely to reach an ethically sound decision than an emotional one. Spock is a better ethicist than McCoy.

However, the role of emotions in decision making is being reconsidered in light of evidence from both social psychology and neuroscience. For example, social psychologist Jonathan Haidt (pronounced "height") has conducted experiments in which he asks participants to react to various scenarios. Here is one of them.

> Julie and Mark are brother and sister. They are traveling together in France on summer vacation from college. One night they are staying alone in a cabin near the beach. They decide it would be interesting and fun if they tried making love. At the very least it would be a new experience for both of them. Julie is already taking birth control pills, but Mark uses a condom too, just to be safe. They both enjoyed making love, but they decide not to do it again. They keep that night as a special secret, which makes them feel even closer to each other. What do you think about that? Was it okay for them to make love? (Haidt, 2001, p. 814).

Participants typically respond with disgust or strong disapproval to this vignette. When asked to give reasons for their disapproval, they will often state that Mark and Julie will get hurt, that there is the danger of pregnancy, or give another reason why their behavior was harmful. However, the story is constructed in such a way to preclude harmful outcomes. When faced with this fact, participants will typically say, "I don't know, it just seems wrong." Haidt calls this response, "moral dumbfounding," which occurs when people have strong moral reactions to a situation without a plausible rationale why. Haidt believes this shows that our moral judgments often involve quick and automatic responses and that we later create reasons to justify our reactions (the emotional "tail" may wag the rational "dog"). In that sense, we are similar to lawyers who have been given a predetermined position when representing a client in court and then must find reasons to justify that position.

Traditionally rationalistic interpretations, such as Kohlberg's stages of development, have dominated moral psychology. However, Haidt and others argue that moral development is not only the result of rational, slow, and deliberate thinking processes (as Kohlberg believed), but also involves another intuitive moral system that is emotional, fast, automatic, and activated without conscious awareness. These two moral systems are compared in Table 1.

Haidt does not deny the importance of moral reasoning and notes that we can use reasoning to override our moral intuitions. However, activating the rational system is difficult. We are predisposed to react like McCoy and have to work to think like Spock. Nonetheless we can train ourselves to think about issues deliberately. In fact the whole scientific enterprise could be viewed as an effort to create conditions to override our natural inclination to rely too much on a fast, intuitive system.

Philosopher Joshua Greene also believes in a mixed process for ethical decision making. According to Greene, moral thinking is a "complex hodge podge of emotional responses and rational (re)constructions, shaped by both genetic and cultural influences, that do some things well and other things extremely poorly" (n.d., p. 4). Evidence for the hodge podge nature of ethical decision making comes from a series of studies looking at the neuropsychological responses to simulated ethical problems, such as Trolley Problems. Trolley Problems were first developed by the English philosopher Phillipa Foot to help participants consider how they would respond to various hypothetical ethical dilemmas. Participants have to decide how to respond when faced with the problem of a trolley bearing down on innocent victims. Here are two examples of the Trolley Problem:

The Switch

An out-of-control trolley is heading toward five people on the track who are unaware of its approach and are facing certain death. You are nearby and can, by turning a simple switch, divert the train on to a spur. However, there is one man on the spur who will certainly die if you turn the switch. Will you turn the switch?

The Large Gentleman

An out-of-control trolley is heading toward five people on the track who are unaware of its approach and are facing certain death. You are nearby and can, by pushing a large gentleman on to the track, stop the trolley and save the five lives, although the large gentleman will certainly die if you do so (you are not large enough to stop the trolley yourself; jumping on to the trolley tracks yourself will not save the five people). Will you push the large gentleman?

When given this first dilemma (the Switch) 90% of people would turn the switch to save five people. However, when given the second dilemma (the Large Gentleman) 90% of people would NOT push the large gentleman, even though it would also save five people. On the surface these findings do not make sense. In both scenarios, an action would save five people and lose one. However, it appears that our natural inhibition against harming others influences our perceptions of the morality of the behavior.

Greene et al. (2001) monitored research participants with an fMRI while they pondered these problems and found that, when faced with difficult ethical dilemmas such as whether to push the large gentleman, the most activity occurred in those portions of the brain often involved in emotional arousal (not cognitive activity). Also, participants deliberated longer in the Large Gentleman Problem (Do I push the large gentleman?) than they did in the Switch Problem (Do I pull the switch?), suggesting that the decision to push the large

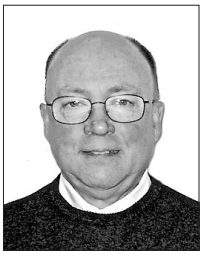
Table 1

Comparison of Intuitive and Rational Systems (adapted from Haidt, 2001)

Intuitive system	Rational system
Fast and effortless	Slow and deliberate
Unintentional and automatic	Intentional and controllable
Common to all mammals	Appears in humans in childhood
Context dependent	Context independent

Expert Witness vs. Fact Witness

Bruce E. Mapes, PhD



Dr. Bruce E. Mapes

According to Pennsylvania Rules of Evidence (Rules 701–706) an expert witness is one who by reason of skill, training, education, or experience has scientific, technical, or specialized knowledge (beyond that possessed by a layperson) which will assist the trier of fact to understand the evidence or to determine a fact at issue. Whether a psychologist is allowed to testify as an expert in a given case will be determined by the judge who must balance the benefits and prejudicial risks of the testimony.

Expert witnesses may testify on the basis of knowledge derived from what they have directly seen or heard, as well as information from third parties. The expert may offer opinions concerning certain legal questions, may answer hypothetical questions, and may offer opinions concerning what the expert believes to be true. Experts can interpret third-party data and offer observations/opinions that go beyond what the expert personally observed.

Regardless of one's training or experience, a fact witness may testify about knowledge derived from what the witnesses actually saw or heard, but may not testify about information from third parties unless the expert normally considers that third-party information. Fact witnesses may not offer opinions concerning the legal question, nor can they answer hypothetical questions.

Consider Dr. Anhedonia, who is a world-renowned expert on depression. A man whom he evaluated and treated is arrested for aggravated assault. Dr. Anhedonia is likely to be qualified as an expert if he is testifying about how the depression reduced criminal responsibility. On the other hand, if his testimony is being introduced only to establish the fact that the patient is or was depressed and needs treatment, he is most likely to be a fact witness.

The testimony of an expert can have major consequences for a defendant, and the side retaining the expert should be able to reasonably expect that the expert has the special skills and competencies to appear credible to the trier of fact, who may be skeptical about experts. For example, the expert should know the legal standards and criteria as opposed to the clinical standards and criteria. The expert should have good image management skills and know, for example, with whom to make eye contact and when, appropriate dress and manners on the stand, and the ability to communicate in "plain English." Experts must be prepared to handle common cross-examination strategies and to prepare the retaining attorney for any rehabilitation that may be necessary. The expert must have a comprehensive knowledge of the relevant research and common legal challenges to that research. Experts are expected to know what research and assessment tools are admissible in a court of law, and which are not. Imagine having half of one's expert report thrown out because the techniques used or research cited is not admissible. The experts must be seen by the trier of fact as a neutral, objective professional who is advocating for their opinions, rather than for the side that retains the expert. This is often a major obstacle for psychologists who are providing expert testimony for someone with whom they have had a prior professional relationship. The knowledge, skills, and competency of the expert are of no value if the psychologist is not seen as impartial and credible.

Many times psychologists are concerned when they are a fact witness as opposed to an expert witness because of differences in reimbursement. The fee differential is due to the difference in the demands and expectations for the two types of witnesses; e.g., see the previous discussion of Dr. Anhedonia. Some psychologists will routinely include a provision in their informed consent agreements with all patients that holds the patients financially responsible if the psychologist is called into court. Even in the absence of such an agreement, most times attorneys respect the time of the psychologist and will pay the psychologist's usual fee as long as it is reasonable. Occasionally an attorney may not be interested in the expertise of the psychologist but have other motivations. For example, the attorney may want to find out what is in the psychologist's records as part of a "fishing expedition" in a personal injury claim. Or an attorney may want the psychologist to take the stand with the patient's file so the attorney can review the file. Finally, the attorney may subpoena the psychologist as a fact witness not because he or she plans to call the psychologist to testify, but to keep the opposing side from calling the psychologist as a witness. Attorneys who expect the psychologist to help their cases are unlikely to risk developing a "hostile witness" by reimbursing the psychologist at the fact witness rate. In more than 30 years, this author has testified as a fact witness more than 100 times but has been paid as a fact witness in only two cases.

gentleman created ambivalence or emotional turmoil and required more deliberation on their part. This finding suggests that emotions – not just cognitive processes – influence decision making.

According to Greene, the act of pushing someone who is physically close to us may evoke stronger emotional reactions than pulling a switch. Perhaps this is why we can appear uninvolved or unmoved when we hear of the plight of starving people thousands of miles away, yet become deeply concerned and motivated when the same event occurs to one person whom we see personally (Greene, 2003).

So is McCoy a better ethicist than Spock? Both the intuitive and rational systems have distinct points of view. One can activate strong feelings of compassion and concern (or disgust), and the other can deliberate on the consequences of our behavior. Perhaps we do our best when we are a little of both.

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Suggested Readings

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ZINA/Emerging Voices: Teaching Psychology in Kenya

Kristen Hennessy, PhD

My Journey to Kenya

My Kenyan adventure began with an e-mail to Jim Nowak, my former high school sociology teacher, who had been building schools in Kenya since his retirement. Jim suggested that I develop a project to empower girls. First, though, I needed to see Kenya. I arranged to fly in with a group through his organization, Building Futures, and to stay on to learn more about Kenya.

Jim was in a fatal car accident three weeks before my trip. I didn't know what to do, so I went to Kenya anyhow. I spent my first day in Africa attending Jim's funeral and absorbing the radically different culture, the poverty, and the shock of Jim's death. By day three, I was alone in rural Kenya and without an itinerary to boot!

In Kenya, you figure it out and keep going, because there's nothing else to do. I don't think that it's quite right to say that Kenyans are less impacted by tragedy than their Western counterparts. Struggle is assumed and is therefore met with acceptance. And so, I settled into Springs of Hope Kenya, a children's care home in Nakuru, far off course from my original plans, but in good hands. I left Kenya eager to return and ready to work.

The creativity and resilience that I see in Kenyan girls are powerfully reminiscent of my child clients back in Pennsylvania.

Zinazoikoeteza Sauti/Emerging Voices

Zinazoikoeteza Sauti (ZINA) means Emerging Voices. ZINA provides twice-annual week-long seminars to women working as caregivers in orphanages in the Great Rift Valley. The ZINA trainees are typically "aunties" who are in the orphanages alongside the children six days a week. Their hours never end, as each bedroom of children hosts an auntie sleeping on a mattress. They represent many of Kenya's 42 tribes. The women are intelligent, dedicated, and enthusiastic, but do not have many tools to care for the highly traumatized children in their care. Many are themselves traumatized. The children in their care have been orphaned by HIV or election violence, and others have been placed due to abuse or neglect. We teach basic listening skills, sexual abuse prevention, and crisis intervention. A Kenyan colleague and disability rights activist teaches about the protections afforded to women and children in the new constitution. The girls attend two days of the five-day training. The women have the opportunity to practice what they've been learning and the girls have a chance to express themselves in a safe environment.

Working in Kenya

I am struck by the vast difference in cultures but also by the universality of the struggle to come to voice, to work through and process trauma. The creativity and resilience that I see in Kenyan girls are powerfully reminiscent of my child clients back in Pennsylvania. The centrality of play to the processing of childhood trauma is salient with both groups. These girls, like my child clients, are both wounded and eager to find peace.

I cannot adequately sum up the experience of working with these women and girls. Instead, I offer a glimpse of the experience:

We have asked each girl to write a story about herself, including something about her past, present, and future. After the girls create their stories – often complete with drawings – almost all choose to read the story to their caregiver. We reconvene as a group and I say, "Any girl who would like to may come up and read her story to the group." A few children approach and present their stories.

Abruptly, a young girl steps forward. Grace describes herself in the third person and reads "... and the man is hurting the girl and she is hurt and scared and sad." Tears drip down Grace's cheeks as she continues her story, but her voice is steady and strong. "He keeps hurting her and hurting her and she wants him to stop." A trainee whispers to the child's caregiver, "Go to her." The caregiver comes forward as Grace reads on, "She tells her father and he calls her a prostitute and beats the girl; the girl is sad." The tears are truly streaming now, but Grace continues, making solid eye contact with her audience as she speaks the story of her pain. Grace's caregiver appears to be uncomfortable and begins to usher Grace towards her seat. I say, "Let her finish" and a trainee adds, "stand with her." Grace goes on, "she wants to be safe. And now she lives in a care home and they treat her good and someday she will grow up and she will help protect the children." Grace is done. We clap and she takes her seat.

I announce a break for "free play." I do not want the power of Grace's story to be diluted by continuing the session and permitting the tension to break. Further, I am aware that I have a room full of traumatized girls and women who may need a space to speak their own stories of trauma privately, in their own ways. I spread crayons, paper, jump ropes, and toy animals out, and invite the girls to play.

I sit on the ground outside the classroom attempting an approachable but nonintrusive presence. Grace sits beside me and holds my hand. Mary, a young survivor of multiple rapes, approaches Grace with a sense of urgency. Her small arms are brimming with toy animals. The girls get to work. Silently, they arrange the toys. I have the sense that I am witnessing important work, much like the work of the sand tray, and stay still and silent. They place animals in the center of a circle, surrounded by rocks. They finish the arrangement by placing two large pterodactyls on the rocks. The girls look at me and I say, "tell me about it." Mary holds my gaze intensely, saying, "the animals, here, were scared. The rocks are a fence that protects them. These are the guards. They are safe now." With that, she grabs Grace's hand, and the pair run off to skip rope.

And so the girls skip off, doing their best to figure it out and keep going.

LESSONS LEARNED...

Continued from page 3

do. Lack of resources and heavy faculty loads are often cited reasons for not providing more supervision training. As Knapp and VandeCreek (2012) note, there is no universal program of study to produce a competent clinical supervisor. And it is not unusual to find otherwise competent professionals doing clinical supervision despite their never having read a book on it or received any direct training.

I most often use my therapy model (cognitive-behavioral) as a supervisory model. This enables supervisees to experience the therapy through my modeling. The structure of supervision sessions with my Cognitive Therapy (CT) supervisees parallels CT session structure with updates, agenda-setting, review of homework and client progress, etc. A downside of this approach is that therapy models may not address supervisee developmental levels or provide alternative theoretical perspectives. Falender and Shafranske (2004) review supervisee developmental models useful for identifying and remediating supervisee deficits. Students value getting accurate and specific evaluations. I've had several supervisees thank me for giving them specific feedback. This surprises me but some have said that other supervisors were "...cheerleaders who said I was doing fine all the time...." But they were left with doubts about their skills and unanswered questions. This raises the question as to why some supervisors give vague praise and little else to their supervisees. I can give a partial answer: because giving students negative feedback is difficult and potentially threatening to all parties.

Given the ethical, legal, and pragmatic impacts of supervision on trainees and the clients they serve, supervisors should develop and communicate reasonably clear competency criteria; they should regularly observe or otherwise directly review supervisees' clinical work; and they should work from a clearly communicated and consistent theoretical framework. The practical and ethical challenges of providing (negative) evaluations to supervisees, developing supervisee training plans and keeping good supervision records will be discussed in Part Two of this article.

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Vol. 73, No. 1

The Pennsylvania
Psychologist

JANUARY 2013 • UPDATE

The Pennsylvania Psychologist
416 Forster Street
Harrisburg, PA 17102-1748

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The *Pennsylvania Psychologist* Update is published jointly by the Pennsylvania Psychological Association (PPA) and the Pennsylvania Psychological Foundation in January, February, April, May, July/August, October and November. The *Pennsylvania Psychologist* Quarterly is published in March, June, September and December. Information and publishing deadlines are available from Marti Evans at (717) 232-3817. Articles in the *Pennsylvania Psychologist* represent the opinions of the writers and do not necessarily represent the opinion or consensus of opinion of the governance, members, or staff of PPA. Acceptance of advertising does not imply endorsement.

Save the Date

PPA's annual **Advocacy Day** in Harrisburg will be Monday, April 15, starting at 9:30 a.m. in the state Capitol. More information will be forthcoming. Please plan to attend.

2013 CE Calendar

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

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

April 15, 2013
Advocacy Day
State Capitol Building
Harrisburg, PA
Rachael L. Baturin, MPH, JD
(717) 232-3817

June 19-22, 2013
Annual Convention
Harrisburg, PA
Marti Evans (717) 232-3817

October 31/November 1
Fall Continuing Education and Ethics Conference
Exton, 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

Excess Weight and Weight Loss – NEW!
3 CE Credits

*Ethical Practice Is Multicultural Practice**
3 CE Credits

*Introduction to Ethical Decision Making**
3 CE Credits

Staying Focused in the Age of Distraction: How Mindfulness, Prayer and Meditation Can Help You Pay Attention to What Really Matters
5 CE Credits

*Competence, Advertising, Informed Consent and Other Professional Issues**
3 CE Credits

*Ethics and Professional Growth**
3 CE Credits

*Confidentiality, Record Keeping, Subpoenas, Mandated Reporting and Life Endangering Patients**
3 CE Credits

*Foundations of Ethical Practice**
6 CE Credits

*Ethics and Boundaries**
3 CE Credits

Readings in Multiculturalism
4 CE Credits

*Pennsylvania's Psychology Licensing Law, Regulations and Ethics**
6 CE Credits

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

For all Home Study CE Courses above contact: Katie Boyer (717) 232-3817, secretary@PaPsy.org.