IN THIS ISSUE

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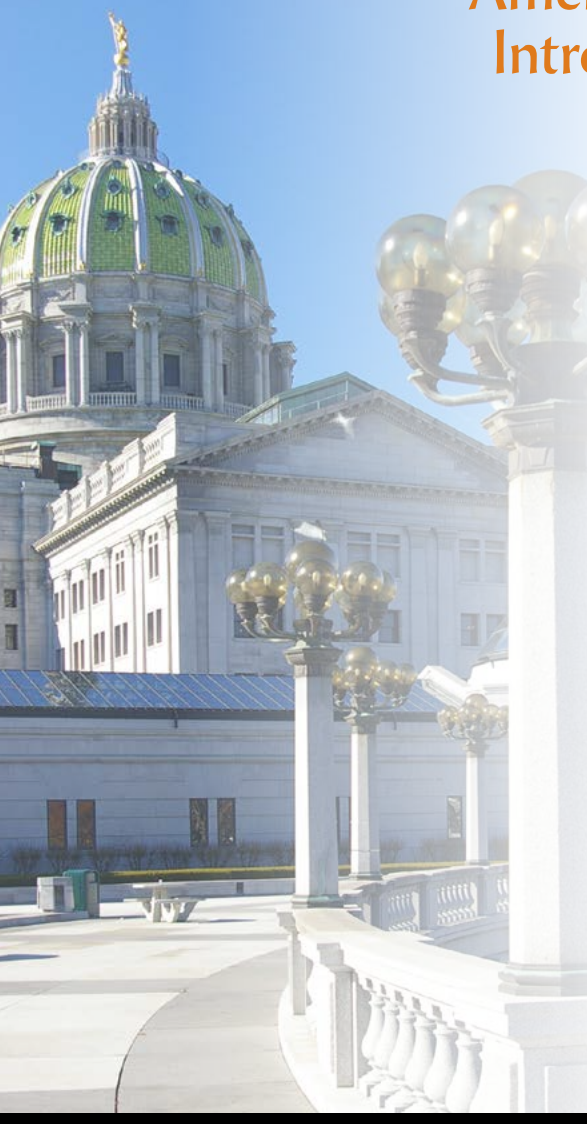

Amendments to Psychology Licensing Law Introduced into Pennsylvania Legislature

Samuel Knapp, EdD, ABPP; Director of Professional Affairs

Senator John Gordner (R-Columbia) has introduced SB 980 which would make several amendments to the Professional Psychological Practice Act. PPA endorses SB 980.

The proposed changes to the Professional Psychology Practice Act contain several technical and several substantive amendments. None of the proposed provisions would expand the scope of practice of psychology or alter the qualifications to become a psychologist. They do, however clarify the scope of practice of psychology, provide an option for altering the sequence of acquiring the supervised training needed to become licensed, eliminate current exemptions to the practice of psychology that are not in the public interest, improve the ability of the State Board of Psychology to enforce disciplinary actions on psychologists, and make other technical changes that this article will not review.

Clarify the Scope of Practice of Psychologists

Currently all insurance companies (including Medicare) permit psychologists to diagnose and treat mental illnesses. Also, the ability to diagnose and treat can be inferred from the wording of the scope of practice in the current licensing law, but it is not stated explicitly. The proposed amendment would clarify that diagnosis is within the scope of practice of psychology. It would not expand the scope of practice of psychology because the licensing law would continue to restrict the treatment techniques to psychological methods.

Eliminate Exceptions to Licensing

SB 980 would eliminate three types of exemptions for the practice of psychology. First it would eliminate the current exemption that allows hospitals and state, county, or municipal governments to fill

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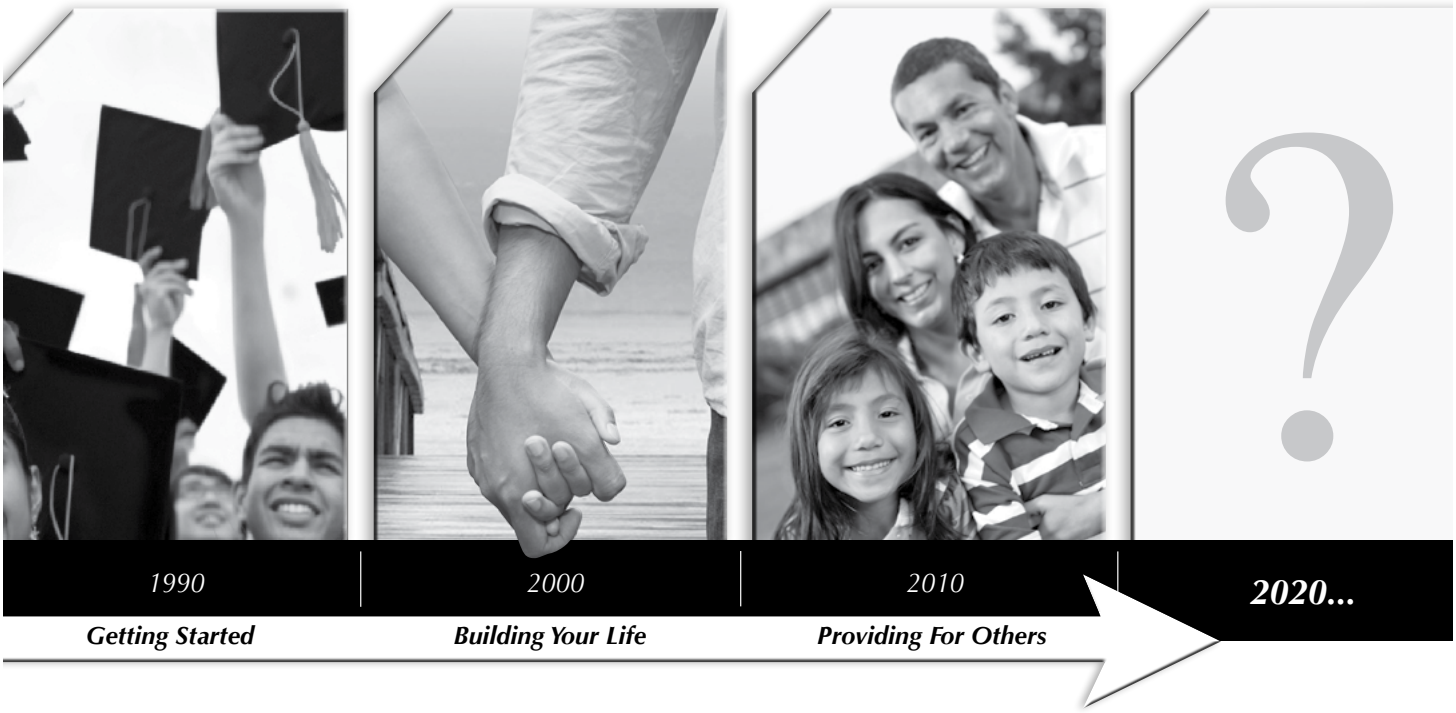

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PSYCHOLOGY LICENSING LAW

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psychologist positions with unlicensed persons. Isolated examples of abuse have occurred, but we do not believe that this would be a major burden on anyone. Hospitals and state, county and municipal governments could still hire persons to do work of a psychological nature within their scope of training. They simply could not call them "psychologists" (unless they were licensed).

None of the proposed provisions would expand the scope of practice of psychology or alter the qualifications to become a psychologist.

Also, the licensing law currently contains an exemption for "social psychologists." This refers to persons working in academic departments of sociology who teach social psychology courses. However, such academic sociologists would already be covered by the exemption of faculty at accredited colleges and universities from the licensing law. We view this section as redundant.

Finally, the proposed amendments would phase out the "independent practice school psychology exemption," although it would allow for a very generous grandparenting period. Currently school psychologists are exempted from the licensing law as long as they are working in public or private schools in the Commonwealth. This exemption would remain. In addition, school psychologists (school personnel who hold educational specialist certificates in school psychology) have an independent practice exemption in that they can do in the private sector the same work that they currently do in the public schools of Pennsylvania. SB 980 would gradually phase out this "private practice school psychology" exemption. As written, SB 980 would protect the private practices of those certified school psychologists who are already eligible to practice under the existing school psychology private practice exemption. It would also allow those who are currently enrolled in school psychology programs or who enroll in school psychology programs within one year of the effective date of this law to practice under the private practice exemption. However, persons who enroll in graduate school in school psychology after one year of the effective date of the law would not be eligible for the private practice school psychology exemption.

Improve Ability of Board to Protect the Public

SB 980 would clarify the Board's authority to issue temporary licenses. The current licensing law states that "nothing in this act shall be construed to prohibit the practice of psychology by a person, who in the opinion of the Board meets the minimum qualifications for licensure under this act, provided said person is on temporary assignment in this Commonwealth." This clearly gives the Board the authority to allow a psychologist licensed in another state, province, or territory to practice in the Commonwealth temporarily if he or she were, for example, participating with the Red Cross in a disaster relief service or being hired as an expert witness in a forensic case being heard in Pennsylvania courts. It is also being construed to allow the Board to grant temporary licenses to individuals who are licensed in other states and who are moving to Pennsylvania with the intention of becoming licensed in Pennsylvania. Nonetheless, SB 980 would give the Board the clear authority, if it so chose, to deny such a temporary license to any psychologists licensed in other states who have had a disciplinary action against them that, in the opinion of the Board, would render them unfit to practice in Pennsylvania.

Also, SB 980 would require psychologists to report all health care licenses they might have. This would alert the State Board of Psychology in the event of a disciplinary action against the psychologist as a result of an action occurring while practicing under another health care license.

Furthermore, SB 980 would strengthen the power of the Board to enforce disciplinary actions. Currently, there are legal questions as to whether the State Board of Psychology has the authority to prevent licensees who have had their licenses revoked from doing work of a psychological nature without a license (practicing under the Section of the licensing law dealing with "qualified members of other recognized professions"). This language would give the Board authority to prevent that. Unfortunately, there have been cases that have been brought to the attention of the State Board of Psychology where psychologists who had had their licenses revoked by the State Board of Psychology have continued to practice counseling as "qualified members of another recognized profession."

Offer Option to Change Sequence of Training

The licensing law requires a doctoral degree, passing two examinations, and two years of supervised experience. SB 980 would not change these requirements, but it would give applicants the option of getting two years of the supervised experience before they earn their doctorate; instead of having to get one year of supervision after they receive their doctorate. Several states (Ohio, Maryland, and Washington) have made this change already.

Other Technical Changes

Finally, SB 980 contains several technical changes. For example, one change would eliminate the requirement that applicants who fail to pass the licensing examination have to wait six months to reapply to take the examination. This provision was written years ago when the examination was offered only twice a year, and a six-month wait did not impose any additional burden on the applicant. However, now applicants can take the examination at multiple locations and many times during the year, so that waiting these additional months would create an unnecessary delay.

Senate Bill 980 has been referred to the Senate Consumer Protection and Professional Licensure Committee.

Self-Care Has Two Distinct Components

Jeffrey L. Sternlieb, PhD; jsternlieb@comcast.net

Dr. Jeffrey L. Sternlieb

With the increasing awareness of the risks of stress and burnout in all helping professions, there is greater attention paid to self-care. Self-care seems to be equated with balance in one's life. When clinicians talk about self-care, we offer examples such as the gym, the hobbies and other interests we pursue, and the time we spend with our family and friends as evidence. Doing all these activities well gets us 50% of the way there – emotionally healthy health care provider.

Where is the other 50% of unmet self-care, you ask? The percentage or proportion is not exact, but there is a significant component of the stress that being a health care professional – psychologist, physician, or any other allied health care field – that is buried by all the other activities with which we fill our lives. It might be a misnomer to call it stress because we do not feel it. It is very much like high blood pressure – we have no idea that our blood pressure is high until there is some physical consequence. Using an alternate metaphor, the accumulation of unacknowledged emotional baggage from our work drains our resources and compromises our capabilities in the same way storing files on a computer uses up processing power. Consider the following scenario:

Imagine for a moment that you are walking on a beach in the off season – think about a favorite beach – and you come upon a magic lamp. Of course, you rub it gently, half expecting nothing to happen and half joking about a genie. Lo and behold, a genie appears and grants you three wishes. The genie explains that the three wishes are opportunities to redo any three cases of patients you have treated or encountered at any time in your psychology career. Since the genie wants you to take maximum advantage of this offer, heor she offers some suggestions of how to proceed.

If we reflexively choose the first three cases we can think of that did not go as well as we would have hoped, we might only think of recent cases or we might miss cases that were more significant that we might have forgotten. So, the genie has suggested we schedule some time to sit down and write about any case we can remember where we had misgivings about the way it ended, OR any case where we said or did something that we regret, OR any case where we missed an opportunity to do or say something that we think would have made a difference, OR any case that did not end in a manner with which we were comfortable. We may need to imagine being in our office and thinking about the patients who come and go. We may recall phone calls that ended relationships. We may remember appointments that were cancelled and not rescheduled. There are all kinds of ways we may have unfinished business with an emotional impact that we can feel, especially if we resist the impulse to screen, censor, or rationalize it away. It is a challenge of how honest we can be with ourselves.

- How long would your list be?
- Which patients would be on your list?
- Which patients do you wonder about? worry about? think about?
- What is the nature of the business with any one patient that is unfinished? incomplete? or has loose ends?
- Which have you processed intellectually, but not emotionally?

Here is the other 50% or more of the stress of doing the work we do. We accumulate experiences that we may discuss and process with colleagues to make sure we have not overlooked anything and to get more ideas about how to manage certain challenges. However, the piece we do not attend to, ironically, is the emotional impact on ourselves. These include the human emotions we experience when we hear our patients' stories – sadness, worry, fear, and pain. In addition to our own emotional reactions to our patient's story, we may have our own emotional reactions to our professional performance. These may include frustration, blame, shame, embarrassment, a sense of inadequacy, a regret for things said or unsaid or for things done or undone. There may be patients we liked and did not stay objective enough, or people we had difficulty liking and then wondered if it impacted our treatment.

We as professionals need to make more room for opportunities to do this very personal work in emotionally safe environments.

There are a number of reasons this 50% of self-care goes unaddressed. One prime reason is that we might have to confront our own sense of being less competent or more human than we would like to think we are. Who of us can say we have never felt badly about how a therapy case ended? Who of us has discussed this with colleagues? Our colleagues are the best ones to validate this experience, yet it would require the most unusual group to create an emotionally safe enough professional environment where this discussion could

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SELF-CARE

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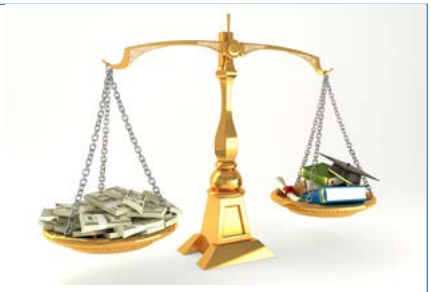
take place. Even in the support group with which I enjoyed membership for 25 years (!), we did not always explicitly talk about the emotional impact of our cases.

How much emotional baggage could this be? One test would be to write a narrative about the case – include all your recollections of the interactions, and describe the nature of the relationship. It would be especially instructive to also write about the emotions that bubbled up during the process of treating this client. Then read out loud, exactly as you wrote it, the entire narrative to a group of trusted colleagues. My guess is that you would experience the emotions in a way that might surprise you. These emotions are locked up in the narrative, and when we externalize them by reading out loud – not summarizing – the emotion emerges. Multiply this experience by each person on your list, and consider the possibility that you may not have even thought about every relevant case.

We as professionals need to make more room for opportunities to do this very personal work in emotionally safe environments. Reflective practices of varying kinds are designed for this goal and are structured with leadership designated to attend to the group's dynamics. Regularly meeting groups are ideal because they create opportunities to develop the trust necessary to allow deeper, more personal conversations. I have led several continuing education programs that allowed this focus. Ongoing small groups are much more effective. What would it take for us, the membership of PPA, to accomplish this personally and professionally valuable task?

Student Debt and Careers



Samuel Knapp, EdD, ABPP
Director of Professional Affairs

Why would young people want to go into psychology if they graduate with a debt of $100,000, will have difficulty getting a paying job for postdoctoral supervision, and then end up in a career where they can expect to earn an average of $90,000 a year? One reason is that Americans entering the workforce are encountering a set of economic challenges that cross many disciplines, professions, and occupational fields. The overall college debt to earning potential is changing for the worse for a large number of professions.

Occupations are attractive for a variety of reasons including the quality of work life and extent to which the work is congruent with an individual's value and its economic rewards (Do you like it? Do you value it? Does it pay enough?). The economic value of an occupation depends on the length of education (in part because every year of schooling means a year less of earning a full-time income), the debt acquired in getting the education, the likelihood of getting a job, and the income after getting a job. Across a wide range of professions, the debt load of recent graduates has increased substantially and the employability rates in some fields have plummeted. The increased debt has occurred, in part, because of the costs for higher education which over the last 20 years, have increased three times the rate of inflation, and twice the rate of increase in medical costs.

Why Does College Cost so Much?

Many scholars have debated the reasons for the increase in the cost of college education. I will only mention those factors that I think are not controversial (although the relative contribution of these factors may be controversial). The costs of higher education have increased because of the decline in public financing for colleges, the need for more support services as more students are entering college who have special needs or who need special support services, and an improvement in the quality of student residences such as single room apartments and higher quality student food, and "bling" (extravagant facilities, additional administrators who are not really needed, or competitive and unprofitable sports teams that do not contribute to the overall quality of the academic curriculum). Faculty costs are not responsible for much of the increase in the cost of higher education. Although some faculty at elite universities earn high salaries, overall faculty salaries have been stable in recent years accounting for inflation and have risen far less than the rate of college tuition inflation.[1]

What Is the Outlook in Other Professions?

Medical students are in the best position because nearly 100% of physicians find employment (the few who are not employed are usually unemployed voluntarily; perhaps to raise a family) and the yearly earning to debt ratio is favorable. The debt of medical students has risen to a median of $170,000 by the time they

[1]**For example, the APA salary survey found that psychology faculty in 1991 earned an average of $45,000 which, when adjusted for 2013 dollars would equal about $77,000. The average salary of a faculty member in 2012 was $83,000, only slightly higher than what would be expected by the increase in inflation.**

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STUDENT DEBT

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graduate (AAMC, 2013), although they earn about $180,000 a year (Bureau of Labor Statistics).[2] Dental students are also in a favorable position although not as well off as physicians. They averaged $221,000 in debt by the time they graduate, and expect to earn an average of $149,000 a year.

Psychologists and veterinarians are comparable in debt (an average of $106,000 for veterinarians; Maday, 2013), although veterinarians make slightly more than psychologists ($84,000 a year compared to $70,000; adjusted to $106,000 or $90,000 respectively when we account for the under reporting by the Bureau of Labor Statistics). Bachelor level nurses earned an average of $65,000, but advance practice nurses earned an average of $96,000 (and a few specialties quite a bit more). Psychologists, veterinarians and bachelor level nurses have high employment rates (diploma nurses may have more difficulty getting a job).

Engineering and computer science are two of the most attractive professions outside of health care. I had trouble finding information on the average debt of engineers and bachelor's level computer scientists. I assume that engineers would have a debt around the average for bachelor's level graduates (around $27,000) or perhaps higher because many of the engineering schools are private schools with higher costs. Nonetheless, an engineer starts working after only 4 years of college and the average income for an electrical engineer is $89,000 and software engineers average $74,000. Engineers and computer science graduates tend to have high employability. However, engineers and computer scientists may be more restricted in where they can find work depending on their specialties.

Law is no longer as attractive a profession as it was several years ago. A few attorneys do very well, but getting a foothold into a legal career is increasingly difficult. About 85% of recent law school graduates have debts of $100,000 or more and there is only one job available for every two recent law school graduates and the long term projections are that this will continue for the next 10 years. The average attorney earns about $113,000 a year.

Public school teachers have a poor employment outlook. Currently the supply of education majors (except for math and science teachers) greatly exceeds the demand. I could not find precise data on this on the extent of the oversupply (although one source said there were 10 recent graduates looking for a position for every 1 position open in Illinois). The oversupply has been exacerbated by the recent recession which has led to the layoffs of many teachers. However, even when the country recovers from the recession, the employment outlook for public school teachers remains poor given the decline in the number of school-aged children. I found estimates that the average public school teacher earns about $54,000 a year.

Of course, income is not the only factor to be considered in choosing a career. Traditionally, psychologists and teachers have reported high satisfaction with their careers, while attorneys and physicians are near the middle in job satisfaction (Smith 2007), although job satisfaction ratings can vary depending on changes in the economic climate and market place and other factors.

[2]For all occupations, I am using information from the Bureau of Labor Statistics. However, their data consistently under reports the incomes compared to other sources. For example, Crane (2013) reported that the average income of physicians was closer to $218,000 and APA survey data shows that the average salaries of psychologists are about $90,000 compared to $70,000 in the Bureau of Labor Statistics data. Given the systematic under reporting of salaries from the Bureau of Labor Statistics across professions, it is reasonable to inflate the salary figures across the board by about 20%. A review of the Bureau of Labor Statistics methodology shows that they include unlicensed persons with training in psychology in the field of "psychology." The reasons for the under reporting of salaries in other professions is unknown.

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Responding to Hateful Comments in Psychology Practice

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Richard Small, PhD; Spring Psychological Services, Reading, PA
Steven Cohen, PhD; Independent Practice, Southampton, PA

In some ways, Americans are becoming more tolerant, at least when it comes to religion (Putnam & Campbell, 2010), although there is also data that suggests considerable racial tensions, especially now that a majority of White Americans believe that they are the victims of prejudice (Norton & Sommers, 2011). Whatever these long-term trends, prejudice still exists and harmful or hate-filled comments are acceptable (or promoted) among some subgroups of Americans. Most psychologists will hear patients make some hateful comments during their careers.

Often psychologists can uphold the overarching principle of general beneficence or justice....

How should psychologists respond to such comments? Psychotherapy can never be "valueless" and psychologists must be honest with themselves about their values and how they influence the conduct of therapy. From the standpoint of principle-based ethics psychologists need to consider relevant values or ethical principles when dealing with patients who make hate-filled comments. First, psychologists have an obligation to provide good services to their patients (promoting the overarching ethical principle of ***beneficence***) and show ***respect for patient autonomy*** (right to make their own decisions about treatment). But, psychologists also have a social obligation to address harmful remarks made at others because of race, religion, sexual preference or other factors (promoting the overarching ethical principles of ***general or public beneficence*** or ***justice***).

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Often psychologists can uphold the overarching principle of general beneficence or justice (promoting the well-being of the public) without sacrificing or harming beneficence (promoting the well-being of their patient) or respect for patient autonomy and can speak on behalf of the targeted group without alienating the patient. When dealing with children, a psychologist can often act in an educational manner and instruct the child as to what is, or is not appropriate language. For example, a psychologist was treating a young teenage boy who used a derogatory phrase to describe an ethnic group. The psychologist educated him as it appeared that the teenager was not aware that the phrase had a derogatory connotation.

At other times, the overarching ethical principles of beneficence and general beneficence clearly conflict. In those situations psychologists must figure out the most ethical action and attempt to minimize harm associated with any of the principles. This occurs, for instance when we involuntarily hospitalize an adult patient in serious danger of dying from suicide. We sacrifice autonomy for beneficence by hospitalizing the individual, but provide as much autonomy as possible throughout the hospitalization and make treatment voluntary as soon as possible.

In contrast to some children, most adults know of the intent of their hostile comments and feel comfortable with them. Although prejudice involves overgeneralizations and false negative stereotypes (and thus represents suboptimal psychological functioning), it is seldom a symptom of mental illness and is often normative in the patients' immediate social group (Martin, 2006). Nor can we necessarily show that these prejudices are causing the distress for which they are seeking help. Emphasis on "educating" the patient to be a fair and decent person (in the eyes of the therapist) may distract attention away from alleviating the patient's presenting problems. And psychologists who go too far away from the patients' perceptions of their problems by addressing hateful comments risk having the patients drop out of treatment because they perceive that the psychologists had not respected their preference to focus on their own treatment goals. Furthermore, the psychologist must differentiate what are truly discriminatory or racist

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RESPONDING TO HATEFUL COMMENTS

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views from more legitimate ones that are at odds with those of the therapist. The perspective we propose is that psychologists should not respond to their patients' hate-filled comments without considering the impact on the patient's well-being or autonomy. That is to say, the psychologist may consider addressing hate-filled comments, but should do so in a manner that minimizes harm to the overarching ethical principles of beneficence and respect for patient autonomy.

I (RFS) have found that gentle affirming statements are more likely to be effective than harsh "corrections." Within the context of a positive relationship offhand therapist comments such as "I don't think ***they*** are ***all*** like that" or "I'd really prefer that you don't use that expression" can be effective. It is important to realize that sometime by not saying anything the clients may infer that you agree with their point of view. For example, a patient complained that he had been "jewed" by a salesman, I (SJK) corrected him and rephrased his statement and said that "the salesman cheated you. You don't want to use the word 'jew' in that context," I explained. "Okay," he said, and then went on with his story. Although I did not elaborate, I inferred that the patient understood my concern and I saw no point in pressing the issue.

Of course the optimal response depends on the context. I (SJK) have worked with a patient in an acute psychotic state who made racial slurs as part of his tirade. I did not interrupt him because I believed that the severity of his condition made getting him into the hospital the highest priority. I believed that I could not have addressed the principle of general beneficence without having the patient walk out and having him continue to suffer (and possibly present a danger to harm others).

However, in another situation a patient complained that he wanted "a real American psychiatrist" instead of the psychiatrist I (SJK) sent him to. The psychiatrist was an American citizen of Filipino descent who was highly competent, spoke good English, and had a responsible treatment plan for the patient. I responded instinctively without conscious consideration of overarching ethical principles. I stated "He *is* an American and you have to see him." In retrospect, my response was motivated in part by my offense at a comment against a man whom I considered a friend. In part my reaction was motivated by the substantial logistic difficulty of finding another psychiatrist. Fortunately, the patient continued to see the psychiatrist and had a successful treatment relationship with him (and with me).

Sometimes psychotherapists can be taken off-guard by the intensity of the comments, especially if the psychotherapist is a member of the targeted group. Psychiatrist Michael Grodin wrote that he was treating a Palestinian patient who blurted out "Hitler should have finished the job" (Grodin, 2011, p. 28). The patient might not have known that Dr. Grodin was Jewish. Given the distress of the patient and the immediacy of the patient's need to ventilate, Dr. Grodin did not address the comment immediately, but planned to do so later. However, the patient then dropped out of treatment. Dr. Grodin genuinely felt compassion for the patient, but was deeply troubled by the comment. In hindsight, he wrote that he probably should have interrupted the patient to address the issue immediately. Nonetheless, it could also be argued that his initial lack of response was warranted because the patient's need for services was acute and it appeared unlikely that any comment by the psychiatrist at this time would have altered the patient's belief.

Psychologists can respond better to these comments if they expect that some patients will make such comments, and have developed a general philosophy to address the comments if it is possible to do so without harming the patient or the relationship. As with many difficult ethical situations, much depends on the context.

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Pennsylvania Psychological Association

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How Long Should Psychologists Keep Records?

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Record retention is governed by numerous different laws or contractual obligations. There are also risk management and practical considerations. There is no one standard. The absolute minimum that every psychologist must follow comes from the State Board of Psychology which requires the retention of records for 5 years since the last patient contact(PA Code §41.57 (d)). The APA *Record Keeping Guidelines*, which the State Board of Psychology makes mandatory for psychologists in Pennsylvania, defers to state law on the length of the retention of records (American Psychological Association, 2007).

However, psychologists may also engage in contracts, such as contracts with insurance companies that obligate them to keep records longer. For example, Medicare requires keeping records for at least 5 years, although Medicare Advantage Plans require keeping records for at least 10 years (Medicare Learning Network, 2010). Psychologists who do not have contracts with an insurance company do not need to abide by the requirements of that insurer. A psychologist who does not participate in Medicare Advantage programs would not, for example, be required to adhere to the 10 year standard required of providers who participate in Medicare Advantage plans.

Psychologists may also consider some risk management factors. Although the State Board of Psychology requires keeping records for a minimum of 5 years, some psychologists will keep records for children for 2 years after the child turns 18 (or 5 years whichever is longer) because, in Pennsylvania, any child has 2 years after he or she turns 18 to file a lawsuit against a health care professional. In reality, however, I have never seen this happen. If the child was really harmed or really dissatisfied with treatment, a parent will usually file a suit on behalf of the child long before that. Consequently, individual psychologists will vary on whether or not to keep the records of children for 2 years after they turn 18. Although there may be no legal or risk management reason to keep the records of children for more than 2 years after they turn 18 (or 5 years, whichever is longest), some psychologists will keep the records longer on a case-by-case basis if the child has a serious developmental delay or intellectual disability and there is a likelihood that the child will be applying for disability benefits.

Also, there is no limit on the length of time a patient has to file a complaint with the State Board of Psychology. Nonetheless, prosecutors are reluctant to initiate "stale" complaints, or complaints that are several years old because of the difficulty of establishing proof when memories fade over time or when witnesses move and cannot be located. I cannot give a precise time in which a complaint could become stale. Nonetheless, some psychologists may wish to keep records of patients who were highly disgruntled in the off chance that these patients would eventually file a complaint.

Psychologists vary enormously on how long they keep records. The APA *Record Keeping Guidelines*, which the State Board of Psychology makes mandatory for psychologists in Pennsylvania, defers to state law on the length of the retention of records, but notes that the decision to keep records beyond the minimum required can be a complex decision in which the psychologist needs

Dr. Samuel Knapp

Rachael Baturin

to weigh "the risks associated with obsolete or outdated information, or privacy loss versus the potential benefits associated with preserving the records" (American Psychological Association, 2007, p. 999). I have known experienced psychologists who tell me with great pride that they have never destroyed a record (and have records that are 30 or more years old). Sometimes they can identify a situation where a patient needed a copy of records that were 10, 20 or even 30 years old and they had a copy of the records. Other psychologists feel it is more prudent and responsible to destroy records as soon as they are legally able to do so (whether 5, 7, or 10 years). They will argue that it makes storage easier, and requests for records more than 5 (or 7 or 10) years old are rare, and the information contained in very old records is of limited usefulness or may even be harmful because the recipient might not appreciate that the information could be outdated.

References

American Psychological Association. (2007). Record keeping guidelines. *American Psychologist, 62,* 993–1004.

Medicare Learning Network. (2010 September). *Medical Record Retention and Media Format for Medical Records.* Retrieved from http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MLN_Podcast_Medical_Record_Retention_and_Media_Format.pdf

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Dr. Samuel J. Knapp, ABPP

Greetings membership!

As many of you are already aware, Sam Knapp, after an exceptionally distinguished and productive career, has decided to progress into retirement. Sam's career spanned many years and touched a multitude of lives professionally as well as personally. As a fitting recognition for his service, we would like to solicit your memories, comments, and best wishes for inclusion in the December issue of the *Pennsylvania Psychologist*.

Though it may not be possible to include each and every tribute comment, all submissions will be assembled and given to Sam.

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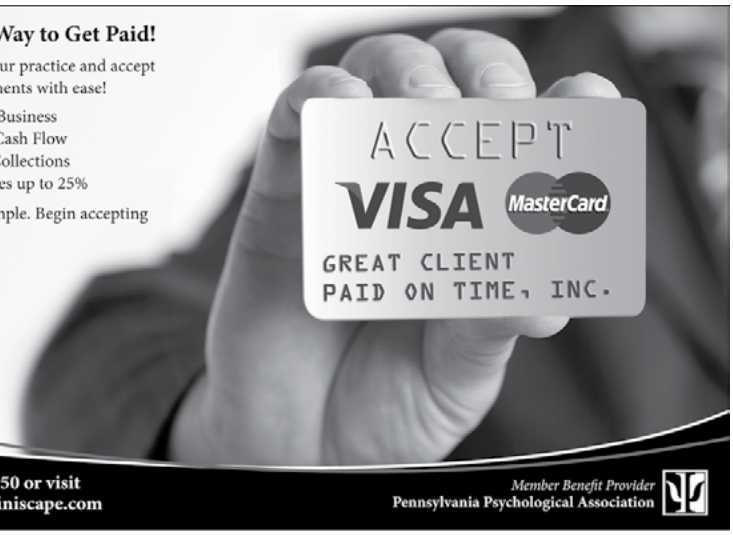

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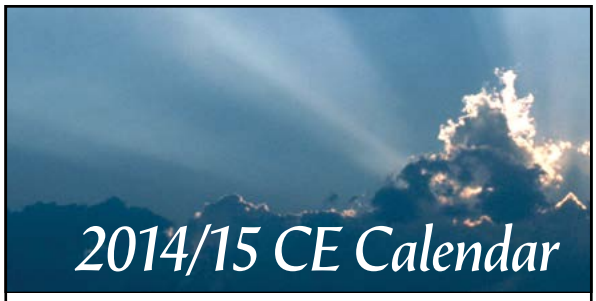


2014/15 CE Calendar

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

October 31, 2014
Fall Continuing Education and Ethics Conference
Best Western Premier Eden Resort & Suites
Lancaster, PA

March 19 and 20, 2015
Spring Continuing Education and Ethics Conference
DoubleTree Hotel Monroeville
Monroeville, PA

June 17–20, 2015
Annual Convention
Hilton Harrisburg
Harrisburg, PA

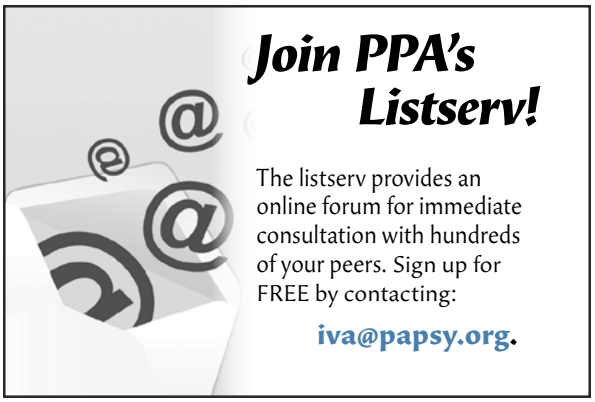
Contact: ppa@papsy.org

Podcasts
New podcasts for CE credit by Dr. John Gavazzi are now available on www.papsy.org.

For CE programs sponsored by one of the Regional Psychological Associations in Pennsylvania, visit www.papsy.org.

Registration materials and further conference information are available at www.papsy.org.

If you have additional questions, please contact ppa@papsy.org.



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