The Pennsylvania Psychologist

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MAY 2014 • UPDATE

ICD-10 to Begin October 1, 2015

Transition Date Moved Back One Year

Starting on October 1, 2015, all insurance companies will be required to accept only diagnoses for illnesses, including mental illnesses, based upon the 10th edition of the International Statistical Classification of Diseases and Related Health Problems (ICD-10). Services provided before October 1, 2015, should continue to be billed using the current ICD-9 diagnoses, which correspond almost perfectly with the DSM-IV diagnoses. Services provided on or after October 1, 2015 should be billed with the ICD-10. CPT codes are not influenced by the change in the ICD.

The previous transition date had been October 1, 2014. However, Congress moved the transition date back one year at the request of providers and insurers who did not feel they were ready for the transition. While the United States will be using the ICD-10 in 2015, the rest of the world will be transitioning to ICD-11 when it is released in 2015 or 2016. Eventually the United States will be using the ICD-11, although there is no due date yet set for the United States to adopt the ICD-11.

Bill Authorizing Courts to Appoint Psychologists as Insanity Evaluators Signed by Governor

Rep. Glen Grell

Governor Corbett has signed House Bill 21 which allows courts the option to appoint psychologists as evaluators of persons for insanity pleas. By coincidence, House Bill 21 has become Act 21 of 2014. Previously, Pennsylvania law only permitted courts to appoint physicians to testify on the determination of insanity. However, the passage of House Bill 21, introduced by Representative Glen Grell (R-Cumberland), has altered that standard.

Pennsylvanians will benefit now that the courts have the discretion of choosing from a wider pool of qualified professionals. It is estimated that perhaps as many as 100 psychologists in Pennsylvania have proficiency in forensic psychology and many of those psychologists could be available to offer such opinions. This estimate is based on a survey by the Association of State and Provincial Psychology Boards, the national association of state psychology licensing boards; it found that about 4% of psychologists had a proficiency in forensic work, thus allowing us to extrapolate that 4% of the more than 5,000 licensed psychologists in Pennsylvania have a similar proficiency. However, many of these may have proficiencies restricted to forensic areas other than insanity determinations.

Recognizing psychologists as evaluators of the insanity defense is consistent with the scope of practice of psychologists and the recognition of psychologists in a variety of forensic areas.

The enactment of this law will end the anomaly whereby the courts could only appoint physicians to do the insanity evaluations, although the defense had the option of presenting testimony from other experts, including psychologists.

Nothing in this law alters the standards for an insanity defense in Pennsylvania. Insanity determinations are rare and probably constitute less than 1% of all homicides, although attorneys will often seek private evaluations to

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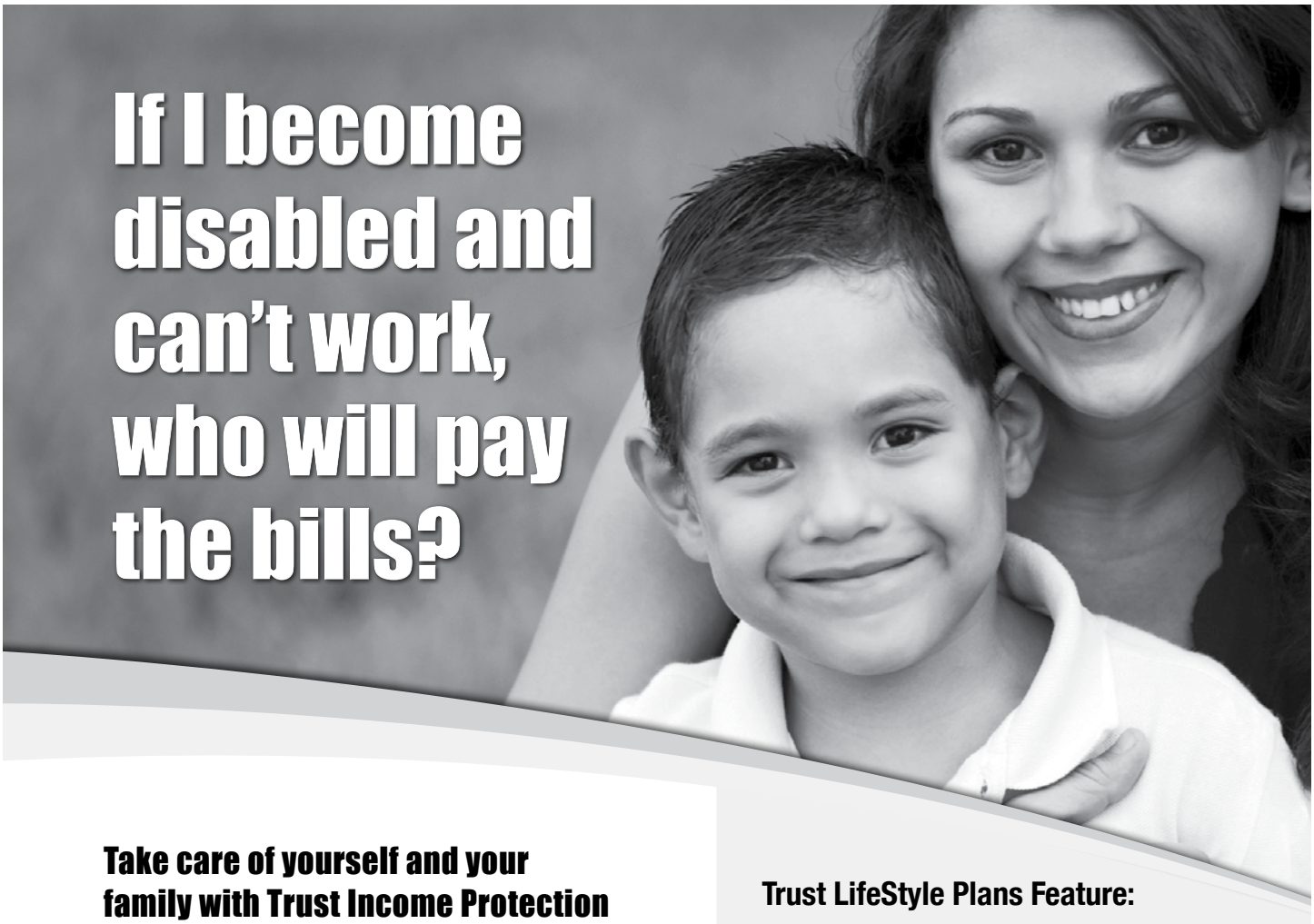
If I become disabled and can't work, who will pay the bills?



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SUMMARY

PPA 2013 Member Survey

Samuel Knapp, EdD, ABPP, Director of Professional Affairs
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Dr. Jeffrey Leitzel

Dr. Peter Keller

Every year since 1996, PPA has been conducting surveys of its members to help the PPA Board of Directors gather data to help guide their policy decisions and to monitor trends in the profession. The annual survey sent to PPA members in January 2013 showed that the legislative priorities remained stable. Parity and managed care are the most important issues to our members while support for prescriptive authority for psychologists was rated as a low priority by most respondents. These priorities have changed little in the last 17 years.

Since PPA began collecting data in 1996, the average income of psychologists has remained stable when adjusted for inflation. Nonetheless, one pernicious trend was that more psychologists reported a decline in incomes from 2011 to 2012 than reported an increase (38% saw a decrease in income from 2011 to 2012 and 23% saw an increase in income). Also, optimism in the profession was the lowest it had ever been since surveys were started in 1996. Whereas 72% of psychologists were optimistic or very optimistic about the future of the profession in 2010, only 41% reported the same level of optimism in 2013. This decline in optimism may have reflected the change and confusion surrounding CPT codes that occurred about the time the survey was distributed (January 2013), anxiety about the possible impact of the Affordable Care Act on the practice of psychology, and an actual small decline in income. Of course the change could reflect differences in the group of respondents from one year to the next, with more pessimistic responders completing the 2013 survey, though there is no reason to suspect that such a systematic bias existed.

Child Abuse Reporting

The 2013 survey also asked specific questions concerning child abuse reporting. In the last two years, 10% of psychologists made one report of abuse, 8% made two, 4% made three, and 5% made four or more reports. Of those reports, 40% were for non accidental injury, 15% for emotional abuse, 32% for sexual abuse, and 13% for neglect. Among all child abuse reports, about 25% are for non accidental injury, less than 1% for emotional abuse, 65% for sexual abuse, and about 4% for neglect and 4% for imminent risk (Department of Public Welfare, 2012). The figures on neglect are misleading, however, because Pennsylvania refers many neglect reports to an alternative program, called General Protective Services, and does not include these as reports in its statewide reporting data.

Psychologists reported that 19% of the cases they referred were founded, 22% were not founded, and they did not know the results for 59% of the cases. The Pennsylvania Department of Public Welfare does not have separate reporting data for psychologists. Instead the reports that come from psychologists may come from a hospital, school, or other agency. However, it does have a separate reporting category for private psychologists and psychiatrists where 14% of their reports were considered substantiated. Respondents to this survey believed that the standards for reporting child abuse are too narrow for neglect or emotional abuse, but appropriate for physical and sexual abuse.

Voting/Politics

The survey asked about the voting patterns of PPA members. About 99% of respondents reported that they voted in the 2008 Presidential election, and 98% said that they voted in the 2012 Presidential election. Although most psychologists (74%) rated themselves liberal on social issues, a plurality (42%) rated themselves moderate on fiscal issues. Data on voting patterns is helpful when PPA engages in governmental advocacy. It shows that our members are active voters and that they represent a range of political opinions, albeit with a liberal one on social issues.

Demographic Trends

Compared to licensed psychologists in general, PPA members are older because PPA has a higher percentage of psychologists who work in or own an independent practice. Whereas about 46% of psychologists reported that an independent practice was their primary work location (Michalski & Kohut, 2011), almost 60% of PPA members report an independent practice as their primary work location and another 37% reported independent practice as a secondary source of employment.

The number of members with professional (PsyD) degrees continues to increase while the number of members with degrees related to psychology or terminal master's degrees continues to decline. These are consistent with long-term trends since the State Board of Psychology no longer licenses individuals with degrees related to psychology or terminal master's degrees.

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INSANITY BILL SIGNED

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determine if a reasonable basis exists for their clients to claim insanity. Recognizing psychologists as evaluators of the insanity defense is consistent with the scope of practice of psychologists and the recognition of psychologists in a variety of forensic areas.

The enactment of HB 21 is part of a long-term "small steps" strategy whereby in every session of the Pennsylvania Legislature, PPA will try to identify and address at least one area where an archaic state law unnecessarily restricts the practice of psychology. As a result of these efforts, psychologists are able to testify at the hearings of persons convicted of drug and alcohol offenses, evaluate drivers suspected of impairment, evaluate impaired physicians or nurses, or evaluate professional fire fighters. Although each of these changes had little impact in and of themselves, they have gradually established a pattern which recognizes the specialized skills of psychologists.

The first bill to permit courts to appoint psychologists was introduced in 2010 by Representative Kathy Manderino at the request of PPA. When Rep. Manderino retired, PPA then asked Representative Glen Grell to introduce a similar bill in 2011, which he did. That bill passed the Pennsylvania House of Representatives in 2012, but failed to pass the Pennsylvania Senate.

We are proud to officially introduce our new and improved PPA website!

Launched April 15, 2014

www.papsy.org

As you may have been reading over the past several months, we have been working on developing the new site since last December in order to provide additional resources, including online registration, membership collaboration, CE registry, more organized practice resources, and other benefits, to our membership.

If you have not yet logged in to the new site as a PPA member, we encourage you to do so today! To help you with this process, we have created a member resource guide to provide **step-by-step instructions**, helping you to:

- Log-in to the site for the first time
- Update your member profile
- Access your groups (PPA committee pages)
- Navigate to Practice Resources
- Register for events

We understand that this is a new process for you, so we are standing by ready to help! Please refer to the guide to discover your system **username and password** in order to get started. If you have any questions, or have difficulty accessing your membership information, please let us know. We look forward to your feedback.

Thank you for investing in PPA!

Completing Third-Party Requests for Information

What Are the Obligations of Psychologists?[1]

Samuel Knapp, EdD, ABPP, Director of Professional Affairs

Can a psychologist refuse to write reports requested by a patient for purposes unrelated to treatment? For example, does a psychologist have to complete a report for Social Security Disability, workers compensation, or some other third party? At times, the requests may be for sending factual information (did the patient arrive in therapy, what were the presenting problems, etc?) and at times the requests may be for a professional opinion (did this patient experience a disability as a result of the injury at work, etc?).

I have been unable to find any statute, regulation, or court case that deals directly with this topic. So I cannot point to any specific statement that says that psychologists have to provide such services or that they definitely can refuse to do them. Ordinarily, patients appreciate psychologists who are willing to write such reports. Nonetheless, I believe that psychologists may (but do not have to) complete some requests and should refuse others, as long as this limitation is made clear to patients ahead of time.

The portions of the APA Ethics Code relevant to this question deal with Multiple Relationships involving forensics (3.05c), Informed Consent (3.10), and Informed Consent to Therapy (10.01). Standard 3.05 (c) dealing with multiple relationships involving forensics states that psychologists should clarify changes in roles if they move from a treatment to a forensic relationship. The standards dealing with informed consent specify certain information that has to be given to patients at the start of therapy (or as soon as feasible). Although it does specifically state that psychologists disclose their policy toward doing reports for third parties,

Psychologists need to explain the limitations to their services at the start of treatment.

Standard 10.01 does require psychologists to disclose the "nature and anticipated course of therapy" and some may interpret this as requiring psychologists to disclose their third-party reporting policy. Since nothing in these standards requires psychologists to perform these services, I believe that psychologists can refuse these services under certain conditions. However, I strongly urge caution in managing expectations of patients and I believe that such decisions need to be made with a concern for the impact on the patient.

Forensic Assignments

Under some circumstances, psychologists may assume a hybrid role in which they would, for example, provide psychotherapy for a patient on parole when it is known to all parties that the results of the psychotherapy would be sent to a parole officer and that failure to comply with treatment could be grounds for terminating parole. These are legitimate roles as long as the patient understands the limitations to confidentiality and other parameters of the treatment ahead of time.

However, I assume that a forensic role may be clinically contraindicated under some circumstances. For example, a psychologist who is providing psychotherapy services would not become a custody evaluator, except under very extraordinary or unusual circumstances. Often the patients do not know that they are requesting a custody evaluation, in that they may "simply" ask the psychologist to send a report to their attorney noting their superior qualifications as a parent (or some similar language). Sometimes the patient may ask the psychologist to include information that transforms an informational letter into a de facto custody evaluation, in that it includes information designed to influence the court to award custody or favorable visitation to one parent as opposed to the other. Of course, psychologists should avoid making any comment on custody issues that turns an informational letter into a custody evaluation.

Psychologists need to explain the limitations to their services at the start of treatment. The explanation should be given in such a manner that an ordinary patient is likely to have learned the limitations at the start of therapy or as soon as feasible. For example, it is unlikely that the average patient would learn of this policy if it were only embedded in page 6 of an 8-page document that the psychologist told the patient to read.

However, at other times, a psychologist may have the only source of information needed to resolve a forensic case. For example, a psychologist may be treating a patient in therapy who then experiences a serious traffic accident. Only the treating psychologist has direct knowledge of the state of the patient before the accident and

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[1] Appreciation goes to members of the PPA Ethics Committee who reviewed an earlier draft of this article.

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the likely impact of the accident on the mental health of the patient. We can find no law that requires a psychologist to participate in the court case. However, psychologists who refuse to do so may engender the ire of the patient and the court.

Non-Forensic Requests

At other times, psychologists will receive request for records unrelated to forensic purposes. Sometimes current or former patients ask for reports for life insurance applications, security clearances, or for Social Security disability claims. At times, current patients may request an excuse for work leave.

Two types of issues may arise with these requests. First, they are a professional service that takes time for the psychologist. Of course psychologists can charge for the time spent for these services as long as they inform the patients of such charges ahead of time. Many psychologists will write brief letters for no charge, reasoning that it is more burdensome to charge patients for 10 minutes of work, than it is to do the work itself. I have no problem with a psychologist who decides to waive such fees on a case-by-case basis. However, I would recommend that psychologists include the option of billing for such services in their informed consent agreement. I am aware of situations where an apparent simple request for a letter gradually morphed into requests that required psychologists to spend hours doing work without compensation.

Second, these requests can sometimes create conflicts between the psychologist and the patient if the patient does not agree with the content provided by the psychologist. Some psychologists respond to this possibility by refusing to do any reports for patients. Such a policy has advantages and disadvantages. On the one hand, it gets psychologists out of any potential conflict of interest with their patients. On the other hand, most of the requests are routine, but important for the patients, and it can generate ill feelings if psychologists refuse to, for example, complete a life insurance form or a report that allows the patient to get security clearance for a job. Often the patients did not anticipate that they would be making such a request at the time that they started service.

Psychologists should make the policy concerning third-party reports clear in the informed consent procedure. It is not sufficient to embed such a policy deeply in an informed consent agreement without discussing it with the patients ahead of time. Because writing non-forensic reports is commonly done as part of health care services, many patients will feel angry or disappointed that their psychologists have refused to complete such forms unless they were informed of this limitation ahead of time. Consequently, most psychologists I know agree to write such reports. Given the minimal intrusions into the psychologist/patient relationship, and considering the potential negative impact upon the patient, I would recommend that psychologists who decide not to do non-forensic third-party reports highlight that fact prominently in their informed consent agreements.

"Tiger Parenting" in 2014: What Have We Learned?

Samuel Knapp, EdD, ABPP, Director of Professional Affairs

Amy Chua's 2011 book, *The Battle Hymn of the Tiger Mother,* appeared to promote child rearing practices that demanded high academic standards through harsh, uncompromising, and demeaning disciplinary practices. In an article in the *Wall Street Journal* Chua claimed that her "Asian" method of parenting was superior to those of Westernized parents. The proof of the value of tiger parenting, according to Chua, was that her daughter got to perform at Carnegie Hall at the age of 16. However, it was later revealed that much of the *Wall Street Journal* article took portions of her book out of context. In the actual book, Chua describes how she moderated her "tiger" approach in response to the negative impact it was having on her youngest daughter.

The *Wall Street Journal* article set off intense reactions among Asian-Americans as well as non-Asian Americans. Some Asian-Americans resented being stereotyped as persons who were only concerned with overachievement. Other Asian-Americans resented the apparent praise for harsh and unsupportive parenting practices. One critic entitled her blog "Parents like Amy Chua are the reason why Asian-Americans like me are in therapy" (Liu, 2011).

Much has happened to the concept of "tiger parenting" in the last two years. In a 2013 interview Chua clarified her position on parenting. She claimed that she was writing her own personal story and was not trying to act as an expert on parenting in general. She said she welcomes research on Asian-American parenting and believes that "'traditional' Asian parenting often is too harsh and oppressive in a nonproductive way" (Jones, 2013, p. 2).

Also, psychologists have continued their research on parenting practices among Asians and Asian-Americans. The results can be summarized in one sentence: tiger parenting isn't that common and it doesn't work that well. For example, Kim et al. (2013) conducted an eight-year longitudinal study of more than 400 Chinese-American families in Northern California. They had started their research long before Chua's book came out, but they decided that the word "tiger" described one of the parenting styles (authoritarian) that they were researching. Supportive parenting among Chinese parents was similar, but not identical, to supportive parenting in studies of Western parenting. Kim et al. found that children of supportive parents had a higher GPA and better adjustment than children of "tiger" parents. Academic achievement did not come at the price of emotional adjustment. As in other studies, Kim et al. found that "levels of achievement and adjustment are found to go hand in hand" (p. 16).

Other researchers found that parenting among Chinese and Chinese-Americans is changing. Cheath et al. (2013) found that Chinese mothers who emigrated to the United States endorsed standards of discipline stricter than most European-Americans would, yet they commonly used praise and encouragement when raising their children and cared about their overall development, not just academic achievement. Even Chinese mothers in Nanjing (People's Republic of China) gave their children more freedom than they had as children and "were first and foremost concerned about their children's happiness and health" (Way et al., 2013, p. 65). Chen and Li (2012) found that parents in urban China were more likely to encourage their children to take initiative than parents in rural China. They speculated that urbanized Chinese parents realize that their children must act more assertively in order to compete in a market-driven world economy.

What can we conclude from these studies? Any comment about parenting requires a number of disclaimers. Parenting styles are inherently difficult to study, especially because parenting styles change over the lifetime of the child (and the parent) and may even vary considerably from child to child within the same family. Furthermore, the Western notions of distinct types of authoritarian and authoritative parenting as conceptualized by Diane Baumrind (1971) may not capture the nuances and mixture of parenting practices of non-Western families. Even some of the words used to describe parenting in one culture may not translate easily into English, thus making it hard to compare parenting practices across cultures. Although some patterns of effective parenting may be universal, these patterns may be expressed differently by different cultures, depending upon the historical traditions of that culture and the unique social demands placed on the family. Moreover, cultures are not stagnant. Instead, social aspects of culture, such as parenting, change over time as the demands on parents and children change.

The results can be summarized in one sentence: tiger parenting isn't that common and it doesn't work that well.

Until all these methodological issues can be resolved, what advice do Kim and Wang have to give to parents?

We encourage parents to consider using supportive parenting techniques with their children. Being warm, using reasoning and explanation when disciplining

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"TIGER PARENTING" IN 2014

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children, allowing children to be independent when appropriate, and monitoring children's whereabouts and activities are all good parenting strategies. Parents should also ensure that they minimize shouting or yelling at their children . . . expecting unquestioned obedience from their children, and blaming children or bringing up past mistakes (2013, p. 9).

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Is It Ever Ethical to Lie to a Patient?

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

Dr. Samuel Knapp

Dr. John D. Gavazzi

All of us have been taught to speak honestly and refrain from lying. Honesty is part of building trust in a relationship, although it can be important to temper honesty with courtesy and tactfulness. However, is it ever ethical to lie to a patient? Are there certain circumstances in which a psychologist may consider being deceitful with patients? If so, how does this behavior square with our personal values and professional ethics? Consider this situation:

> Dr. Doe receives a phone call from a prospective patient and quickly identifies her as the woman who is having an affair with the husband of one of his current patients. Dr. Doe has an opening and expertise in the area of concern for this prospective patient. However, Dr. Doe wants to avoid the difficulties that would occur if he were to treat this patient.

Ordinarily, Dr. Doe would simply tell the patient he did not think he would be the best fit for her and refer her to another highly competent practitioner in the community. However, this prospective patient had already mentioned, in their brief phone conversation, that she knew he listed relationship issues as one of his areas of proficiency on his website.

What is the solution to this dilemma? Dr. Doe knew of one situation where another psychologist accepted a patient into therapy, only to learn that there were extreme conflicts between her and another existing patient. In that case, the psychologist did not learn of the relationship problems until both patients were well into therapy and the psychologist believed that terminating one or both of them would cause more harm than benefit. However, this psychologist had to monitor her words carefully to ensure she did not allow information obtained from one patient to slip into the conversation when dealing with the other patient. Also, the psychologist had to make sure she scheduled the patients on different days so they did not encounter each other in the waiting room.

Dr. Doe reflected on another situation in which a psychologist found out, well into the course of therapy, that she was treating the hated sister-in-law of one of her current patients. Because the hated sister-in-law was nearly finished with therapy, the psychologist decided to see her for a few more sessions until therapy would end naturally. However, one patient came into the office to reschedule an appointment and ran into the other in the waiting room. The result was not good. Both patients felt betrayed. One patient dropped out of treatment.

These outcomes were on Dr. Doe's mind as he weighed his decisions. What options does he have? Dr. Doe could simply give the patient a vague statement like "there is a conflict of interest that prohibits me from working with you." This vague explanation has the advantage of maintaining honesty on the part of the psychologist. However, it might confuse or upset the prospective patient. Furthermore, the patient might infer the nature of the conflict of interest and the psychologist would

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IS IT EVER ETHICAL TO LIE TO A PATIENT?

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indirectly be telling her that her nemesis was in therapy with Dr. Doe.

Should Dr. Doe lie and say that because of scheduling purposes he was only taking a very few short-time patients and therefore could not see her? It has the advantage of sparing the feelings of the prospective patient and protecting his current patient. However, it is still a lie.

Consider another situation:

> Dr. Jones did an intake on a patient. She was very concerned her patient might die from suicide. This man came from a very impoverished background and took pride in the fact that he was able to pay his debts and live independently, although he was currently struggling financially and would probably drop out of therapy if he had to pay for it. Unbeknownst to the patient, his insurance would not cover most of his mental health costs. After the second session, the patient asked if the insurance covered the services and if he owed anything.

If Dr. Jones told the truth about the insurance, it might increase the likelihood of the patient dropping out of therapy, and increase the likelihood that the patient might attempt suicide. Although Dr. Jones might try to persuade the patient to stay in therapy as a pro bono patient, it is unlikely that the patient would accept that arrangement and would likely feel very offended.

Is it ethical for Dr. Jones to lie and say that nothing was owed? In this situation, Dr. Jones said that his insurance was pretty good and if Dr. Jones thought there were any problems with payment, she would let him know promptly. Dr. Jones told herself that what she said was technically accurate because she used the phrase "if I thought there were any problems . . ." While technically correct, the psychologist clearly deceived the patient. Was Dr. Jones being ethical? If Dr. Jones lied after the second session and treatment continued, would she cause more harm if the patient later found out that Dr. Jones had been lying to him throughout treatment?

There may be other situations where a psychologist may contemplate deceiving a patient for beneficent reasons. If you were Dr. Doe, would you lie to the prospective patient about your schedule? If you were Dr. Jones, would you tell the truth about the limited coverage under his insurance policy? How would you feel about engaging in such behaviors? The goal of this article is to prompt psychologists to reflect on both personal values and professional ethics especially when dilemmas have no easy or "correct" answer.

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2014 CE Calendar

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

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